STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056127	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Rehab Center	537 W Live Oak San Gabriel, CA 91776

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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 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** 48395 Based on observation, interview and record review the facility failed to promote dignity and respect for one (1) of 1 sampled resident (Resident 44) when Certified Nursing Assistant 6 (CNA 6) was observed standing above Resident 44's eye level while assisting the resident during mealtime. This failure had the potential to affect Resident 44's self-esteem and self-worth and violated Resident 44's right to be treated with dignity. Findings: During a review of Resident 44's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of metabolic (the chemical process in the body that creates energy and materials for life) encephalopathy (a general term for brain damage or disease that affects how the brain functions) and generalized muscle weakness (weakness or lack of strength in most muscles throughout the body making it difficult to perform normal movements). During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 12/9/2024, the MDS indicated the resident was moderately impaired (decision poor; cues/supervision required) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 44 was dependent (helper does all of the effort) with personal hygiene and putting on/taking off footwear, needed substantial/maximal assistance (helper does more than half the effort) with upper and lower body dressing (that ability to dress and undress above and below the waist) and needed partial/moderate assistance (helper does less than half the effort) with transfers (how a resident moves to and from bed, chair, wheelchair, standing position) and eating. During a review of Resident 44's Nutritional Status Care Plan, dated 10/25/2024, Resident 44's Nutritional Status Care Plan indicated Resident 44 had difficulty with her nutrition and indicated an intervention for providing assistance with eating as needed. During an observation on 2/18/2025 at 12:35 PM in the hallway outside of Resident 44's room, Resident 44 was observed sitting in her wheelchair with her lunch tray on top of a bedside table in front of her. Resident 44 was being assisted with her meal by CNA 6 who was standing and feeding Resident 44. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/20/2025 at 1:01 PM in the hallway outside of Resident 44's room, Resident 44 was observed sitting in her merry walker (a mobility aid that combines a walker and a wheelchair) with a bedside table placed in front of her. Resident 44 was being assisted by CNA 6 who was standing next to Resident 44 and holding up a cup containing a beige thick liquid to her mouth while Resident 44 drank the contents of the cup. During an interview on 2/21/2025 at 10:45 AM with CNA 6, CNA 6 stated she should not be standing while assisting a resident with feeding and should be eye level with the resident. During an interview on 2/21/2025 at 10:55 AM with the Director of Nursing (DON), the DON stated when staff assist a resident with feeding, regardless of whether the resident was sitting in their wheelchair or merry walker, staff should be sitting down and eye level with the resident for their dignity. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, revised March 2022, the P&P indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals. During a review of the facility's P&P titled, Dignity, revised February 2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P also indicated: a. Residents are treated with dignity and respect at all times. b. When assisting with care, residents are supported in exercising their rights. For example, residents are: a. Provided with a dignified dining experience.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to follow up to ensure a Level 2 Preadmission Screening and Resident Review (Level 2 PASARR, comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has mental disorder [MD-a health condition that affects a person's thinking, mood, behavior, or feelings], intellectual disability [ID-a condition characterized by significant limitations in both intellectual functioning and adaptive behavior that originates before the age of 22] or related condition, determines the appropriate setting for the individual, and recommends what if any, specialized services and/or rehabilitative services the individual needs) was conducted for one of one sampled resident (Resident 79) with a diagnosis of schizophrenia (serious mental illness in which people interpret reality abnormally) as indicated in the facility policy. This failure placed Resident 79 at risk for not receiving care and services in a setting appropriate to resident's needs. Findings: During a review of Resident 79's Admission Record, the Admission Record indicated Resident 79 was admitted on [DATE] with diagnosis of schizophrenia. During a review of Resident 79's Minimum Data Set (MDS, a resident assessment tool), dated 12/11/2024, the MDS indicated Resident 79 had severe impaired cognition (ability to think, reason, and make decisions) for daily decision making. The MDS indicated Resident 79 required setup or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eat. Resident 79 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, personal hygiene, lower body dressing, putting on footwear, sit to stand, and chair to bed transfer. Resident 79 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) to roll left and right, sit to lying down, lying to sitting on side of bed, oral hygiene, and upper body dressing. During a concurrent observation and interview on 2/19/2025 at 1:06 PM in Resident 79's room, with Certified Nursing Assistant 7 (CNA7), Resident 79 was observed laying down in his bed, his head laid on the foot of the bed, and his feet were laying on the head of the bed. Resident 79 was curled up in fetal position, and his lunch tray remained untouched against the wall on a bedside table. The CNA7 stated Resident 79 gets confused, can get aggressive, and sometimes grabs her arm while she's trying to provide care. CNA7 stated, Resident 79 refuses care sometimes and does not want to comply with completing activities of daily living (ADLs). During an interview on 2/19/2025 at 4:05 PM with the Director of Staff Development (DSD), the DSD stated Resident 79 is very combative, refuses care a lot of times, will start eating then stops eating all together, is difficult to communicate with, and gets aggravated with anything so fast, that they have to approach him in a certain way to prevent getting him upset. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/2025 at 10:14 AM with the Director of Nursing (DON), the DON stated Resident 79 had been evaluated for a PASARR Level 1 on 5/19/2024 at the hospital where he was admitted which indicated Resident 79 required a Level 2 Mental Health Evaluation. The DON stated when Resident 79 returned to the facility, after hospitalization , the facility failed to contact the agency responsible for conducting Level 2 PASRR for further evaluation as indicated. The DON stated failing to follow up on the Level 2 PASRR placed Resident 79 at risk for unmet needs because the facility did not have recommendations on what type of care and outside services were needed to care for Resident 79 who had a diagnosis of schizophrenia and was taking a psychotropic (drugs/medications that affect a person's mental state) medication for mental illness. The DON stated after the Level 1 PASRR was performed, the Level 2 PASRR is usually performed within one week. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASARR), dated 6/2024, the P&P indicated if a Level 2 evaluation is necessary, the facility will assist the contractor with additional information, face-to-face visit for further evaluation, review available information from the PASARR online system regularly to follow up on Level determination/ recommendations, document and maintain the records.

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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** 46919 Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan (a document that outlines the facility's plan to provide personalized are to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) to reflect a pharmacological intervention (refers to the administration of medication to treat or prevent a disease or illness) for pain for one of 20 sampled residents (Resident 197) in accordance with the resident's physician order. This deficient practice resulted in inadequate pain management and interventions for Resident 197. Findings: During a review of Resident 197's Admission Record, the Admission Record indicated Resident 197 was initially admitted to the facility on [DATE] with diagnoses that included fracture (a crack of break in a bone that occurs when there is too much force applied to it) of upper and lower end of right fibula (calf bone), other displaced fracture of upper end of right humerus (the long bone of the upper arm that extends from the shoulder to the elbow), displaced (when the broken bone pieces move out of alignment) fracture of olecranon (the bone at the back of the elbow that forms the elbow's outer bump) process without intra-articular extension (a fracture that extends into a joint) of right ulna (the bigger of two bones in the forearm, located on the pinkie side), and unspecified fracture of the lower end of right radius (the smaller of two bones in the forearm, located on the thumb side) and lower end of right ulna. During a review of Resident 197's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 197 was independent with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 197 required substantial/maximal assistance (helper does more than half the effort) with shower/bathe self, upper/lower body dressing, personal hygiene, sit to lying, sit to stand, and toile transfer. Resident 197 was dependent (helper does all of the effort) with putting on/taking off footwear. Resident 197 was assessed to have pain almost constantly which occasionally made it hard for her to sleep at night. Resident 197 was assessed having frequently limited day-to-day activities because of pain. During a review of Resident 197's Order Summary Report, dated 2/19/2025, the Order Summary Report indicated a physician order the following orders: Fentanyl (a potent synthetic pain medication used to treat chronic severe pain or severe pain following surgery) Patch 72 hour 25 micrograms (mcg-unit of measurement)/hour (hr), apply 1 patch transdermally (through the skin) every 72 hours for pain for 14 days, rotate site and remove per schedule with a start date of 2/4/2025. (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 with Resident 197 in her room on 2/18/2025, at 11:12 AM, Resident 197 was observed lying in bed, rubbing her right leg, grimacing, and teary. Resident 197 stated her pain was 11 out of 10 and needed her Fentanyl patch and her Norco. Resident 197 stated Licensed Vocational Nurse 1 (LVN 1) did not apply a new Fentanyl patch after LVN 1 removed the old Fentanyl patch at around 9AM. During a concurrent interview and record review with Infection Prevention Nurse 1 (IPN 1) on 2/20/2025, at 10:21 AM, the care plan with focus on Resident 197's potential for alteration in comfort/pain related to fracture, arthritis (a group of conditions that cause inflammation and pain in the joints), migraine (severe, throbbing or pulsating headaches that typically occur on one side of the head) , positioning discomfort, rehabilitation therapy, and gout (a type of arthritis that causes sudden and severe pain and swelling in the joints caused by a buildup of uric acid in the joints) was reviewed. IPN 1 stated Resident 197 was ordered for Fentanyl patch every 72 hours on 2/4/2025 for severe pain. IPN 1 stated Resident 197's Fentanyl patch was a strong medication for pain that continuously released the medication once applied to the skin. IPN 1 stated the Fentanyl patch had special handling instructions that needed to be followed for the safety of Resident 197 and facility staff. IPN 1 stated Resident 197's care plan was not and should have been revised on 2/4/2025 after the Fentanyl was ordered. IPN 1 stated Resident 197's care plan for pain did not include Fentanyl and how it should be handled and administered to Resident 197. IPN 1 stated it was the responsibility of all licensed staff to update and revise Resident 197's care plan if there are any new interventions such as use of new pain medication. During an interview with the Director of Nursing (DON), on 2/21/2025, at 11:15 AM, the DON stated Resident 197's care plan should have been updated to include her Fentanyl patch as soon as it was ordered by the physician on 2/4/2025. The DON stated it was important for the care plan intervention to include the side effects of Fentanyl, possible reactions from the medication, assessing the effectiveness of the medication, protecting the resident and staff from unnecessary contact with the medication, and safe handling of the Fentanyl. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised on 3/2022, the P&P indicated the assessment of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 60), who was a non-English speaking resident had access to a communication board (a visual tool that displays pictures, symbols, or illustrations, allowing individuals with limited verbal communication abilities to express themselves by pointing to the images to convey their needs, wants, or thoughts; essentially acting as a bridge for communication through visual cues instead of spoken words.) or translation services. This failure placed Resident 60 at risk for unmet needs which may have led to increased distress and a decline in psychosocial well-being. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was admitted on [DATE] with diagnosis of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities) and that resident's primary language was not English. During a review of Resident 60's Minimum Data Set (MDS, resident assessment tool), dated 1/6/2025, the MDS indicated Resident 60 had severely impaired cognitive (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 60 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to carry out activities of daily living (ADLs). The MDS indicated Resident 60 was rarely able to make self-understood and understand others. During a review of Resident 60's Care Plan, dated 12/4/2024, the care plan indicated Resident 60 was at risk for having needs unmet related to difficulty in communication. Staff interventions included were to use a communication board in the Resident's language or use a staff member to translate in the Resident's language as needed. During a concurrent observation and interview on 2/19/2025 at 12:46 PM in Resident 60's room, with Certified Nursing Assistant 8 (CNA8), Resident 60 was observed holding her right hand to cover her right eye and had a bruise (a discoloration of the skin that occurs when small blood vessels break) on her left hand. CNA8 attempted to communicate with Resident 60 by using hand gestures and pointing to Resident 60's left hand where she had a bruise and asking Resident 60 if she had pain on her eye using the English language. Resident 60 did not respond and looked confused. CNA8 stated Resident 60 did not speak English and it was difficult to communicate with her. CNA8 stated Resident 60 was always contracted (a condition that causes a loss of movement in the joints of the arms or legs. They can occur due to a number of conditions, including injuries, neuromuscular diseases, and prolonged inactivity), but she had not noticed the bruise on her hand this morning during care and that her eye was teary a lot of times. CNA8 tried to look for a communication board in the room, but no communication had been provided to Resident 60. CNA8 did not seek staff who spoke the Resident's language to help translate for Resident 60. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 9:49 AM, the Director of Staff Development (DSD) stated the staff member who speaks the Resident's language was out with a resident for an appointment, and no other staff member was at the facility to help translate for Resident 60. The DSD stated staff could use communication boards or google assist to help translate. During an interview on 2/20/2025 at 11:10 AM with the Director of Nursing (DON), the DON stated staff is the number one resource for providing interpretive services to residents, and that Resident 60 required more of a human approach for communicating due to her complex medical conditions to meet her needs. The DON stated, although not all staff members have been in serviced on using translation services, the CNAs should use the resources available to communicate with residents who do not speak English and require translation. The DON stated every resident should at least have a communication board in the room. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Supporting, dated March 2018, the P&P indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with communication (speech, language, and any functional communication systems).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility staff failed to provide nail care (the practice of keeping resident's fingernails clean, short, and properly trimmed) for one of one sampled resident (Resident 80), who needed total physical assistance with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands). This deficient practice had the potential to place Resident 20 at risk for increased risk for infection, skin breakdown around the nails and potential complications. Findings: During a review of the admission record, the admission record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain tissue), respiratory failure (a serious medical condition where the lungs are unable to adequately exchange gases, leading to insufficient oxygen levels in the blood [hypoxemia- low oxygen in blood]) unspecified whether with hypoxia (a condition where there is an inadequate supply of oxygen to the body), unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain). During a record review of Resident 80's History and Physical (H&P), dated 4/27/2024, the H&P indicated Resident 80 does not have the capacity to understand and make decisions. During a review of Resident 80's Minimum Date Set (MDS -resident assessment tool), dated 12/25/2024, the MDS indicated Resident 80 is in need of dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) for oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 80's care plan, initiated on 4/26/2024, the care plan indicated Resident 80 has self-care deficits needs from extensive to total assistance with Activities of Daily Living (ADLs- referring to basic personal care tasks like bathing, dressing, eating, toileting, transferring, getting in and out of a chair or bed, and walking, which are used to assess a resident's functional ability and determine the level of care they need within the facility) related to cognitive deficits (impairments in their cognitive abilities, such as problems with memory, thinking, reasoning, decision-making, or understanding, which can affect their daily functioning and require additional care support), communication deficits, joint limitation, muscular weakness, poor balance, poor safety awareness. The care plan indicated interventions are to assist with ADLs as needed and assist with grooming and trimming of fingernails. During initial observation of Resident 80 on 2/18/2025 at 9:52 AM, Resident 80 was resting in bed, eyes open but unable to speak. Observed Resident 80's both hands to be contracted (a condition that can cause one or more fingers to curl toward the palm, making it difficult to straighten them) and fingernails to be short with a brown color crust around the nailbed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of Resident 80 on 2/19/2025 at 1:12 PM, Resident 80 was resting in bed. Observed Resident 80's nails to be dirty with thick brown crust around nail bed (similar to what was observed on 2/18/2025 at 9:52 AM). During an interview with Family (F1) on 2/18/25 12:42 PM, F1 stated she visited Resident 80 often and noticed that Resident 80's fingernails are not being cleaned or washed daily and have fungus (are decomposers that get their food from dead and decaying matter. Fungi are found in many places, including soil, water, air, and on and in plants and animals and some fungi can be harmful to humans. Fungal infections can range from mild to life-threatening). During an interview with the Director of Nursing (DON) on 2/19/2025 at 1:15 PM, the DON stated the certified nursing assistants (CNAs) are responsible for providing ADL care including cleaning nails for all the residents in the facility including the residents that are on hospice care (a type of specialized medical care that focuses on providing comfort and support to people who are nearing the end of their lives). The DON stated it is unacceptable to leave a resident with dirty nails and it could cause an infection and harm to the resident. The DON also stated the CNAs are extra support for residents on hospice care and need to clean their nails as needed. During a review of the facility's policy and procedure (P&P) titled, Care of Fingernail/Toenails, revised 2/2018, the P&P indicated that the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy also indicated review the resident's care plan to assess for any special needs of the resident which includes daily cleaning and regular trimming, removing the dirt from around and under each nail with an orange stick. The policy indicated proper nail care can aid in the prevention of skin problems around the nail bed. During a review of the facility's P&P titled, Supporting Activities of Daily Living (ADLs), revised 3/2018, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy also indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to assess and provide specific resident preferred activities and interests for one of one sampled resident (Resident 39). This deficient practice had the potential to negatively affect Resident 39's sense of self-worth and psychosocial well-being Findings: During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included hemiplegia affecting right dominant side (paralysis or weakness affecting the right side of the body), unspecified sequelae of nontraumatic intracerebral hemorrhage (deficit that occurs after a brain bleed), and aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language). During a review or Resident 39's MDS, dated [DATE], the MDS indicated it was very important for Resident 39 to do his favorite activities, listen to music he liked, have books/newspapers/and magazines to read, and keep up with the news while he was in the facility. The MDS also indicated it was somewhat important for Resident 39 to do things with groups of people. During a review of Resident 39's Minimum Data Set (MDS- a resident assessment tool), dated 1/22/2025, the MDS indicated Resident 39 was assessed having modified independence (some difficulty in new situations only) with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 39 required setup or clean-up assistance with eating. Resident 39 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 39's care plan, , revised 12/30/2024, the care plan indicated Resident 39 was a younger resident. Activity participation challenged by limited time out of bed related to (r/t) due to medical condition. Need for social and sensory stimulation r/t unable to make needs known. Resident 39's care plan indicated the following interventions: > Identify lifestyle activities of daily living (ADLs - routine tasks/activities such as bathing, dressing, and toileting as Resident performs daily to care for themselves) > Allow to attend activities r/t lifestyle ADL > Conduct rounds to monitor activity needs and offer appropriate interventions During a review of Resident 39's care plan, dated 7/23/2024, revised 12/30/2024, the care plan indicated Resident 39 was younger than the majority of other residents in the facility. Resident 39's care plan indicated to assess resident for activities of interest and to provide activities appropriate for resident's age. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 39's Activity Assessment, dated 7/6/2024, the Activity Assessment indicated Resident 39's current activity preference included music (independent), reading/writing (independent), watch television (independent) and talking/conversing (independent). During a concurrent observation and interview with Resident 39 in his room, on 2/18/2025, at 9:43 AM, Resident 39 was in bed using his electronic device (iPad) and watching television. Resident 39 refused to speak but shook (to move the head from side to side to indicate disagreement or refusal) or nodded (to move head up and down to indicated agreement, understanding, or approval) his head when asked questions. Resident 39 shook his head when asked if he participated in activities. Resident 39 shook his head when asked if he went to the Activity Room. Resident 39 nodded when asked if he wanted to participate in activities. During a follow up interview with Resident 39 in his room, on 2/19/2025, at 2:38 PM, Resident 39 stated he does not go to the Activity Room or participate in activities because there is nothing to do there. Resident 39 stated the Activity Director did not offer him activities for his age. During an interview with Certified Nursing Assistant 1 (CNA 1), on 2/19/2025, at 2:56 PM, CNA 1 stated Resident 39 always refused to participate in activities or go to the Activity Room when he was asked. CNA 1 stated most residents who participate in activities were older. CNA 1 stated Resident 39 might be interested in activities that were more appropriate for his age. During a concurrent interview and record review with Activities Director (AD), on 2/19/2025, at 3:11 PM, Resident 39's Activity Assessment, dated 7/9/2024, was reviewed. AD stated Resident 39 was one of the younger residents in the facility. AD stated she completed Resident 39's Activity Assessment form on 7/9/2024 but did not ask Resident 39 what specific activities he wanted to do. AD stated she did not know that Resident 39 refused to go to the Activity Room because he felt there was nothing to do there. AD stated staying in the room all day can cause Resident 39 to feel bad about being in the facility. AD stated Resident 39's specific activity preference should be identified to help make him feel good about himself. During an interview with the Director of Nursing (DON), on 2/21/2025, at 11 AM, the DON stated it was important for activities to be specific to Resident 39's age and ethnicity (a way to describe a group of people who share a common culture, such as language, religion, traditions, and ancestry). The DON stated Resident 39's preferred activities and interests should be assessed yearly. The DON stated the facility did not and should have a policy regarding activities and assessing the residents preferred activities yearly. The DON stated it was important for residents to engage in activities and socialize with other residents for stimulation and to prevent decline. The DON stated activities in the facility should be personalized and feed the interests of the residents. During a review of the Job Description for the Activity Director/Coordinator, dated 1/27/2022, the Job Description, under essential duties and responsibilities, included the following: > Interviews and evaluates each resident, as well as family, friends, or responsible party, to determine his/her background, interests, abilities, physical limitations, and needs for the purpose of planning and implementing a meaningful program. > Ensures residents are brought to all appropriate activities and that every Resident has a reasonable and adequate activity plan. (continued on next page)

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F 0679 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, Dignity, revised on 2/2021, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated the facility culture supports the dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. The individual needs and preferences of the resident are identified through the assessment process. During a review of the P&P titled, Accommodation of Needs, revised on 3/2021, the P&P indicated the following: > Our facility's environment and staff behaviors are directed toward assisting the Resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. > The Resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to ensure that one of five (5) sampled residents (Resident 79), who was experiencing significant weight loss, received Restorative Nursing Assistant (RNA-helps patients regain their ability to perform daily tasks after an illness or injury. They work in long-term care settings like nursing homes and rehabilitation centers) feeding assistance as ordered by physician and that staff accurately and timely documented Resident 79's nutritional intake on 2/18/2025 and 2/19/2025. This failure had the potential for Resident 79 for inadequate nutrition and hydration (the process of replacing water in the body) causing further weight loss. Findings: During a review of Resident 79's Admission Record, the admission record indicated resident was admitted on [DATE] with diagnosis of metabolic encephalopathy (A problem in the brain caused by a chemical imbalance in the blood. The imbalance is caused by an illness or organs that are not working as well as they should. It is not caused by a head injury. When the imbalance affects the brain, it can lead to personality changes), cancer of the rectum, dementia (a progressive state of decline in mental abilities), and hemiparesis (one-sided muscle weakness caused by a disruption of the brain, spinal cord, or nerves connected to the affected muscles) affecting right dominant side. During a review of Resident 79's Minimum Data Set (MDS- resident assessment tool), dated 12/11/2024, the MDS indicated Resident 79 required set up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating. The MDs indicated Resident 79 had severe impairment with cognitive skills (ability to think, reason, and make decisions) for daily decision making. The MDS indicated Resident 79 weighed 122 pounds (lbs- a measure of weight). Resident 79 had a weight loss more than 5 percent in the last month or loss of 10 percent or more in the last six months. Resident 79 was on a therapeutic (low salt, low cholesterol, diabetic [a healthy eating plan focused on managing blood sugar levels by prioritizing whole foods like fruits, vegetables, whole grains, lean proteins, and low-fat dairy, while limiting added sugars, refined carbohydrates, and saturated fats, essentially aiming for a balanced diet with controlled portion sizes and consistent meal times to maintain stable blood glucose level]) diet, and required a change in texture of food or liquids. During a review of Resident 79's Progress Notes, dated 2/14/2025, by the Registered Dietician (RD), the progress notes indicated Resident 79's current body weight was 113 pounds. The Progress Notes indicated Resident 79 had lost seven (7 lbs) in one month, and 20 lbs in 3 months, and Ideal Body Weight range should be between 112-136 lbs. During a review of resident 79's order summary, dated 2/4/2025, the order summary indicated Resident 79 was on a Restorative Nursing Assistance (RNA) feeding program for breakfast and lunch for weight management. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 79's Interdisciplinary Team (IDT-a group of professionals from different fields who work together to address a complex issue by combining their unique expertise and knowledge, often collaborating to provide comprehensive care for a patient or client, considering all aspects of their needs) Weight Management Care Plan, dated 2/9/2025, the care plan indicated Resident will consume 80-100% of the diet ordered daily for three months. During a review of Resident 79's Nutritional Amount Eaten, dated 2/20/2025, the report indicated Resident 79 had eaten 100 percent of his lunch meal on 2/18/2025. No nutritional intake was found in the Resident's record for 2/19/2025. During an interview on 2/19/2025 at 1:06 PM with Certified Nursing Assistant 7 (CNA7), CNA7 stated she was assigned to Resident 79 on 2/18/2025 and remembers Resident 79 eating about 75 percent of his lunch tray but could not remember exactly how much he ate because she was switched assignments various times and could not remember if she was even assigned to Resident 79. CNA7 stated she was not aware that Resident 79 was having weight loss, and believed he was eating ok, but had not assisted him in eating on 2/18/2025 because he can do it on his own. CNA7 stated Resident 79 gets confused, can get aggressive, and sometimes grabs her arm. CNA7 was not aware that Resident 79 was on the RNA feeding program. CNA7 stated she had not assisted Resident 79 to eat, nor cue him to encourage him to eat his lunch because Resident 79 speaks a non-English language, and CNA7 does not. During an interview on 2/19/2025 at 3:15 PM with the RD, the RD stated Resident 79 has rectal cancer (a type of cancer that develops in the rectum) and is on weight management due to unplanned significant weight loss over the last six months. The RD stated she reviews the nurse's documentation regarding nutritional intake and the nurses should notify her when residents have poor oral intake. The RD stated the staff should be with Resident 79 to assist him to eat, and that is why he was placed on the RNA feeding program for breakfast and lunch to ensure he would meet nutritional needs and prevent further weight decline. During an interview on 2/19/2025 at 3:51 PM with the Registered Nurse Supervisor 1 (RNS1) the RNS 1 stated the purpose of Resident 79 being on the RNA feeding program is to provide him with cueing and encouragement to eat his meals, even if he can independently feed himself, someone should be there to ensure he is eating, offer him snacks, and document the amount he eats to measure his progress. During a concurrent interview and review on 2/20/2025 at 9:10 AM with the Director of Staff Development (DSD), the DSD stated CNA8 forgot to enter Resident 79's percentage eaten for breakfast and lunch on 2/19/2025. The DSD confirmed Resident 79 had received meals; however, the lack of documentation made it impossible to verify whether the resident was meeting daily nutritional requirements. The DSD stated failure to properly document and monitor nutritional intake had the potential to compromise the resident's health, weight maintenance, and placed him at risk for unmet dietary needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/2025 at 10:45 AM with the RNA1, the RNA 1 stated during morning huddle she gets a list of residents who are on the RNA1 feeding program and require assistance during breakfast and lunch. The RNA1 stated she was assigned to Resident 79 on 2/18/2025, but she was feeding other residents in the dining room and was not able to assist Resident 79 at lunch time, however, when she went to check on Resident 79 in his room at around 12:45 PM, she noticed Resident 79 only ate about 10 percent of his lunch. The RNA1 stated she did not relay this information to CNA7 so that she could document this on resident's chart. The RNA1 stated she did not report Resident 79's 10% intake on 2/18/2025 to a licensed nurse, or that she was unavailable to assist Resident 79 to eat his lunch. During an interview on 2/21/2025 at 11:26 AM with the Director of Nursing (DON), the DON stated inadequate documentation of feeding assistance, staffing assignments not aligning with resident needs, and lack of consistent oversight in RNA implementation placed Resident 79 at risk for further weight loss and associated health complications. The DON stated it is important to document in real time to monitor resident's intake, progress, and to prevent further decline. The DON stated staff were required to monitor and record meal consumption to ensure appropriate dietary intake and identify any concerns regarding weight loss or nutritional deficiencies. During a review of the facility's undated policy and procedure (P&P) titled, Restorative Feeding Program-Promoting Nutritional Status, the P&P indicated the Restorative Feeding Program is to be conducted by certified RNAs and should include helping the resident set up the meal tray, explain the feeding procedure to the resident, provide verbal cues, and document the meal percentage after the meal. During a review of the facility's P&P titled, Nutrition Impaired/ Unplanned Weight Loss-Clinical Protocol, dated 9/2017, indicated the staff will monitor nutritional status, an individual's response to interventions, and possible complications. When medical conditions contribute to altered nutritional status, the staff will adjust interventions, considering the resident's goals, wishes, prognosis, and complications.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to assess and manage the resident's pain timely and effectively for one of one sampled resident (Resident 197) when the licensed nurses failed to: 1. Ensure the licensed nursing staff assessed Resident 197's potential to have pain after the Fentanyl patch was removed. 2. Reorder Fentanyl (a potent synthetic pain medication used to treat chronic severe pain or severe pain following surgery) five days in advance per facility policy 3. Implement Resident 197's care plan (a document that outlines the facility's plan to provide personalized are to a Resident that includes measurable objectives and timeframes to meet a Resident's medical, nursing, and mental and psychosocial needs) interventions to address and manage resident's pain. This deficient practice resulted in Resident 197 not receiving pain medication as scheduled and experience unnecessary pain. Findings: During a review of Resident 197's Admission Record, the Admission Record indicated Resident 197 was initially admitted to the facility on [DATE] with diagnoses that included fracture (a crack of break in a bone that occurs when there is too much force applied to it) of upper and lower end of right fibula (calf bone), other displaced fracture of upper end of right humerus (the long bone of the upper arm that extends from the shoulder to the elbow), displaced (when the broken bone pieces move out of alignment) fracture of olecranon (the bone at the back of the elbow that forms the elbow's outer bump) process without intra-articular extension (a fracture that extends into a joint) of right ulna (the bigger of two bones in the forearm, located on the pinkie side), and unspecified fracture of the lower end of right radius (the smaller of two bones in the forearm, located on the thumb side) and lower end of right ulna. During a review of Resident 197's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 197 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 197 required substantial/maximal assistance (helper does more than half the effort) with shower/bathe self, upper/lower body dressing, personal hygiene, sit to lying, sit to stand, and toile transfer. Resident 197 was dependent (helper does all of the effort) with putting on/taking off footwear. Resident 197 was assessed to have pain almost constantly which occasionally made it hard for her to sleep at night. Resident 197 was assessed having frequently limited day-to-day activities because of pain. During a review of Resident 197's Order Summary Report, dated 2/19/2025, the Order Summary Report indicated a physician order the following orders: a. Pain management consult and treatment as needed with a start date of 1/29/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Pain assessment (0= no pain), (1-3= mild pain), (4-6= moderate pain), (7-9= severe pain), (10= very severe pain) every four hours for pain management related to (r/t) multiple fractures with a start date of 2/1/2025. c. Fentanyl Patch 72 hour 25 micrograms (mcg-unit of measurement)/hour (hr), apply 1 patch transdermally (through the skin) every 72 hours for pain for 14 days, rotate site and remove per schedule with a start date of 2/4/2025. d. Norco (a pain medication used to relieve moderate to severe pain) oral tablet 10-325 milligrams (mg- unit of measurement) give 1 tablet by mouth every six hours as needed for severe pain (7-10) with a start date of 1/30/2025. During a review of Resident 197's Medication Administration Record (MAR), dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 197's Fentanyl Patch was removed on 2/18/2025, at 9:23 AM. The MAR indicated the replacement Fentanyl Patch was not applied on 2/18/2025, at 9 AM. During a review of Resident 197's Pain Risk Assessment, dated 1/29/2025, the Pain Risk Assessment indicated a total pain risk score of 19 (a total score of above 10 indicated high risk for potential pain, a prevention protocol should be initiated immediately and documented in the plan of care). During a review or Resident 197's Progress Note, dated 2/18/2025, at 9:42 AM, the Progress Note indicated, out of Fentanyl Patch 25 mcg/hr apply 1 patch transdermally every 72 hours for pain for 14 days. It also indicated pharmacy was notified and the Fentanyl patch was on its way now and should be at the facility shortly. During a concurrent observation and interview with Resident 197 in her room on 2/18/2025, at 11:12 AM, Resident 197 was observed lying in bed, rubbing her right leg, grimacing, and teary. Resident 197 stated her pain was 11 out of 10 and needed her Fentanyl patch and her Norco. Resident 197 stated Licensed Vocational Nurse 1 (LVN 1) did not apply a new Fentanyl patch after LVN 1 removed the old Fentanyl patch at around 9AM. Resident 197 stated she asked facility staff (not identified) for pain medication, but no one came to her room to administer it. During an observation in Resident 197's room on 2/18/2025, at 11:18 AM, the Infection Prevention Nurse 1 (IPN 1) entered Resident 197's room. Resident 197 informed IPN 1 she needed her Norco and asked for her Fentanyl patch. IPN 1 stated she will notify LVN 1. During an observation in Resident 197's room on 2/18/2025, at 11:20 AM, IPN 1 and LVN 1 entered the room. Resident 197 was crying and informed IPN 1 and LVN 1 she needed her Fentanyl patch and Norco. Resident 197 informed IPN 1 and LVN 1 her Fentanyl patch was not replaced after the old one was removed. During an interview with IPN 1 and LVN 1 on 2/18/2025, at 11:29 AM, LVN 1 stated Resident 197's Fentanyl patch was removed at 9 AM as ordered. IPN 1 stated the facility did not have Resident 197's Fentanyl patch. IPN 1 stated Resident 197's replacement Fentanyl patch has not been delivered by the pharmacy. LVN 1 stated she did not administer Resident 197's Norco upon learning the replacement Fentanyl patch was not available because Resident 197 did not complain of pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with IPN 1 on 2/20/2025, at 10:21 AM, IPN 1 stated it was the responsibility of the charge nurse who last administered the Fentanyl patch to order the medication from the pharmacy. IPN 1 stated Resident 197's Fentanyl patch should have been ordered from the pharmacy on 2/15/2025 when the last patch was administered. IPN 1 stated Resident 197's Fentanyl patch was not ordered until 2/18/2025 at around 9 AM. IPN 1 stated LVN 1 should have reassessed Resident 197's pain 30 minutes to an hour after her Fentanyl patch was removed because the efficacy of Fentanyl wears out over time. IPN 1 stated LVN 1 should have offered Resident 197 Norco 30 minutes to an hour after the Fentanyl patch was removed. IPN 1 stated Resident 197's care plan for pain which included monitoring the signs and symptoms (s/sx) of pain and administering medications as ordered was not followed. During an interview with the Director of Nursing (DON), on 2/51/2025, at 11:15 AM, the DON stated the Fentanyl patch should have been ordered when there was only one patch remaining in Resident 197's medication cart. The DON stated it was not acceptable for Resident 197's to receive her Fentanyl patch five hours later than the scheduled time. The DON stated Resident 197's pain should have been reassessed 30 minutes after the Fentanyl patch was removed. The DON stated Resident 197 could suffer from rebound pain (when pain comes back worse after pain medication wears off) since the Fentanyl patch was not replaced after it was removed. The DON stated it was not acceptable that Resident 197 had to wait two hours to get her Norco pain medication. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy, dated 4/2008, the P&P indicated medications and related products are received from the dispensing pharmacy on a timely basis. The P&P further indicated to reorder medication five days in advance of need to assure an adequate supply is on hand. During a review of the facility's P&P titled, Pain Assessment and Management, revised on 3/2020, the P&P indicated the following: > The purpose of this procedure re to help the staff identify pain in the resident, and to develop intervention that are consistent with the resident's goals and needs and that address the underlying causes of pain. > The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choice related to pain management. > Pain management is defined as the process of alleviating the Resident's pain based on his or her clinical condition and established treatment goals. > Pain management is a multidisciplinary care process that includes the following: a) Assessing the potential for pain. b) Addressing the underlying causes of the pain. c) Modifying approaches as necessary. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> Acute pain (or significant worsening of chronic pain) should be assessed every 30 minutes after the onset and reassessed as indicated until relief is obtained. > In recognizing pain, the P&P indicated to review the medication administration record to determine how often the individual requests and receives as needed (PRN) pain medication, and to what extent the administered medications relieve the resident's pain.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to provide trauma-informed care (an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma and recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans [a document that outlines the facility's plan to provide personalized care to resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs] to avoid re-traumatization [when stress reactions experienced as a result of a previous traumatic event are relived when faced with a new similar incident]) for one of 20 sampled residents (Resident 71) who was diagnosed with post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). This deficient practice had the potential for Resident 71 to experience re-traumatization that could lead to severe psychosocial harm and negatively affect her quality of life. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated Resident 71 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and PTSD. During a review of Resident 71's History and Physical (H&P), dated 10/6/2024, the H&P indicated Resident 71 had a past medical history (PMH) of sexual assault (sexual contact or behavior that occurs without explicit consent of the victim). During a review of Resident 71's Minimum Data Set (MDS- a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 71 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 71 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing, personal hygiene and sit to lying. Resident 71 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, lower body dressing, sit to stand, and toilet transfer. During a concurrent observation of Resident 71 in her room and interview with Certified Nursing Assistant 5 (CNA 5) on 2/18/2025, at 10:11 AM, Resident 71 was observed covering her face with her left hand while speaking to CNA 5. Resident 71 reminded CNA 5 to make sure she closed the curtains before CNA 5 leaving the room. CNA 5 stated she was unsure why Resident 71 spoke to her with her face covered. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 4 on 2/20/2025, at 12:13 PM, CNA 4 stated was familiar with Resident 71 and has been assigned to her more than once. CNA 4 stated Resident 71 wanted to always have her curtains drawn and wanted a female staff assigned to her. CNA 4 stated Resident 71 disliked hearing male voices. CNA 4 stated she did not know Resident 71 had a history of PTSD. CNA 4 stated she was not informed of Resident 71's triggers (anything including sound, sight, smell, or thought that is a reminder of a traumatic event). CNA 4 stated it was important that Resident 71's triggers be communicated with staff caring to increase awareness and to lessen Resident 71's stress. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 2/20/2025, at 12:30 PM, LVN 2 stated caring for Resident 71 on more than once occasion. LVN 2 stated Resident 71 did not like men in her room and was always bothered by the light. LVN 2 stated she was never informed of Resident 71's PTSD diagnosis and her triggers. LVN 2 stated it was important to know Resident 71's triggers to avoid disturbing and stressing Resident 71. LVN 2 stated Resident 71 should have a care plan about her PTSD diagnosis and her triggers, so staff knows how to properly care for Resident 71. During a concurrent interview and record review, on 2/20/2025, at 12:30 PM, with Social Services Director (SSD), SSD stated Resident 71's trigger males. SSD stated Resident 71 would also get triggered outside of the facility during her outside appointments. SSD stated Resident 71 does not talk about her triggers to the facility staff. SSD stated Resident 71's daughter was the one who provided SSD information regarding Resident 71's PTSD and triggers. SSD stated Resident 71 did not have a trauma assessment (a comprehensive evaluation of how a person has been impacted by a traumatic event) specifically for PTSD. SSD stated she did not know Resident 71 had a PMH of sexual assault. During the same concurrent interview and record review, on 2/20/2025, at 12:30 PM, SSD stated Resident 71 did not have a care plan specifically for PTSD and her triggers. SSD stated it was important for Resident 71 to have a care plan for PTSD to inform the staff of Resident 71's triggers and diagnoses. SSD stated it was important to prevent triggers and retraumatization for Resident 71. During an interview with the Medical Records Director (MRD) on 2/20/2025, at 3:30 PM, the MRD stated Resident 71 did not have an interdisciplinary team (IDT- a group of healthcare professionals who work together to help residents receive the care they need) meeting for PTSD. During an interview with the Director of Nursing (DON) on 2/21/2025, at 11:09 AM, the DON stated the facility should have had an IDT meeting regarding Resident 71's PTSD. The DON stated Resident 71's PTSD diagnosis should have been care planned by facility staff. The DON stated Resident 71's triggers should have been communicated to licensed staff directly involved in her care to prevent her traumas from coming back. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring, revised on 3/2019, the P&P indicated: 1. The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. 4. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: a. the resident's usual patterns of cognition, mood, and behavior. b. the resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts. c. the resident's typical or past responses to stress, fatigue, fear, anxiety, frustrations and other triggers; and d. the resident's previous patterns of coping with stress, anxiety (a feeling of fear, dread, and uneasiness), and depression 5. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the Resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to follow the physician's order to Give with food when administering Oyster Shell Calcium/D tablet (medication used to prevent or treat low blood calcium levels in people who do not get enough calcium from their diets) for one of two sampled residents (Resident 54). This failure increased the risk for Resident 54 to experience adverse reactions and or reduced effectiveness of the medication. Findings: During a review of Resident 54's Admission Record, dated 2/20/2025, the admission record indicated Resident 54 was admitted on [DATE], with diagnosis of dementia (a progressive state of decline in mental abilities) and multiple fractures of ribs and vertebra (bone and cartilage that form the spine). During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool), dated 11/27/2024, the MDS indicated Resident 54 had mildly impaired cognitive (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 54 required set up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating. During a review of Resident 54's Order Summary Report, dated 2/20/2025, the order summary report indicated Oyster Shell Calcium/D tablet 500-5 milligram-microgram (unit of mass) give one tablet by mouth one time a day for bone supplement Give with food. During a concurrent observation and interview on 2/19/2025 at 9:05 AM in Resident 54's room, with Licensed Vocational Nurse 2 (LVN 2), the LVN 2 stated she was passing scheduled medications to Resident 54, and the last time Resident 54 had food was at 7:30 AM for breakfast. LVN 2 stated she was giving Resident 54 the Oyster Shell Calcium/D tablet without food since she had already eaten at 7:30 AM, and believed Resident 54 didn't need any food. LVN 2 did not ask Resident 54 to take her medication with food, as ordered by physician. During an interview on 2/19/2025 at 3:35 PM with Infection Prevention Nurse 1 (IPN 1), the IPN 1 stated best practice for administering medications that were ordered to be given with food was to give food within 15-20 minutes before administering the medication. The IPN 1 stated if a medication was ordered to be given with food by the physician, the order must be followed and food be given with the medication to prevent any unwanted side effects such as nausea (feeling of sickness or discomfort in the stomach that can lead to an urge to vomit), upset stomach, diarrhea, and because some medications may be better absorbed with food. The IPN 1 stated giving medication one and half hours after ingesting food was not acceptable since food may already be digested, and apple sauce, or crackers should have been offered to the resident. (continued on next page)

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F 0755 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, Administering Medications, dated 4/2019, the P&P indicated medications are to be administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48395 Based on observation, interview and record review the facility failed to ensure safe provision of pharmaceutical services as indicated in the facility policy by failing to: 1. Lock/secure over the counter medications (OTC, medications that can be bought without a prescription) in the facility's central supply room. 2. Lock/secure a liquid vial of Lorazepam (brand name of a controlled anxiety medication) in the medication fridge in the medication room. 3. Ensure OTC medications were kept in a locked storage room that was not accessible by non-licensed and authorized staff. This deficient practice had the potential to result in unauthorized access to medications by residents, visitors, and staff and predisposing them to possible medication overdose (taking a toxic or poisonous amount of a drug or medication), unauthorized use of medications, adverse reactions (any unexpected or dangerous reaction to a drug), and drug-to-drug interactions (a reaction between two or more drugs or between a drug, and a good, beverage, or supplement). Findings: 1. During an observation on 2/20/2025 at 12:08 PM in the central supply room, the central supply room had a long four-tier shelf along the wall with multiple rows of OTC medication bottles such as loperamide (generic anti-diarrheal medication), ClearLax (brand name for polyethylene glycol - a laxative medication that promotes bowel movements), Vitamin D (supplement) and fish oil (supplement) stored on the top two shelves and the gate to the room was observed to be unlocked. During a concurrent observation and interview on 2/20/2025 at 12:12 PM with Maintenance Supervisor (MS) in the central supply room, the central supply room was observed to have a gate that was unlocked. MS stated the gate was unlocked and that it should have been locked. 2. During a concurrent observation and interview on 2/18/2025 at 3:07 PM with Registered Nurse Supervisor 1 (RNS 1) in medication room, a liquid vial of Lorazepam was observed inside the medication fridge which was unlocked. RNS 1 stated Lorazepam is a controlled medication (a drug of substance whose production, possession and use are regulated by law due to its potential for abuse or misuse) which means it should be kept inside a locked refrigerator which could only be accessed by licensed staff. During an interview on 2/20/2025 at 11:48 AM with the Director of Nursing (DON), the DON stated, Controlled medications are a big deal and can be lost, misplaced or misused which could negatively affect resident care. The DON stated it is expected of the licensed staff and those who have authorization to access the medication room and medication fridge to lock them after retrieving what they need. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 12/21/2025 at 12:20 PM with the DON, the facility's policy and procedure (P&P) titled Medication Storage in the Facility, dated April 2008 was reviewed. The DON stated the P&P indicated, Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The DON stated the P&P also indicated, Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. The DON stated the central supply room should always be locked since OTC medications are stored in there and to follow their policy, the OTC medications in the storage room that was accessible by staff other than licensed and authorized staff should be moved into a locked medication room to prevent unauthorized staff from potentially taking them without anyone's knowledge. 45523 3. During a concurrent observation of the facility storage room on 2/20/25 at 12 PM with certified nurse assistant 3 (CNA3), the storage room was observed with a door code access. During a concurrent observation inside the storage room on 2/20/25 at 12:05pm, observed multiple unlocked cupboards with ADL supplies for residents and over the counter (OTC- medication that can be bought at a pharmacy without a prescription) medication such as milk of magnesia (used as a laxative), iron supplements (helps the body produce red blood cells that carries oxygen to the body), glucose gel (a medication that contains dextrose and water, and is used to treat low blood sugar), stool softener, allergy relief, melatonin (to help regulate sleep), pain relief and acetaminophen (a drug that reduces pain and fever) tablets. During an observation and interview with RN Supervisor (RN Sup) on 2/20/25 at 12:06pm, RN Sup stated that everyone knows the code to the storage room including the licenses nurses and CNAs. RN Sup stated maintenance supervisor and the rest of the housekeeping team also have access to the storage room because they stock up the room. RN Sup stated staff have access to the storage room so the staff can get the residents' ADL (Activities of Daily Living) supplies. RN Sup also confirmed that anyone that had access to the room also had access to the OTC medication inside the cupboards. During a consecutive interview with RN Sup on 2/20/25 at 12:10pm, RN Sup stated there were two medication storage rooms in the facility and confirmed that OTC medication should be stored inside the medication rooms. RN Sup stated that some OTC medications have been stored in the storage room a long time but it would make sense for all the OTC medications to be kept in the medication room so it can be locked up and accessed by only authorized staff. During a concurrent observation and interview in the storage room with RN Sup on 2/20/25 at 12:09 pm, observed Housekeeper (HKP1) to unlock the storage room door, walked in and began to stock resident ADL supplies. HKP1 stated he has been working in the facility for four (4) months and has always had access to the storage room including the code to the door. HKP1 stated he stocks supplies for the staff like basic needs like shampoo and razors so the CNAs can have access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continued interview and observation in the storage room with RN Sup on 2/20/25 at 12:14pm, observed CNA3 unlock door and walked inside the storage room. CNA3 stated she had noticed the OTC medication stored inside the cupboards but never thought anything of it because It's always been here, at least since I have been working here, and I've been here since 1995. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated April 2008, the P&P indicated, Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review the facility failed to provide two (2) of 2 sampled residents (Residents 61 and 82) meal trays that were appetizing and palatable (agreeable to one's sense of taste). This failure had the potential to result in dissatisfaction, decreased food intake and placed Residents 61 and 82 at risk for unplanned weight loss. Findings: 1. During a review of Resident 61's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of gastro-esophageal reflux disease (GERD, a condition where stomach contents flow back up into the esophagus [a muscular tube that connects the throat to the stomach]) and type two (2) diabetes mellitus (DM2, a disease in which glucose [sugar] levels in the blood are higher than normal). During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool), dated 11/13/2024, the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 61 needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 61 needed partial/moderate assistance (helper does less than half the effort) with personal hygiene and upper body dressing (the ability to dress and undress above the waist) and was independent with eating. During a review of Resident 61's Order Summary Report, dated February 2025, the Order Summary Report indicated an order for controlled carbohydrate (CCHO; a dietary pattern that restricts carbohydrate intake to manage blood sugar levels), no added salt (NAS) diet regular texture, thin consistency. During a review of Resident 61's nutrition care plan, dated 12/17/2024, the nutrition care plan indicated that Resident 61 is cognitively intact and is clear with her decisions/preferences. Staff interventions included were to provide diet as ordered and follow nutrition and hydration standard of care. During a concurrent observation and interview on 2/18/2025 at 12:45 PM with Resident 61 in her room, Resident 61's lunch tray was observed with jambalaya with tomatoes, garlic toast and soup with her meal ticket indicating her dislike of tomatoes. Resident 61 stated the jambalaya is too spicy and has tomatoes and cannot eat it. During the test tray on 2/19/2025 at 12:25 PM, a regular texture, mechanical soft (soft, moist foods that are easy to chew and swallow) texture and pureed (foods that have been blended, mashed, or processed into a smooth, lump-free consistency) texture tray was sampled with scalloped potatoes, meatloaf and peas. The trays were observed to not look appetizing, were dull in color, and the scalloped potatoes were bland with a sticky, gum like texture. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the test tray on 2/20/2025 at 12:38 PM, a regular texture, mechanical soft and pureed texture tray was sampled with mashed potatoes, rice and meat with gravy and carrots. The trays did not look appealing, and the meat and gravy appeared gray in color. The pureed texture mashed potatoes were very thick, gummy, and sticky in texture that stuck to the roof of one's mouth. The mechanical soft texture white rice was very watery in texture and bland while the regular texture fried rice was spicy and the meat was dry. During the same test tray on 2/20/2025 at 12:38 PM with Dietary Staff 1 (DS 1), DS 1 tasted the pureed texture mashed potatoes and stated, It is sticky and thick in texture. I would not feed it to my loved ones. During the same test tray on 2/20/2025 at 1:10 PM with the Administrator (ADM), the ADM tasted the pureed texture mashed potatoes and stated it was thick and sticky. The ADM also tasted the mechanical soft texture white rice and stated it did not have a lot of flavors and was sticky in texture. 45523 2. During a review of the Admission Record, the Admission Record indicated Resident 82 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified hypertension (a type of high blood pressure that does not have a clear cause), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). During a review of Resident 82's History and Physical (H&P), dated 9/27/2024, the H&P indicated Resident 82 has the capacity to understand and make own decisions. During a review of Resident 82's MDS, dated [DATE], the MDS indicated the resident has no cognitive impairment (mental process of thinking and understanding) and is dependent (helper does all of the effort) for showers, lower body dressing and putting on/taking off footwear, also Resident 82 requires substantial assistance (helper does more than half the effort) for toilet use and personal hygiene. During a review of Resident 82's Order Summary Report, dated 9/28/2024, the Order Summary Report indicated diet of no salt added (NAS) regular texture, thin consistency. During a review of Resident 82's Care Plan Report initiated 6/07/2024, the care plan staff intervention included was to provide diet as ordered, follow nutrition/hydration standard of care, and staff to encourage resident to eat 75%-100% of the diet as tolerated. During an initial observation and interview on 2/18/2025 at 10:35 AM, Resident 82 was resting in bed with breakfast tray on side table untouched. Resident 82 stated, The chicken is rubbery and low quality. Resident 82 stated she spoke to Dietary Staff Supervisor (DSS) and was informed that the facility has a menu and it can't be changed. Resident 82 stated, I would like to be provided with a decent meal, fresh food not processed. I've been here for over eight (8) months and have been eating the same thing over and over. It's just not right only because they want to stick to a budget. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 82 on 2/19/25 10:51 AM, Resident 82 stated, The food is not appetizing or flavorful, the food tastes processed and I'm tired of eating it. At times I just won't eat because it's not a good experience. During a review of the facility's Weekly Menu for 2/19/2025, the menu indicated the residents lunch consisted of, Old fashioned meatloaf, scalloped potatoes, seasoned peas with red peppers, wheat roll, and orange blossom parfait. During a sample of the facility's lunch test tray (sampling of food) on 2/19/2025 at 12:30 PM, observed the test tray to have a plate of meatloaf, peas with red peppers and scallop potatoes. The texture for the potato was thick and sticky, bland with no flavor. The meatloaf in the Regular diet tray did not have much flavor. Visually it did not look appetizing. The test tray had a brown meatloaf, green peas, and grey scallop potatoes. The test trat was not attractive and not appetizing or flavorful. During a concurrent sample of the facility's lunch test tray on 2/20/2025 at 12:30 PM with Dietary Aid 1, observed the food tray to have roast beef, red beans rice, white rice, and carrots with parsley. tested the potato and the flavor was bland (lacking taste or flavor), and texture was thick and sticky and hard to swallow. The rice with beans was a bit spicy, the white rice was sticky, watery and bland, and the roast beef was hard to chew. During a test of the facility's lunch tray with Dietary Aid (DS1) on 2/20/2025 at 12:36 PM, DS1 confirmed the potatoes texture was gummy, sticky and thick. DS1 also stated that it could be a potential harm for a resident because it can cause the resident to choke (airway is partly or completely blocked, meaning they may be unable to breathe properly). During same testing of sample lunch tray with Administrator (Admin) in the presence of DSS on 2/20/25 01:10 PM, Admin stated the potato texture was gummy and sticky, and the white rice was bland and sticky. Admin stated the food texture and flavor could be improved. During a concurrent interview with Resident 82 on 2/20/2025 at 3:25 PM, Resident 82 stated, I eat to survive. I'm hungry. I eat only because I have to but not because I look forward to eating my meals. During a review of the facility's undated Policy and Procedure (P&P) titled, Food Preparation, the P&P indicated: a. All food will be prepared by methods that preserve nutritive value, flavor, and appearance and will be attractively served at the proper temperature an in a form to meet the individual needs of the resident. b. A substitute of equal nutritive value will be provided as a replacement for the food not acceptable to the resident. During a review of the facility's P&P titled, Accommodation of Needs revised March 2021 indicated, the P&P indicated Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning dignity and well-being. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Rehab Center	537 W Live Oak San Gabriel, CA 91776

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review the facility failed to ensure one (1) of 1 sampled resident (Resident 61) received food that accommodated resident intolerances and preference as indicated on the facility policy. This failure had the potential to result in Resident 61 having a decreased meal intake which would lead to weight loss and malnutrition (a state of nutritional deficiency or imbalance that occurs when the body does not receive or absorb sufficient nutrients [calories, protein, vitamins, minerals] to maintain health and function properly). Findings: During a review of Resident 61's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of gastro-esophageal reflux disease (GERD; a condition where stomach contents flow back up into the esophagus [a muscular tube that connects the throat to the stomach]) and type two (2) diabetes mellitus (DM2; a disease in which glucose [sugar] levels in the blood are higher than normal). During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool), dated 11/13/2024, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident 61 needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 61 needed partial/moderate assistance (helper does less than half the effort) with personal hygiene and upper body dressing (the ability to dress and undress above the waist) and was independent with eating. During a review of Resident 61's Order Summary Report, dated February 2025, the Order Summary Report indicated an order with a start date for 2/19/2025 to provide soft foods as requested by resident due to right upper tooth/gum discomfort with meals until 2/21/2025. During a review of Resident 61's nutrition care plan, dated 12/17/2024, the nutrition care plan indicated that Resident 61 cognition was intact and was clear with her decisions/preferences. Staff interventions included were to provide diet as ordered and follow nutrition and hydration standard of care, provide substitutes if resident does not like what is on the menu, and the resident may be provided assistance with eating as needed. During an interview on 2/28/2025 at 9:37 AM with Resident 61, Resident 61 stated she had a preference of no tomatoes and even though it was indicated on her preference sheet, Resident 61 was still served food with tomatoes, and that it upsets her stomach since she has GERD. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/18/2025 at 12:45 PM with Resident 61 in her room, Resident 61's lunch tray was observed. Resident 61's tray had jambalaya with tomatoes and the preference sheet on the lunch tray indicated Resident's 61's dislikes which included tomatoes. Resident 61 stated the jambalaya was too spicy and had tomatoes, and Resident 61 could not eat the lunch provided on 2/18/25. During a concurrent observation and interview on 2/19/2025 at 12:33 PM with Resident 61 in her room, Resident 61's lunch tray was observed to be a regular diet tray of meatloaf with reddish colored gravy, scalloped potatoes and peas. Resident 61 stated, I can't eat that, and further stated she had spoken to the Dietary Supervisor 1 (DSS 1) earlier that morning letting her know that for lunch she would like only rice and a bowl of soup since she had a toothache. During an interview on 2/19/2025 at 12:37 PM with DSS 1, DSS1 stated she spoke with Resident 61 earlier in the morning and Resident 61 had informed her of her toothache and requested chicken noodle soup and rice for lunch instead of her normal lunch tray. During an interview on 2/19/2025 at 3:23 PM with Resident 61, Resident 61 stated they fixed her tray to what she had originally requested and stated there was a lack of communication between the kitchen staff and it frustrated her. During a concurrent interview and record review on 2/20/2025 at 10:27 AM with Registered Dietician (RD), Resident 61's Nutrition/Dietary Note, dated 2/5/2025, indicated Resident 61's food preferences included that she dislikes tomatoes. RD stated Resident 61's meal ticket should also indicate Resident 61's dislike for tomatoes so that when the kitchen prepares Resident 61's meals, the kitchen does not serve Resident 61 tomatoes. RD stated if there was anything on the menu that includes tomatoes, they need to offer Resident 61 an alternative or something else that similar in nutritional value. During a concurrent interview and record review on 2/20/2025 at 10:39 AM with DSS 1, the facility's recipe sheet titled, Recipe: Chicken Jambalaya (undated) was reviewed. The Recipe: Chicken Jambalaya sheet indicated ingredients including, diced tomatoes with juice. DSS 1 stated the chicken jambalaya that was served on 2/18/2025 had tomatoes in it. DSS 1 stated since Resident 61 has a preference of disliking tomatoes, she should have provided the resident a tray that day of chicken jambalaya with no tomatoes. During the same interview on 2/20/2025 at 10:39 AM with DSS 1, DSS1 stated on 2/19/2025 Resident 61 did speak with her that morning and ordered what she would like to eat for lunch but still received the wrong tray. DSS 1 stated when a resident's preferences were not met, it could make them feel upset and frustrated. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised March 2021, the P&P indicated, The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. During a review of the facility's P&P titled, Food Preparation, (undated), the P&P indicated: a. The list of resident food dislikes will be recorded in the resident profile card and meal ticket and will be updated as needed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A substitute of equal nutritive value will be provided as a replacement for the food not acceptable to the resident.

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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** 45523 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure (P&P) by failing to ensure: 1. To discard expired food items which were stored in Refrigerator 3. 2. Staff's personal food container was not in the kitchen refrigerator. 3. Food items stored in the dry food storage were labeled with delivery and use by dates. 4. Micro-kill germicidal alcohol wipes (a powerful disinfectant solution premoistened with alcohol solution that effectively kills bacteria and viruses) and ThickenUp instant food and drink thickener (a powder based, instant thickening agent that can be used with both liquids and food to help manage swallowing difficulties) were not stored together (one area) in the kitchen, by the coffee machine. 5. Dietary [NAME] 1 perform hand hygiene prior to handling food and after touching/opening trash can lid. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed 95 residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: 1. During a concurrent observation in the kitchen and interview with the Dietary Staff Supervisor (DSS) on [DATE] at 7:58 AM, observed bottle of opened cranberry juice in the Kitchen Refrigerator 3, with label indicating DO [DATE] and [DATE] date. DSS stated, DO meant date opened, which was [DATE] and [DATE] was the use by date. DSS stated the opened cranberry juice bottle's used by date was [DATE] which means it is already expired. 2. During a concurrent observation in the kitchen and interview with DSS on [DATE] at 8 AM, observed a small plastic container of food in the Kitchen Refrigerator 3. DSS stated the plastic food container was a staff's personal lunch. DSS stated staffs' personal food was not supposed to be in the refrigerator. DSS stated staff were aware that they cannot have personal food mixed with residents' food to prevent any type of contamination. 3. During concurrent observation in the kitchen and interview with DSS on [DATE] at 8:11 AM, observed inside the dry food storage were plastic containers containing dry food (Rice, Pasta, Mashed Potato) labeled with name of item and delivery date. DSS stated, We go by delivery day. The date on the label is [DATE] which is when we received it. DSS stated that the label on the dry food items should not only have delivery date but should include a use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation in the kitchen and interview with DSS on [DATE] at 8:37 AM, observed one container of micro-kill one germicidal alcohol wipes mixed in with two (2) Nestle ThickenUp instant food and drink thickener. 5. During a concurrent observation and interview with the Dietary [NAME] (DC1) in the kitchen on [DATE] at 6:25 AM, DC1 was observed not wearing gloves while preparing breakfast, walking back and forth to different stations (kitchen area, prepared food table area, and utensil storage area) and touching multiple surfaces in the kitchen area with bare hands. DC1 was observed wearing oven mitts as she opened the oven and removed food containers from the oven and placed them on a serving table. DC1 then removed the foil from top of the tray of bacon and proceeded to open the trashcan lid while still using the oven mitts, threw the foil inside the trashcan. DC1 then continued to remove the foil from other food containers in the oven without removing contaminated oven mitts. Once DC1 removed food items from the oven, DC1 removed oven mitts and placed them on the serving table then proceeded to grab a bag of bread, took out the bread with bare hands and placed the bread slices inside the toaster. DC1 then placed oven mitts back on and continued to remove food items from the oven. DC1 removed the oven mitts and grabbed the serving utensils and placed them on table to get them ready for tray line. During observation of DC1 in the kitchen on [DATE] at 6:55 AM, DC1 without performing hand hygiene and with her bare hands was observed placing the frying pan on the burner. DC1 was observed pouring liquid eggs from a cardboard box container onto the frying pan. DC1 then proceeded to opening the trash can lid with his bare hands and threw out the empty egg container in the trash. DC1 then went back to cooking the eggs without washing hands or wearing gloves. At 7 AM, observed DC1 reach inside the bread bag, pulled out some bread slices and began to prepare toast. DC1 then was observed opening the trash can lid with her bare hands and threw out the empty bread bag in the trashcan. During interview on [DATE] at 7:10 AM, DSS stated that using oven mitts or using bare hands to open the trashcan lid and then back to kitchen area without washing hands was considered cross contamination and was a danger to residents and can cause potential harm. During an interview with the Director of Nursing (DON) on [DATE] at 12:13 PM, DON stated that there is a possibility for cross contamination and infection control if handwashing was not performed by kitchen staff before they touch the food or after opening the trash can lid prior to food preparation. The DON stated that another option to prevent cross contamination is to have clean hands and use hand sanitizer or wash hands every time kitchen staff touches the trash can or the lid before going back to touching the food. During a review of the facility's undated policy and procedure (P&P) titled, Refrigerator/Freezer Storage, the P&P indicated, 11. All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: Delivery date- upon receipt Open date- opened containers of PHF (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Thaw date- any frozen items 15. No food item that is expired or beyond the best buy date are in stock. Dry goods storage guidelines to be followed unless manufacture recommendation showing it can be kept longer. During a review of the facility's undated P&P titled, Storage of Canned and Dry Goods, the P&P indicated Food and supplies will be stored properly and in a safe manner. 3. No chemicals or cleaning products will be stored with food items. Separate storage area should be available for chemical and cleaning products. 7. Plastic or metal containers (with tight fitting lids and NSF approved), or re-sealable plastic bags will be used for staples and opened packages (like pasta, rice, cereal, flour, etc.) Food items will be dated and labeled when placed in the containers. Scoops should not be left in the container and will be cleaned after each use. 15. No food item that is expired or beyond the best buy date are in stock. During a review of the facility's undated P&P titled, Sanitation and Infection Control, the P&P indicated, Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. 8. Employees must wash hands frequently. 12. Employee personal belongings (i.e. clothing, food, cell phone, etc.) should be stored in a separate area away from food or items used in food service. Handwashing 8. After handling any waste and waste products. Use of Disposable Gloves 1. Disposable gloves will be worn when handling food directly with bare hands to prevent food borne illnesses. 2. Disposable gloves are a single use item and should be discarded after each use, or when damaged or soiled. Disposable gloves are to be worn when handling food directly with hands when: *Handling ready-to-eat foods *Working with raw meat, poultry, eggs, and fish Wash hands when changing gloves. Change disposable gloves when: *Beginning a different task (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*After handling waste *During food preparation, as often as necessary when it gets soiled and when changing task to prevent cross contamination. During a review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised ,d+[DATE], the P&P indicated, Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness. Hand Washing/Hand Hygiene 6. Employees must wash their hands g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks: and/or h. after engaging in other activities that contaminate the hands. 7. Antimicrobial hand gel is not used in place of handwashing in food service area. Gloves and Direct Food Contact 8. Contact between food and bare (ungloved) hands is prohibited. 11. Gloves are worn when directly touching ready-to-eat foods. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised ,d+[DATE], the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: o. Before and after handing food 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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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** 46919 Based on observation, interview, and record review, the facility failed to observe infection control measures for two of eight sampled residents (Residents 49 and 299) as indicated on the facility policy by failing to ensure: 1. Resident 49's indwelling catheter drainage bag (Foley catheter- a tube that allows urine to drain from the bladder into a drainage bag) was not touching the floor. 2. Licensed nurse adhered to enhanced barrier precaution (EBP, infection control interventions, primarily used in nursing homes, that focus on reducing the transmission of multidrug-resistant organisms (MDROs) by emphasizing the use of gowns and gloves during high-contact resident care activities) policy by failing to wear a gown when handling Resident 299's feeding tube. This failure had the potential to expose Residents 49 and 299 to harmful bacteria and viruses, leading to infection, delayed recovery, prolonged illness, and/or hospitalization . Findings: 1. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included diverticulosis of large intestine (a condition where small, bulging pouches form in the wall of the large intestine) without perforation or abscess (a collection of pus [a thick yellowish or greenish liquid produced in infected tissue] in any part of the body) without bleeding, acute kidney failure (a sudden loss of kidney function that occurs over a short period of time), and retention of urine (condition that makes it difficult to empty the bladder). During a review of Resident 49's Minimum Data Set (MDS- a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 49 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 49 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with eating, toileting hygiene, upper/lower body dressing, shower/bathe self, sit to lying, sit to stand, and toilet transfer. Resident 49 had an indwelling catheter. During a review of Resident 49's Order Summary Report, dated 2/19/2025, the Order Summary Report indicated a physician order, with at start date of 1/28/2025, for foley catheter attached to bedside drainage bag due to: urinary retention secondary to neurogenic bladder (a condition that causes a loss of bladder control due to nerve damage in the brain, spinal cord, or nerves) every shift. During a review of Resident 49's Care Plan, dated 1/17/2025, the Care Plan indicated Resident 49 had alteration in urinary elimination and at risk for urinary tract infection (UTI) secondary to use of foley catheter due to benign prostatic hyperplasia (BPH- a non-cancerous enlargement of the prostate gland) neurogenic bladder, urinary retention. Resident 49's Care Plan intervention indicated to place a basin underneath foley catheter bag to prevent the bag touching the floor. (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 observation of Resident 49, on 2/18/2025, at 3:13 PM, Resident 49 was observed asleep in bed. Resident 49's bed was on the lowest level and the foley catheter drainage bag was observed touching the floor. Resident 49 did not have a basin underneath his foley catheter drainage bag to prevent the bag from touching the floor. During an interview with Certified Nursing Assistant 2 (CNA 2), on 2/19/2025, at 12:23 PM, CNA 2 stated Resident 49's foley catheter drainage bag should not touch the floor. CNA 2 stated the foley catheter drainage bag should be placed in a basin to prevent it from touching the floor. CNA 2 stated the basin prevents urine from spilling on the floor. During an interview with Treatment Nurse 1 (TN 1), on 2/19/2025, TN 1 stated Resident 49 can get a UTI if the foley catheter drainage bag touches the floor. TN 1 stated a basin should be placed underneath the foley catheter drainage bag to prevent the bag from touching the floor. TN 1 stated a UTI can cause Resident 49 to get sick and end up in the hospital. TN 1 stated Resident 49's care plan to prevent UTI was not followed. During an interview with the Director of Nursing (DON), on 2/21/2025, at 11:04 AM, the DON stated the foley catheter drainage bag should not touch the floor because it is dirty. The DON stated facility staff was responsible in placing the basin under the foley catheter drainage bag. The DON stated Resident 49 can get a UTI and end up septic (a serious condition in which the body responds improperly to an infection) in the hospital. During a review of the facility's policy and procedure (P&P), titled, Catheter Care, Urinary, revised on 8/2022, the P&P, under infection control, indicated to be sure the catheter tubing and drainage bag are kept off the floor. 48678 2. During a review of Resident 299's Admission Record, the Admission record indicated Resident 299 was admitted to the facility on [DATE] with diagnoses of sepsis (a life-threatening blood infection) and gastrostomy tube (G-tube- tube inserted through the belly that brings nutrition directly to the stomach). During a review of Resident 299's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2025, the MDS indicated Resident 299 had severely impaired cognitive (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 299 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for sitting, laying down, lying to sitting on side of bed, sit to stand, transfer to a chair/bed, toilet transfer, shower transfer, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 299 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) to eat, and maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) to roll left and right. During a review of Resident 299's Order Summary Report, dated 2/5/2025, the Order Summary Report indicated Resident 299 was on Enhanced Barrier Precautions due to G-tube. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/19/2025 at 8:40 AM in Resident 299's room, with Licensed Vocational Nurse 2 (LVN2), the LVN 2 entered Resident 299's room and administered scheduled medications to Resident 299 via G-tube, wearing gloves. The LVN 2 did not wear a gown as indicated on the signage outside Resident 299's room. The LVN 2 stated she was aware that she was supposed to wear a gown when handling G-tubes for any resident to protect herself from getting splashed or contaminated with gastric content from the resident's G-tube. The LVN 2 stated she did not see a PPE cart outside the room and that is why she failed to protect herself. The LVN 2 stated she could potentially contaminate her uniform and pass harmful bacteria to other residents she was caring for and giving medications to that morning. During an interview on 2/19/2025 at 3:32 PM with the Infection Prevention Nurse 1, the IPN 1 stated that licensed nurses passing medications to residents who are on EBP precautions must wear a gown, especially when handling the G-tube to prevent cross contamination and spread of bacteria to the staff and residents in the facility in case gastric contents leak out of the G-tube, which could happen when handling the feeding tube. During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, dated 6/5/2024, the P&P indicated examples of high-contact resident care activates requiring the use of gown and gloves for EBPs include feeding tube care or use.