STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056133	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hills Health and Rehabilitation Center	7940 Topanga Canyon Blvd. Canoga Park, CA 91304

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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. 38549 Based on observation, interview, and record review, the facility failed to ensure facility staff (Licensed Vocational Nurse 1 [LVN 1]) knocked on a resident's door before entering the resident's room for one of 31 sampled residents. This deficient practice had the potential to affect the resident's sense of self-worth and self-esteem. Findings: During a review of Resident 118's Admission Record, the Admission Record indicated the facility originally admitted Resident 118 on 7/5/2023 and readmitted Resident 118 on 7/25/2023 with diagnoses including hemiplegia (a symptom of paralysis [inability to move] on one side of the body, often affecting the arms, legs, and face) and hemiparesis (a medical term for partial weakness or paralysis on one side of the body, usually caused by a brain or spinal cord issue). During a review of Resident 118's History and Physical (H & P - a formal assessment that a healthcare provider conducts to evaluate a resident and the resident's medical issues), the H&P indicated the Resident 118 did not have the capacity to understand and make decisions. During a review of Resident 118's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/11/2024, the MDS indicated that Resident 118 had severely impaired cognitive skills (the functions your brain uses to think, pay attention, process information, and remember things, constantly aiding your thought processes and memory retention) for daily decision making and was dependent on staff for assistance with activities of daily living (ADLs - essential self-care tasks that people need to do every day to feel good, stay healthy, and keep themselves safe and clean). During an observation on 8/6/2024 at 8:06 a.m., observed LVN 1 prepare Resident 118's enter Resident 118's room without first knocking on the door. Observed LVN 1 then proceed to to exit the room and enter the room again multiple times without knocking. During an interview with LVN 1 on 8/6/2024 at 8:53 a.m., LVN 1 stated that he (LVN 1) did not knock on Resident 118's door multiple times before entering the room. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 8/8/2024 at 9:13 a.m., the DON stated that it was important to knock on the resident's door before entering a residents' rooms because the residents have a right to know who is entering their room. The DON stated it can possibly make residents feel that their (residents) rights are being invaded if staff do not knock on their (residents) door before entering because the facility is supposed to be their home. During a review of the facility's policy and procedure titled, Dignity, last reviewed on 7/10/2024, the policy indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff are expected to knock and request permission before entering residents' rooms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to: 1. Ensure that an Advance Directives (AD-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and or responsible parties for two of 10 sampled residents (Resident 34 and 81) 2. Obtain a copy of the Advance Directive for one of seven sampled residents (Resident 81) and place the Advance Directive in the chart to be available and retrievable at any time per facility policy. These deficient practices have the potential to create confusion which could lead to conflict with the resident`s wishes regarding his/her health care. Findings: 1. During a review of Resident 34's Admission Record, the Admission Record indicated the facility admitted the Resident 34 on 5/26/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), muscle weakness and heart failure (a condition in which the heart doesn't pump blood as well as it should). During a review of Resident 34s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 7/8/2024, the MDS indicated the resident had the ability to sometimes understand others and the ability to sometimes makes self-understood. The MDS further indicated that Resident 34 was dependent on staff for oral hygiene, toileting hygiene, shower, dressing and putting on footwear. During a concurrent interview and record review on 8/7/2024 at 10:55 a.m., with the Licensed Vocational Nurse 3 (LVN3), reviewed Resident 34's Advance Directive Acknowledgement (ADA)form which blank and not filled up (documented). LVN3 stated that the ADA form is provided to the resident or family member upon admission. LVN 3 stated that the ADA form contains information regarding the resident`s right to be informed and to receive information on how to formulate an advance directive. LVN 3 stated that an Advance Directive is a written instruction relating to the provision of health care when the individual is incapacitated. LVN 3 stated an AD will also contain information on who is the appointed decision maker in the event of an emergency. LVN 3 stated that if no information is provided to the resident regarding AD, then it is a violation of their right to be informed of the option to formulate an AD. A review of the facility's policy and procedure titled, Advance Directive, last reviewed on 7/10/2024, indicated that, the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directives are honored in accordance with state law and facility policy . 48678 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 81's Admission Record, the Admission Record indicated that Resident 81 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of pulmonary fibrosis (a condition in which the lungs become scarred over time), heart failure, seizures (a temporary burst of uncontrolled electrical activity in the brain that can cause changes in physical and mental function), and cerebral infarction (disruption of blood flow to the brain that causes a lack of blood supply and oxygen to the brain). During a review of Resident 81's MDS dated [DATE], the MDS indicated Resident 81 had severe impaired cognition (ability to think, remember and reason). The MDS indicated Resident 81 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) to perform activities of daily living such as toileting, showering, and getting dressed. During a concurrent interview and record review on 8/6/2024 at 8:37 a.m. with the Medical Records Director (MDR), reviewed Resident 81's AD and noted that there was no AD for Resident 81 in Resident 81's medical chart. The MDR stated that there was no AD in Resident 81's medical chart and that the AD should be in the resident's physical chart for the licensed nurses to be able to retrieve at any time. The MDR stated she (MDR) could not locate a copy of Resident 81's AD. The MDR stated it was her (MDR) responsibility to ensure the Resident 81's AD was placed in the medical charts to ensure nurses know how to provide care to residents during a life-threatening situation. MDR stated that Resident 81's AD was with the resident's family and according to the Resident 81's family, Resident 81's AD was not provided to the facility. A review of the facility's policy statement titled Advance Directives last reviewed 7/10/2024 indicated prior to or upon admission of a resident, the social services director inquires of the resident, family members, or legal representative about the existence of any written advance directives. If the resident has executed one or more advance directive (s), copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. advance directives to ensure that such directives are still the wishes of the resident and documented in the medical record.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38549 Based on observation, interview, and record review, the facility failed to ensure that facility staff (Licensed Vocational Nurse 1 [LVN 1]) provided privacy to one of 31 sampled residents (Resident 118) during the administration of medication via gastrostomy tube (g-tube - a small, soft tube that is surgically inserted through the abdomen and into the stomach). This deficient practice violated Resident 118's right to privacy. Findings: During a review of Resident 118's Admission Record, the Admission Record indicated the facility originally admitted Resident 118 on 7/5/2023 and readmitted Resident 118 on 7/25/2023 with diagnoses including hemiplegia (a symptom of paralysis [inability to move] on one side of the body, often affecting the arms, legs, and face) and hemiparesis (a medical term for partial weakness or paralysis on one side of the body, usually caused by a brain or spinal cord issue). During a review of Resident 118's History and Physical (H & P - a formal assessment that a healthcare provider conducts to evaluate a resident and the resident's medical issues), the H&P indicated the Resident 118 did not have the capacity to understand and make decisions. During a review of Resident 118's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/11/2024, the MDS indicated that Resident 118 had severely impaired cognitive skills (the functions your brain uses to think, pay attention, process information, and remember things, constantly aiding your thought processes and memory retention) for daily decision making and was dependent on staff for assistance with activities of daily living (ADLs - essential self-care tasks that people need to do every day to feel good, stay healthy, and keep themselves safe and clean). During an observation on 8/6/2024 at 8:06 a.m., observed LVN 1 inside Resident 118's room administering medications to Resident 118 via g-tube. Observed that Resident 118's privacy curtain was not closed. During an interview on 8/6/2024 at 8:53 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not close Resident 118's privacy curtain while LVN 1 was administering medications to Resident 118. During an interview with the Director of Nursing (DON) \on 8/8/2024 at 9:13 a.m., the DON stated it was important for licensed nurse to provide privacy to the resident while providing care in order to maintain the dignity of the residents. The DON stated that residents can possibly feel embarrassed or uncomfortable if they are not provided with full privacy when being provided care. During a review of the facility's policy and procedure titled, Dignity, last reviewed on 7/10/2024, the document indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49947 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 440) was free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or next to the resident's body that he or she cannot easily remove and restricts freedom of movement or normal access to one's body) of a non-self-release seatbelt (NSRB - when the user of the restrain is unable to release it themselves). This deficient practice placed Resident 440 at increased risk for complications of restraint use such as decline in functioning, injury, and entrapment (event in which a resident is caught, trapped, or entangled in a space where they are being restrained). Findings: During a review of Resident 440's Admission Record, the Admission Record indicated the facility admitted Resident 440 on 7/25/2005 and readmitted Resident 440 on 7/25/2024 with diagnoses including, but not limited to, epilepsy (a brain disorder that causes recurring seizures [a sudden, uncontrolled burst of electrical activity in the brain]) without status epilepticus (a seizure lasting longer than five minutes), quadriplegia (loss of motion and feeling in the arms, legs and torso [main part of the body minus the head, arms and legs]), and dysphagia (swallowing difficulties). During a review of Resident 440's History and Physical (H&P), dated 7/26/2024, the H&P indicated that Resident 440 did not have the capacity to understand and make decisions. During a review of Resident 440's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/29/2024, the MDS indicated that Resident 440 had severe cognitive impairment (a person has a trouble remembering, learning new things, concentrating, or making decisions that affect everyday life). The MDS further indicated that Resident 440 had impairment (deterioration of loss of function) on both sides of the upper extremities (arms) and lower extremities (legs). The MDS further indicated that Resident 440 was dependent on staff with eating, dressing, toileting, and showering. During a concurrent observation and interview on 8/5/2024, at 9:32 a.m. inside Resident 440's room, observed Resident 440 sitting in a high-back wheelchair (when the back of the seat extends up past the head of a resident) with a NSRB around Resident 440 waist attached to the high-back wheelchair. Resident 440 stated that Resident 4 must keep seatbelt on. Resident 440 stated that she (Resident 440) is unable to unbuckle the seatbelt. During a concurrent observation and interview on 8/7/2024 at 11:45 a.m. with Treatment Nurse (TN) 1, inside Resident 440's room, observed TN 1 buckle the NSRB around Resident 440's waist while the resident was sitting in the wheelchair. TN 1 stated that Resident 440 is unable to buckle and unbuckle the NSRB. TN 1 further stated that Resident 440 uses the NSRB for safety due to frequent seizures. TN 1 stated that TN 1 was unsure if Resident 440 had a physician order for the NSRB. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/7/2024, at 12:03 p.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 440's medical records which included physician orders, care plans, assessment, and progress notes for the use of NSRB. RN 1 stated that there was no order, care plan, assessment, or notes for the NSRB restraint in Resident 440's medical record. RN 1 further stated it is necessary to document the need and use of restraints, so all staff members are aware and to monitor and assist the resident accordingly. RN 1 further stated that Resident 440t could possibly slide down the high back wheelchair seat and become trapped by the restraint around Resident 440's body. During a review of the facility's Policy and Procedure (P&P) titled, Use of Restraints, last reviewed on 7/10/2024, the P&P indicated prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need of restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor).

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 108) received an accurate assessment, reflective of the resident's status by not including the following diagnoses in the resident's Minimum Data Set (MDS - an assessment and care screening tool): 1. Congestive Heart Failure (CHF - a condition when the heart cannot pump enough blood to meet the body's needs, causing fluid to build up in other parts of the body). 2. Atrial Fibrillation (AFIB - an irregular heartbeat when the upper part of the heart sends electrical signals rapidly and at the same time). 3. Pulmonary Hypertension (PMH - a chronic condition when the blood pressure in the lungs is higher than normal). 4. Chronic Kidney Disease (CKD - a condition where the kidneys lose their ability to filter waste and fluid from the blood over many years) This deficient practice had the potential to negatively affect Resident 108's plan of care and delivery of necessary care and services. Findings: During a review of Resident 108's Admission Record, the Admission Record indicated the facility admitted Resident 108 on 2/6/2023 and readmitted Resident 108 on 4/5/2024 with diagnoses that included, but not limited to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), gastro-esophageal reflux disease (GERD-a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, irritating it), gastrointestinal hemorrhage (any bleeding that happens in the digestive tract (tube starting from the mouth to the anus), anemia (a blood disorder when the body doesn't make enough healthy red blood cells to carry oxygen to the body's tissues), severe protein-calorie malnutrition (a condition when a person doesn't eat enough protein causing muscle and fat loss), and nonthrombocytopenic purpura (red or purple skin discoloration when there is bleeding under the skin that is not cause by low platelet [cells that help form blood clots] levels. The Admission Record did not indicate Resident 108 diagnoses of PMH, CKD, CHF or AFIB. During a review of Resident 108's Progress Note dated 4/5/2024 by Nurse Practitioner 1 (NP 1), the note indicated Resident 108 can make needs known but is unable to make medical decisions. NP 1's progress notes further indicated Resident 108 had diagnoses of CKD, PMH, and AFIB. During a review of Resident 108's Cardiology (A branch of medicine that specializes in diagnosing and treating diseases of the heart) Consultation Report dated 3/30/2024 by medical doctor (MD) 1, indicated Resident 108 had a past medical history including but not limited to PMH, AFIB, and CHF. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 108's MDS dated [DATE], the MDS indicated Resident 108 was dependent on staff for toileting, bathing, dressing, and mobility. Then MDS did not indicate Resident 108 diagnoses of PMH, CKD, CHF or AFIB. During a concurrent interview and record review on 8/8/2024 at 4:20 p.m., the Director of Nursing (DON) reviewed Resident 108's MDS dated [DATE]. The DON stated Resident 108's MDS dated [DATE] did not indicate Resident 108 had the diagnoses CHF, CKD, PMH, and AFIB. The DON stated Resident 108's MDS should have been accurate because it reflects the baseline medical status of the residents living in the facility. The DON stated it is important for the MDS to be accurate because it is a tool used for the resident's healthcare and the services provided. During a review of the facilities policy and procedure (P&P) titled, Cumulative Diagnoses last reviewed 7/10/2024, the P&P indicated an accurate diagnoses list of the resident must be maintained. The P&P further indicated the facilities' medical records would then input the diagnoses in the resident's chart and MDS nurse would review and update the list with each scheduled MDS assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for four of 31 sampled residents (440, 2, 489, and 123) by failing to: 1. Develop a care plan addressing Resident 440's use of a physical restraint (any manual method, physical or mechanical device, material or equipment that is attached or next to the resident's body that he or she cannot easily remove and restricts freedom of movement or normal access to one's body). 2. Develop a care plan addressing Resident 123's use of narcotic pain medication (a class of drugs that treat moderate to severe pain by blocking pain signals in the brain). 3. Develop a care plan addressing Resident 489's wandering (a behavior in people with dementia [a term for several diseases that affect memory, thinking, and the ability to perform daily activities] where a person roams around and becomes lost or confused about their location) behavior. 4. Develop a care plan addressing Resident 2's use of insulin (a hormone that controls the amount of glucose [sugar] in the bloodstream). These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: a. A review of Resident 440's Admission Record indicated the facility admitted the resident on 7/25/2005 and readmitted the resident on 7/25/2024 with diagnoses including epilepsy (a brain disorder that causes recurring seizures [a sudden, uncontrolled burst of electrical activity in the brain]) without status epilepticus (a seizure lasting longer than five minutes), quadriplegia (paralysis [complete or partial loss of function] that affects all a person's limbs and body from the neck down), lack of coordination (not able to move different parts of the body together well or easily), and altered mental status (a change in mental function). A review of Resident 440's History and Physical (H&P, a comprehensive assessment of a resident and their problem), dated 7/26/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 440's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/29/2024, indicated the resident had severe cognitive (thought processes) impairment. The MDS further indicated the resident had impairment on both sides of the upper extremities (arms), and lower extremities (legs) and dependent on staff with eating, dressing, toileting, and showering. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/5/2024 at 9:32 a.m., in Resident 440's room, observed Resident 440 sitting upright in a high-back (when the back of the seat extends up past the head) wheelchair. Resident 440 stated, Must keep seatbelt on, and gestured to the buckled seatbelt around her waist that was attached to the wheelchair. When Resident 440 was asked if she could unbuckle the seatbelt herself, Resident 440 stated, No, I can't. Resident 440 tried but was unable to unbuckle the non-self-release seatbelt (NSRB - a seatbelt restraint the resident is unable to release/remove without assistance.) During a concurrent observation and interview on 8/7/2024 at 11:45 a.m., with Treatment Nurse 1 (TN 1), inside Resident 440's room, observed TN 1 buckle the seatbelt around Resident 440's waist while the resident was sitting in her wheelchair. TN 1 stated he helps Resident 440 because she is unable to buckle and unbuckle the seatbelt on her own. TN 1 further stated Resident 440 uses the NSRB for safety due to frequent seizures. During a concurrent interview and record review on 8/7/2024 at 12:03 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 440's care plans dated 7/25/2024 to 8/7/2024. RN 2 stated there was no care plan for Resident 440's NSRB restraint. RN 2 stated it is necessary to document restraints properly with a care plan, so all staff members are aware of the NSRB restraint to monitor and assist the resident accordingly. A review of the facility's policy and procedure (P&P) titled, Use of Restraints, last reviewed on 7/10/2024, indicated Care Plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptoms(s). Care Plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. A review of the facility's P&P titled, Care Plan, Comprehensive Person-Centered, last reviewed 7/10/2024, indicated the resident care plan shall be implemented for each resident on admission, and developed throughout the assessment process. The P&P further indicated assessment of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. 38549 b. A review of Resident 123's Admission Record indicated the facility originally admitted the resident on 12/22/2023 and readmitted the resident on 4/28/2024 with diagnoses including low back pain, stage four (4) pressure ulcer (full thickness tissue loss with exposed bone, tendon, and muscle) of the left buttock, and opioid (medications prescribed by doctors to treat persistent or severe pain) abuse. A review of Resident 123's MDS dated [DATE], indicated the resident had moderately impaired cognition (thought processes) and required supervision or touching assistance from staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 8/7/2024 at 4:42 p.m., with Registered Nurse 3 (RN 3), reviewed Resident 123's physician's orders and Resident 123's care plans dated 4/28/2024 to 8/7/2024. RN 3 stated Resident 123 had the following physician's orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Buprenorphine hydrochloride (HCl) (drug used to treat moderate to severe pain) two (2) milligrams (mg - unit of measurement), give one tablet sublingually (situated or applied under the tongue) every eight (8) hours as needed for severe pain 7 - 9 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 7/9/2024. - Buprenorphine HCl 2 mg, give two tablets sublingually every 8 hours for pain management, ordered on 5/1/2024. RN 3 stated she could not find a specific care plan addressing Resident 123's use of buprenorphine. RN 3 stated it was important to have a specific care plan for the use of this medication that included its side effects and specific black box warnings (the highest safety-related warning that medications can have assigned by the Food and Drug Administration). During an interview on 8/8/2024 at 9:24 a.m., with the Director of Nursing (DON), the DON stated there should be a comprehensive care plan to address Resident 123's use of narcotic pain medication. The DON stated that care plans are tools used to help staff coordinate the resident's care. The DON stated, if there was no care plan specifically addressing the use of the narcotic pain medication, there might be a risk of the resident's pain not being managed properly, a risk of not being able to monitor possible adverse reactions (undesired harmful effect resulting from a medication or other intervention), and a possibility of not being able to communicate within the interdisciplinary team (IDT - a group of people who work together to achieve a common goal by sharing their knowledge and expertise) regarding the resident's pain. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 7/10/2024, indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 50033 c. A review of Resident 489's Admission Record indicated the facility originally admitted the resident on 9/13/2021 with diagnoses including but not limited to unspecified dementia, Alzheimer's Disease, psychosis, and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). A review of Resident 489's MDS dated [DATE], indicated Resident 489 had severely impaired decision-making skills, physical behavioral symptoms directed towards others (behaviors that affect another person), experienced wandering, and required moderate assistance to complete dressing, toileting, and personal hygiene. During an interview on 8/6/2024 at 9:43 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 489 had a history of wandering around the facility and into other residents' rooms as well as becoming agitated when staff tried to care for her. CNA 2 stated she was not aware of any care plan that addressed Resident 489's wandering. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/8/2024 at 3:17 p.m., with the DON, reviewed Resident 489's care plans dated 9/13/2021 to 8/8/2024. The DON stated there are no care plans that indicated interventions specific to Resident 489's wandering. The DON stated a wandering care plan should have been implemented after Resident 489 was originally admitted , as she has been wandering since admission. The DON stated care plans inform staff how to manage a resident. The DON stated without a care plan for wandering there is a risk to Resident 489's and other residents' safety. A review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, last reviewed 7/10/2024, indicated a comprehensive, person-centered care plan is developed and implemented for each resident. The P&P further indicated the care plan should include interventions which reflect current standards of practice to attain the resident's highest practicable physical, mental, and psychosocial well-being. 38469 d. A review of Resident 2's Admission Record indicated the facility admitted the resident on 2/24/2021 and readmitted the resident on 5/27/2024, with diagnoses including gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). A review of Resident 2's MDS dated [DATE], indicated the resident's cognitive skills for daily decision-making was impaired. The MDS further indicated Resident 2 required maximal assistance on staff for toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear. A review of Resident 2's physician's orders dated 5/27/2024, included Humalog (fast-acting insulin) subcutaneous (beneath the skin) solution 100 Unit/milliliter (U/ml, a unit of measurement) inject per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) subcutaneously before meals and at bedtime. During a concurrent interview and record review on 8/7/2024 at 11:15 a.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 2's care plans dated 5/27/2024 to 8/7/2024. LVN 3 confirmed by stating that there is no care plan developed for Resident 2's insulin use. LVN 3 stated that there must be a care plan with insulin use wherein goals of treatment are identified, interventions are specified, and determine an evaluation date to see if the goals of treatment are achieved or met. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 7/10/2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38549 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 1 (LVN 1) did not sign the Medication Administration Record (MAR - a report detailing the medications administered to a resident by a healthcare professional) for one (Resident 118) out of 31 sampled residents before the administration of Dorzolamide hydrochloride-Timolol maleate (medication eye drop used to treat increased pressure in the eye caused by open-angle glaucoma or a condition called hypertension of the eye) and Prednisolone acetate (medication eye drop used to treat certain eye conditions due to inflammation or injury). This deficient practice had the potential to result in the resident's medical records being inaccurate and not in accordance with professional standards of practice. Findings: During a review of Resident 118's Admission Record, the Admission Record indicated the facility originally admitted Resident 118 on 7/5/2023 and readmitted Resident 118 on 7/25/2023 with diagnoses including hemiplegia (a symptom of paralysis [inability to move] on one side of the body, often affecting the arms, legs, and face) and hemiparesis (a medical term for partial weakness or paralysis on one side of the body, usually caused by a brain or spinal cord issue). During a review of Resident 118's History and Physical (H & P - a formal assessment that a healthcare provider conducts to evaluate a resident and the resident's medical issues), the H&P indicated the Resident 118 did not have the capacity to understand and make decisions. During a review of Resident 118's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/11/2024, the MDS indicated that Resident 118 had severely impaired cognitive skills (the functions your brain uses to think, pay attention, process information, and remember things, constantly aiding your thought processes and memory retention) for daily decision making and was dependent on staff for assistance with activities of daily living (ADLs - essential self-care tasks that people need to do every day to feel good, stay healthy, and keep themselves safe and clean). During a review of Resident 118's physician's orders, the orders indicated the following: 1. Dorzolamide Hydrochloride-Timolol maleate ophthalmic (relating to the eye) solution 22.3-6.8 milligrams per milliliter (mg/ml-unit of measure). Instill one drop in both eyes every 12 hours for glaucoma with an order date of 8/1/2023. 2. Prednisolone Acetate ophthalmic suspension one percent (%-unit of measure). Instill one drop in both eyes two times a day for inflammation with an order date of 7/25/2023. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/6/2024 at 8:06 a.m., observed LVN 1 administer dorzolamide hydrochloride-timolol maleate ophthalmic solution to Resident 118. LVN 1 stated he (LVN 1) would wait five (5) minutes between administering the dorzolamide hydrochloride-timolol maleate and the prednisolone acetate ophthalmic suspension. Observed LVN 1 sign Resident 118's MAR indicating that LVN 1 administered both Dorzolamide Hydrochloride-Timolol maleate and Prednisolone Acetate. Observed after five (5) minutes, LVN 1 return to Resident 118 and administered prednisolone acetate. During an interview on 8/6/2024 at 8:53 a.m. with LVN 1, LVN 1 stated that he (LVN 1) signed Resident 118's MAR for the prednisolone acetate ophthalmic suspension before administering the medication to Resident 118. During an interview on 8/8/2024 at 9:13 a.m. with the Director of Nursing (DON), the DON stated that a resident's MAR should only be signed after the licensed nurse has administered the medications to the resident. The DON stated if the MAR was signed before administering the medication, then there was a risk for the resident to either miss a dose or be overdosed. During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 7/10/2024, the policy indicated that the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview, and record review the facility failed to ensure that Licensed Vocational Nurse 2 (LVN 2) documented the presence of a hematoma (also known as a bruise, it is a discolored mark on your skin that forms when blood vessels under your skin break) to the left dorsal hand (back of the hand) of one of three sampled residents (Resident 61) as ordered by the physician. This deficient practice had the potential for Resident 61 to not to receive the care and services needed to treat Resident 61's discoloration. Findings: During a review of Resident 61's Admission Record, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (the loss of the ability to think, remember, and reason to levels that affect daily life). During a review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/08/2024, the document indicated Resident 61 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 61 was dependent on staff for toileting, showering, and personal hygiene. During a review of Resident 61's Change in Condition Form (COC), dated 8/05/2024, the document indicated that on 8/05/2024 at 1:20 p.m., TN 2 discovered skin discoloration to left dorsal (back) hand of Resident 61. During a review of Resident 61's Physician's Orders, the document indicated the following: 1. Monitor discoloration site - left dorsal hand (back of the hand) for the following adverse changes; hematoma formation: zero (0) if present and one (1) if present; discomfort: zero (0) if absent and one (1) if present order dated 8/05/2024 and discontinued 8/06/2024. During a review of Resident 61's Medication Administration Record (MAR, a daily legal record of medications taken by a resident) for 8/2024, the document indicated that on there was no bruising to Resident 61's left dorsal hand for the 3:30 p.m. to 11 p.m. shift for 8/05/2024 documented by LVN 2. During a concurrent interview and record review with LVN 2 on 8/07/2024 at 7:29 a.m., reviewed Resident 61's 8/2024 MAR. LVN 2 stated that she (LVN 2) should not have documented that Resident 61 did not have discoloration to Resident 61's left dorsal hand on 8/5/2024 for the 3:30 to 11 p.m. shift. LVN 2 stated that on 8/6/2024 Resident 61 had discoloration of a bruise to the left dorsal hand. LVN 2 stated it is important to make sure resident information is accurately documented in the medical records. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Skin Tears - Care of Abrasions (breakage in the skin such as a scrape) and Minor Breaks, last reviewed 7/10/2024, the document indicated the purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38469 Based on interview and record review, the facility failed to ensure that facility staff provided one of one sampled resident (Resident 47) with a scheduled toileting plan (or bladder training, which can involve assisting a resident to the restroom at specific timed intervals) This deficient practice has the potential for Resident 47 to not to achieve or restore normal bowel (a tube-shaped organ in the abdomen that helps the body digest food and absorb nutrients) and bladder (A sac-shaped muscular organ that stores the urine secreted by the kidneys) function. Findings: During a review of Resident 47`s Admission Record, the Admission Record indicated the facility admitted the resident on 05/15/2023, with diagnoses including gastro-esophageal reflux disease (GERD-a condition in which the stomach contents move up into the esophagus [food pipe]), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and presence of artificial knee joint (a man-made joint that replaces a damaged knee joint). During a review of Resident 47's Minimum Data Set (MDS - an assessment and care screening tool), dated 07/26/2024, the MDS indicated Resident 47's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision-making was intact. The MDS further indicated Resident 47 was dependent on staff for toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear. MDS Section H (section for bowel and bladder) indicated that Resident 47 was incontinent (inability to control) of bladder and bowel. During a review of Resident 47's Bladder and Bowel Screener dated 7/26/24, the documented indicated that Resident 47 received a score of nine, signifying that Resident 47 was a candidate to receive scheduled toileting. During a review of the Certified Nurse Assistant task Scheduling Toileting Plan from 7/26/2024 to 8/8/2024, there was no documented evidence that Resident 47 received scheduled toileting. During a record review and concurrent interview on 8/08/24 at 8:44 a.m. with Registered Nurse 6 (RN6), reviewed the Certified Nurse Assistant task Scheduling Toileting Plan from 7/26/2024 to 8/8/2024. RN 6 stated that Resident 47 was identified as a candidate to receive scheduled toileting. RN 6 stated that the facility should have implemented the scheduled toileting plan for Resident 47 since the resident was identified as incontinent. RN 6 stated that it is uncomfortable and embarrassing to be sitting in urine and can compromise the resident`s skin integrity which can result to the resident developing skin impairment and urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 8/08/2024 at 9:50 a.m., the DON indicated scoring nine on the Bladder and Bowel Screener makes a resident a candidate for scheduled toileting plan. The DON stated that if there is no scheduled time voiding for Resident 47, the staff may not be able to provide the care that the resident needs and can result to skin impairment. During a review of the facility`s policy and procedure titled Urinary Incontinence-Clinical Protocol, last reviewed on 7/10/2024, indicated that .as appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual`s continence status .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38469 Based on interview and record review, the facility failed to ensure that the recommendation of the Consultant Pharmacist`s (CP) to monitor the respiratory rate (RR-the number of breaths a resident takes per minute) and adding a parameter to hold (do not give a medication) the medication of Oxycodone Hydrochloride (Oxycodone HCL -medication to treat pain) if the RR of a resident is less than 12 breaths per minute (normal respiratory rate is 12-20 breaths per minute) for one of five sampled residents (Resident 47) was done during the Medication Regimen Review (MRR-A review of the medication regimen of a resident to identify and, if possible, prevent clinically significant medication issues) for 5/2024. This deficient practice had the potential for Resident 47 to receive unnecessary medication increasing the risk for adverse side effects (unwanted undesirable effects that are possibly related to a drug) such as respiratory depression (slow, shallow breathing). Findings: During a review of Resident 47`s Admission Record, the Admission Record indicated the facility admitted the resident on 05/15/2023, with diagnoses including gastro-esophageal reflux disease (GERD-a condition in which the stomach contents move up into the esophagus [food pipe]), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and presence of artificial knee joint (a man-made joint that replaces a damaged knee joint). During a review of Resident 47's Minimum Data Set (MDS - an assessment and care screening tool), dated 07/26/2024, the MDS indicated Resident 47's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision-making was intact. The MDS further indicated Resident 47 was dependent on staff for toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear. During a review of Resident 47`s physician`s order, the following orders were noted: 1. Gabapentin Oral Capsule 300 milligram (mg-unit of measure), give three (3) capsules by mouth three times a day for neuropathic pain (nerve pain that can happen if your nervous system malfunctions or gets damaged)with an order date of 5/23/2023. 2. Oxycodone HCL Oral Tablet 10 mg, give one tablet by mouth every four hours as needed (PRN) for severe pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 08/08/24 at 10:40 a.m. with the Director of Nursing (DON), reviewed Resident 47`s MRR for 5/2024; and Resident 47's Medication Administration Record (MAR- a report detailing the medications administered to a resident by a healthcare professional) for 6/2024 and 7/2024. The review indicated in the MRR notes that Resident 47 takes Gabapentin and frequent doses of Oxycodone for pain. The pharmacy consultant recommended monitoring for Resident 47's respiratory rate every shift and adding parameter to hold if RR is less than 12 breaths per minute and call MD. During a review of Resident 47's Mar for 6/2024 and 7/2024 indicated that there was no monitoring of Resident 47's respiration rate. The DON stated that there should have been a monitoring Resident 47's respiration rate because Gabapentin and Oxycodone) can cause respiratory depression which could lead to respiratory arrest (the absence of breathing). During a review of the facility`s policy and procedures titled Consultant Pharmacist Reports-Medication Regimen Review, last reviewed on 7/10/2024, indicated that Recommendations are acted upon and documented by the facility staff and or the prescriber .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38549 Based on observation, interview, and record review, the facility failed to ensure that Licensed Vocational Nurse 1 (LVN 1) locked one of three medication carts (Medication Cart 1) before leaving it unattended during a med pass observation. This deficient practice had the potential to result in unauthorized personnel or residents accessing the medications stored in the unlocked medication cart. Findings: During an observation on 8/6/2024 at 8:06 a.m., observed LVN 1 entering a resident's room while leaving Medication Cart 1 unlocked and unattended. Medication Cart 1 was not within LVN 1's line of sight (the direction in which a person must look in order to see a particular object). During an interview on 8/6/2024 at 8:53 a.m. with LVN 1, LVN 1 stated that he (LVN 1) forgot to lock Medication cart 1 before leaving it unattended to enter a resident's room. During an interview on 8/8/2024 at 9:13 a.m., with the Director of Nursing (DON), the DON stated that it was important to ensure the medication cart are locked and secured before leaving it unattended in order to prevent unauthorized personnel gaining access to the medications stored in the cart. The DON further stated that a resident can also possibly gain access to the unlocked medications in the medication cart which can then cause them to experience adverse side effects (An undesired effect of a medication). During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 7/10/2024, the document indicated that the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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	056133	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hills Health and Rehabilitation Center	7940 Topanga Canyon Blvd. Canoga Park, CA 91304

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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 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. 49947 Based on observation, interview, and record review, the kitchen staff failed to ensure the proper storage, preparation, and distribution of food in accordance with professional standards for food service safety for 139 of 140 residents who receive food from the kitchen by: 1. Failing to ensure five open bags of bread and bagels had a documented open date (when a kitchen first opens the container and writes the date it is open to ensure it is removed from circulation in a timely manner). 2. Failing to ensure the ice machine lid (Cover) was not left open and exposed to the environment. These deficient practices had the potential to place residents at increased risk of experiencing foodborne illness (an illness that comes from eating contaminated food or drinks). Findings: 1. During a concurrent observation and interview with the Dietary Supervisor (DS) on 8/5/2024 at 7:45 a.m., observed the kitchen of the facility. Located inside the walk-in refrigerator was five open bags of bread and bagels without a documented open date. DS stated that the five open bags of bread and bagels did not have a documented open date. The DS stated that she (DS) did not know opened bags needed an open date documented on them. During an interview on 8/6/2024 at 11:30 a.m. with the Registered Dietitian (RD), the RD stated that all opened items of food, including bread and bagels, must be labeled with an open date to prevent from keeping and or storing potentially spoiled food. During a review of the facility's P&P titled Canned and Dry Goods Storage, last reviewed on 7/10/2024, indicated all open food items will have an open date and use-by-date per manufacturer's guidelines. 2. During an observation and interview on 8/5/2024 at 8:15 a.m. in the Ice Maker Closet with the DS, the DS the DS observed that the ice maker's lid was left open. The DS stated that the ice machine lid was likely left open by a certified nursing assistant. The DS further stated that the ice maker lid must remain closed when not in use to retrieve ice to prevent debris and germs from contaminating the ice. During an interview on 8/6/2024 at 11:30 a.m. with the Registered Dietitian (RD), the RD stated that the ice machine lid must remain closed when not in use to prevent dust or debris from contaminating the ice that is used by the residents in the facility. During a review of the facility's policy and procedures (P&P) titled, Infection Control, last reviewed on 7/10/2024, indicated the objective to the P&P is to prevent and control infections as well as to maintain a safe and sanitary environment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38469 Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices by: 1. Failing to ensure that Licensed Vocational Nurse 3 (LVN 3) wore gloves during the medication administration for one of two sampled resident (Resident 14) on enhance barrier precaution (EBP-a method of using personal protective equipment [PPE - equipment designed to protect the wearer from injury or the spread of illness or infection] to reduce the spread of pathogens [germs] between residents). 2. Failing to ensure that facility staff (Activities Assistant [AA]) did not eat personal food inside the resident's dining area alongside resident's eating lunch on 8/6/2024. These deficient practices had the potential to increase the risk of spreading infection amongst resident. Findings: 1. During a review of Resident 14's Admission Record, the document indicated that the facility admitted Resident 14 on 12/27/2023 with diagnoses that included hypertension (high blood pressure) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). During a review of Resident 14s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 7/3/2024, the MDS indicated that Resident 14 had the ability to understand others and the ability to makes self-understood. The MDS further indicated that Resident 14 required maximum assistance from staff for toileting hygiene and showering. The MDS indicated that Resident 14 was dependent on staff for lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 8/06/2024 at 4:19 p.m. with Licensed Vocational Nurse 3, observed LVN 3 not wearing gloves as LVN 3 administered medications to Resident 14. Observed outside Resident 14's room was a sign indicated that the resident was on EBP. LVN 3 stated that Resident 14 was on EBP due to the resident having a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). LVN 3 stated that she (LVN 3) should have worn gloves when administering medications to Resident 14 as per facility protocol. LVN 3 stated that wearing gloves will reduce the risk of spreading infection among staff and residents. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions (EBP`s), last reviewed and revised on 7/10/2024, indicated that Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organism multidrug resistant organism [MDROs-bacteria that have developed resistance to multiple types of antibiotics {medications used to treat infections}]) to residents .EBPs employ targeted gown and glove use during high contact resident care activities . 49947 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 8/6/2024 at 12:10 p.m. with AA, observed AA eating personal food inside resident dining room B nearby other residents eating lunch. AA stated that she is not supposed to eating personal food brought from home inside resident dining room B alongside residents eating lunch because of possible infection control issues and contamination. AA stated that eating personal food inside the resident dining room B in front of residents is an infection control and cross-contamination issue (the transfer of harmful bacteria from one person, object, or place to another). During a review of the facility's Policy and Procedure (P&P) titled, Meal Periods, last reviewed on 7/10/2024, indicated an employee may not consume his/her meals at his/her assigned workstation.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review the facility failed to meet the requirement for no more than four residents per room for two of 60 resident rooms (rooms [ROOM NUMBERS]). This deficient practice had the potential to result in inadequate space to provide sufficient nursing care and privacy for the residents. Findings: A review of the Client Accommodation Analysis form signed on 04/05/2024 completed by the facility indicated room [ROOM NUMBER] housed three beds and room [ROOM NUMBER] housed two beds. During the Resident Council Meeting on 08/06/2024 at 10 AM when the residents were asked about their room space, there were no concerns or issues brought up. During the recertification survey from 08/05/2024 to 08/08/2024, observed rooms [ROOM NUMBERS] were connected and partitioned (separated) with a curtain. Residents residing in the rooms had sufficient amount of space for residents to move freely inside the rooms. Observed adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 08/05/2024, the Administrator (ADM) submitted a letter requesting a waiver for room with more than four residents per room for the following rooms: - room [ROOM NUMBER], three beds with 312 square feet - room [ROOM NUMBER], two beds with 252 square feet - Combined square footage is 563 square feet A review of the waiver letter dated 04/05/2024 indicated, The two rooms combined do not restrict the freedom of movement for residents in room [ROOM NUMBER] and 56. The 563 square feet combined is greater than the minimum requirement of 80 square feet per resident in multiple rooms. The residents in 46 and 56 are wheelchair bound and two residents are ambulatory. The space allows the residents freedom of movement. The space in these rooms is sufficient to provide access and freedom of movement for our residents. The number of residents in rooms [ROOM NUMBERS] do not present any adverse impact on the health, safety, or welfare of the residents who reside in these rooms. There is enough room to provide for the residents' care, dignity, and privacy and the rooms are in accordance with special needs of the resident and will not impede the ability of any resident the rooms to attain his or her highest practicable well-being.