STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056144	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility did not ensure the call light was in reach for five of 92 facility residents (Resident 27, 70, 7, 9, and 79). This deficient practice increased the risk for residents to be unable to call for staff assistance or express their needs. Findings: 1. A review of Resident 27's Admission Record indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's admitting diagnoses included generalized muscle weakness and osteoarthritis (when flexible tissue at the ends of bones wears down). A review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 2/13/2024, indicated Resident 27 required partial to moderate assistance with personal hygiene and dressing, required substantial to maximal assistance with toileting, and was dependent on staff for showering and bathing. The MDS indicated Resident 27 required partial to moderate assistance with rolling left to right in the bed, and required substantial to maximal assistance when transitioning from a sitting to lying position, and vice versa. Resident 27 was also dependent on staff for transitioning to a standing position or transferring from the bed to the chair. A review of Resident 27's care plan, dated 11/28/2023, indicated Resident 27 was at risk for falls and injuries. The staff interventions indicated to keep Resident 27's call light within reach. During an observation on 4/29/2024 at 10:14 a.m., at Resident 27's bedside, observed Resident 27's call light on the floor to the left of the resident's bed. During an observation, on 4/29/2024 at 10:11 a.m., outside of Resident 27's room, Resident 27 heard and observed calling out, Hello!. Observed Resident 27's certified nursing assistant (CNA) in a room across the hall with the door closed. Resident 27's call light observed on the floor to the left side of the resident's bed. During an observation on 4/29/2024 at 10:20 a.m., outside of Resident 27's room, Resident 27 observed and heard continuing to call out, Hello! Hello!. No staff observed in the hallway. Resident 27's call light observed on the floor to the left of Resident 27's bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/29/2024 at 10:22 a.m., with CNA 1, CNA 1 stated Resident 27's call light was on the floor. CNA 1 stated the call light was not supposed to be on the floor. CNA 1 stated the call light was supposed to be next to the resident. CNA 1 stated the call light allowed residents to call for help. CNA 1 stated that if the call light was not in reach, the resident might get up unassisted and could fall. 2. A review of Resident 70's Admission Record indicated Resident 70 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 70's admitting diagnoses included generalized muscle weakness and difficulty walking. A review of Resident 70's MDS, dated [DATE], indicated Resident 70 required partial to moderate assistance with toileting, showering, bathing, and getting dressed. The MDS indicated Resident 70 required partial to moderate assistance when turning from left to right in bed as well as when transitioning from a sitting to lying position and vice versa. A review of Resident 70's care plan, dated 3/6/2024, indicated Resident 70 was at risk for falls and injuries. The staff interventions indicated to keep Resident 70's call light within reach. During an observation on 4/29/2024 at 12:15 p.m., at Resident 70's bedside, observed Resident 70's call light on the floor to the left of the resident's bed. 3. A review of Resident 7's Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including muscle weakness and spinal bifida (a defect of the spine). A review of Resident 7's MDS, dated [DATE], indicated Resident 7 usually made themselves understood, understood others, and was totally dependent on staff for toileting hygiene, bathing, and required maximal assistance (helper does more than half the effort) from staff for personal hygiene. A review of Resident 7's care plan, revised 1/26/2024, indicated Resident 7 was at risk for falls and injury related to spina bifida and muscle weakness. The staff's interventions indicated Resident 7's call light should be within reach. During an observation on 4/29/2024 at 10:42 a.m., in Resident 7's room, Resident 7 was lying in bed in a supine position. Observed Resident 7's call light on the right site of Resident 7's bed under Resident 7's pillow. During a concurrent observation and interview, on 4/29/2024 at 11:02 a.m., in Resident 7's room, Resident 7 was observed lying in bed in a semi-Fowler's position (head of the bed elevated 30-45 degree). Observed Resident 7's call light on the floor on the right site of the resident's bed. Resident 7 was calling for nurse assistance and asking for water. Resident 7 was not able to locate his call light. 4. A review of Resident 9's Admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's disease (brain disorder that slowly destroys memory), chronic obstructive pulmonary disease (COPD, a disease that causes airflow blockage and breathing problems), diabetes (high blood sugar), muscle weakness, and dysphagia (difficulty swallowing). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 9's MDS, dated [DATE], indicated Resident 9 was totally dependent on staff for toileting hygiene, bathing, and required maximal assistance from staff for personal hygiene. A review of Resident 9's History and Physical (H&P), dated 1/6/2023, indicated Resident 9 did not have the capacity to understand and make decisions. A review of Resident 9's care plan, revised 2/28/2024, indicated Resident 9 was dependent on staff for activity of daily living (ADLs, self-care activities performed daily such as grooming, personal hygiene, and dressing) self-care deficit related to diabetes and Alzheimer's disease. The interventions indicated Resident 9's call light should be within reach. During an observation on 4/29/2024 at 10:45 a.m., in Resident 9's room, Resident 9 was observed lying in bed. Observed Resident 9's call light on the floor under the resident's bed and not within reach. During an observation on 4/29/2024 at 11:18 a.m., in Resident 9's room, observed Resident 9's call light on the floor under the resident's bed and not within reach. During an interview on 4/29/2024 at 11:22 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents' call lights should be within reach. LVN 1 stated everyone was responsible to check on the residents' status and make sure the call lights were within reach. LVN 1 stated if a resident was unable to reach the call light and call for assistance it could delay resident assessment and care. LVN 1 stated it also put residents at risk for falls and injuries. 5. A review of Resident 79's Admission Record indicated Resident 79 was originally admitted to the facility on Resident 79 on 2/14/2023 and readmitted on [DATE]. Resident 79's diagnoses included hemiplegia (complete paralysis on one side of the body), hemiparesis (partial paralysis on one side of the body), history of repeated falls, and generalized muscle weakness. A review of Resident 79's H&P, dated 3/11/2023, indicated Resident 79 did not have capacity to understand and make decisions. A review of Resident 79's MDS, dated [DATE], indicated Resident 79 was moderately cognitively impaired (ability to think and reason). The MDS indicated Resident 79 required substantial (helper does more than half the effort) assistance with hygiene, toileting, dressing, and was completely dependent on staff for bathing. During an observation on 4/29/2024 at 11:21 a.m., Resident 79 was in her wheelchair with her body leaning towards the right side of her chair, and her head resting on the right-side arm rest. Resident 79 asked for help but the call light was not within reach. During an interview on 4/29/2024 at 11:30 a.m., Infection Preventionist Nurse (IPN) stated Resident 79 asked to be repositioned because she was uncomfortable. The IPN stated Resident 79's call light should have been within reach so the resident could ask for help. During an interview on 5/1/2024 4:51 p.m., with the Director of Nursing (DON), the DON stated call lights were supposed to always be within the residents' reach. The DON stated that if the call light was not within reach the resident could not call for help and stated it was a safety issue. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/2024 at 8:07 a.m., with the DON, the DON stated staff were responsible for checking that the residents' call lights were within reach at the resident's bedside. A review of the facility's policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response, dated 10/2022, indicated the purpose of the P&P was to assure the facility adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. The P&P further indicated: a. Staff will ensure the call light is within reach of resident and secured, as needed. b. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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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** 47092 Based on interview and record review, the facility failed to offer advance directives for one of three residents (Resident 44). This deficient practice had the potential to cause conflict with Resident 44's wishes regarding health care. Findings: A review of Resident 44's Admission Record indicated Resident 44 was admitted to the facility on [DATE]. Resident 44's diagnoses included metabolic encephalopathy (a problem with the metabolism causing brain dysfunction) and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of Resident 44's History and Physical (H&P), undated, indicated Resident 44 did not have capacity to understand and make decisions. A review of Resident 44's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/12/2024, indicated Resident 44 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 44 required substantial (helper does more than half the effort) assistance with hygiene, toileting, dressing, and was completely dependent (helper does all the effort) for bathing. A review of Resident 44's electronic medical record indicated Resident 44 did not have any advance directives or acknowledgement form. During an interview on 5/2/2024, at 9:06 a.m., with the Social Services Director (SSD), the SSD stated when residents were admitted she would ask them or their representative if they had any advance directives. The SSD stated if the resident did not have any she would offer her assistance and document it in a progress note which served as an acknowledgement form. The SSD stated advance directives were important because it could ensure the residents wishes were kept. During an interview on 5/2/2024, at 1:32 p.m., with the Administrator (ADM), the ADM stated residents were offered the opportunity for advance directives upon admission which should be documented in the resident's chart to show that it was offered. During a review of the facility's policy and procedure (P&P) titled Advance Directives, dated 11/2016, the P&P indicated the Patient Self-Determination Act of 1990 required all skilled nursing facilities to inform new residents of their right to establish an advance directive. The P&P indicated that the facility must have the resident or responsible party sign a form that acknowledges they have received this information and whether advance directive already exists or if the resident would like to establish one.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to ensure two of 92 resident's (Resident 37 and 41) beds were not positioned against the wall. This deficient practice reduced the residents' ability to get out of bed freely and also increased the risk for entrapment and subsequent injury. Findings: 1. A review of Resident 37's Admission Record indicated Resident 37 was admitted to the facility on [DATE]. Resident 37's admitting diagnoses included generalized muscle weakness and a history of falling. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 4/2/2024, indicated Resident 37 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 37 required maximal assistance from or full dependence on staff for repositioning herself in bed. During a concurrent interview and record review on 5/1/2024 at 12:02 p.m., with Registered Nurse (RN) 1, Resident 37's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) progress notes and care plans were reviewed. RN 1stated there were no IDT progress notes or care plans indicating Resident 37 preferred to have her bed against the wall. During an observation on 4/29/2024 at 11:41 a.m., inside Resident 37's room, Resident 37's bed was observed against the wall. There was no gap observed between the left side of Resident 37's bed and the wall. There was a padded mat on the ground to the right side of the bed. During an interview on 4/29/2024 at 12:39 p.m., with Resident 37's family member (FM) 1, FM 1 stated Resident 37's bed had been against the wall for a while. FM 1 stated the facility never informed him that it was not required or supposed to be against the wall. 2. A review of Resident 41's Admission Record indicated Resident 41 was originally admitted to the facility on [DATE]. Resident 41's admitting diagnoses included osteoarthritis (when flexible tissue at the ends of bones wears down) of the left knee and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition). A review of Resident 41's MDS, dated [DATE], indicated Resident 41 had moderate cognitive impairment. The MDS indicated Resident 41 required partial to moderate assistance from staff for repositioning herself in bed. The MDS indicated Resident 41 used a wheelchair for mobility. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 41's care plan, dated 10/31/2023, indicated Resident 41 was at risk for falls and injuries. Further review of Resident 41's care plan did not indicate Resident 41 had any preferences for having her bed against the wall. During an observation on 5/1/2024 at 12:02 p.m., at Resident 41's bedside, Resident 41 was observed asleep in bed with the bed against the wall. There was no gap between the right side of Resident 41's bed and the wall. Resident 41's wheelchair was observed on the left side of her bed. During an interview on 5/1/2024 at 11:51 a.m., with the Director of Nursing (DON), the DON stated resident beds were not supposed to be placed against the wall unless it was the resident's preference. The DON stated that if a resident preferred having their bed against the wall it was supposed to be care planned and documented in an IDT progress note. The DON stated that having the bed against the wall which created a high risk for entrapment was a safety issue. The DON further stated that the bed against the wall was considered a restraint and stated that the bed should never be against the wall. A review of the facility's policy and procedure (P&P) titled Restraint Free Environment, dated 12/2021, indicated placing a bed close enough to a wall that the resident cannot independently get out of bed is considered a physical restraint.

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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** 47092 Based on observation, interview, and record review, the facility failed to develop and implement an individualized care plan with measurable objectives, timeframes, and interventions to improve, maintain, or prevent a further decline in range of motion (ROM, full movement potential of a joint) and mobility for one of six sampled residents (Resident 78) who was identified as having decreased mobility and ROM limitations in the right leg. This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 78, and had the potential to lead to contracture (loss of motion of a joint) development and a decline in overall physical functioning. Findings: A review of Resident 78's Admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including an acquired absence of the right leg below the knee (amputation of the right leg below the level of the knee), right knee contracture, and chronic left ankle ulcer (sore that forms on the skin or the lining of an organ that does not heal properly) with necrosis (death of cells or tissue through disease or injury) of the muscle. A review of Resident 78's Minimum Data Set (MDS, an assessment and care-screening tool), dated 2/18/2023, indicated Resident 78 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 78 required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene and total dependence with transfers. The MDS indicated Resident 78 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg and no functional ROM limitations in both arms. A review of Resident 78's MDS, dated [DATE], indicated Resident 78 was cognitively intact. The MDS indicated Resident 78 required moderate assistance for dressing, toilet hygiene, and personal hygiene and partial/moderate assistance with transfers. The MDS indicated Resident 78 had functional limitations in ROM in one leg and no functional ROM limitations in both arms. A review of Resident 78's care plans, indicated there was not a care plan addressing Resident 78's right knee contracture or a care plan to maintain or prevent decline in the resident's ROM to both legs and mobility. During a concurrent observation and interview on 5/1/2024 at 1:20 pm, in Resident 78's room, Resident 78 was observed lying in bed with both knees bent. Resident 78's right leg was observed to be amputated below the knee and was resting on a pillow with the knee fully bent. No splint was observed on Resident 78's right leg. Resident 78 tried to straighten both knees but could not. Resident 78 stated he was unable to straighten both knees and needed help with leg exercises because both of his legs felt very stiff. Resident 78 stated he never had a splint for the right leg, had not received help with leg exercises for about a year, and required assistance getting into a wheelchair, getting dressed and toileting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/2/2024 at 11:14 am, the MDS Director (MDSD), Resident 78's MDS, dated [DATE] and 2/1/2024, and care plans was reviewed. The MDSD stated a comprehensive and individualized care plan was developed for every resident and used as a guideline to ensure proper care was provided for each resident. The MDSD confirmed Resident 78 was identified as having mobility deficits and functional ROM limitations in one leg both upon admission and during the most recent annual assessment. The MDSD stated if mobility and functional ROM deficits were identified on the MDS, a care plan should have been created to ensure interventions such as physical therapy, occupational therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) and/or restorative nursing assistant (RNA) services were part of the resident's care plan interventions. The MDSD reviewed Resident 78's care plan and confirmed there was no care plan and interventions in place to maintain or prevent a decline in mobility and ROM of Resident 78's both legs. The MDSD stated Resident 78's care plan should have included goals and interventions to maintain and prevent a decline in Resident 78's mobility and ROM of both legs since Resident 78 was at high risk for contracture development and a functional decline due to his diagnosis of a right below knee amputation and decreased mobility. The MDSD stated it was important for care plans to be developed, implemented, and accurate to ensure the appropriate care was provided to each individual resident. The MDSD stated the residents may not receive the appropriate treatment and services they required if it was not care planned. During an interview on 5/2/2024 at 2:52 pm, with the Director of Nursing (DON), the DON stated comprehensive care plans were developed for every resident and were used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated a care plan with goals and interventions should be developed for all residents who were identified as having ROM and mobility limitations upon assessments such as the MDS, observations, and/or by report from the resident or staff. The DON stated it was important for care plans to be developed, implemented, and accurate to ensure the appropriate care was provided to each individual resident. During a review of the facility's Policy and Procedure (P/P) titled, Care Plans, Comprehensive, revised 2008, the P/P indicated the facility would develop a comprehensive care plan directed towards achieving and maintaining optimal status of health, functional ability, and quality of life. The P/P indicated the care plan was individualized by identified resident problems, unique characteristics, strengths, and individual needs and should be realistic, have measurable goals and time frames, and responsibility for meeting the specific goals. The P/P indicated the care plan was based on the fundamental information gathered by the MDS, resident assessment protocols, and information gathered through regular observation and assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to provide treatments and services to prevent and/or limit a decline in range of motion (ROM, full movement potential of a joint [where two bones meet]) and mobility (ability to move) for two of six sampled residents (Residents 78 and 29) with identified ROM and mobility concerns by failing to: a. Provide treatment and services to maintain and prevent a decline in mobility and ROM of Resident 78's legs. b. Provide a right knee extension splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 78's right leg in accordance with Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) recommendations on 2/14/2023. c. Implement the Restorative Nursing Program (RNP, nursing program that uses restorative nursing aides [RNAs] to help residents maintain their function and joint mobility) for ambulation (to walk), five times a week, as established and recommended by PT to maintain Resident 29's mobility upon discharge from PT services on 11/10/2023. These deficient practices led to the decline in Resident 78's mobility and left knee ROM and had the potential to lead to further contractures (loss of motion of a joint associated with stiffness and joint deformity) and a decline in Resident 78 and Resident 29's overall physical functioning and quality of life. Findings: 1. A review of Resident 78's Admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including an acquired absence of the right leg below the knee (amputation of the right leg below the level of the knee), right knee contracture, and chronic left ankle ulcer (sore that forms on the skin or the lining of an organ that does not heal properly) with necrosis (death of cells or tissue through disease or injury) of the muscle. A review of Resident 78's PT Evaluation and Plan of Treatment (PT Eval), dated 2/14/2023, indicated Resident 78 was referred to PT services for an evaluation due to limited and painful movement, decreased ROM, decreased strength, and decreased functional mobility (ability to move around and perform daily tasks). The PT Eval indicated Resident 78's left leg ROM was Within Functional Limits (WFL, sufficient joint movement to functionally complete daily routines). The PT Eval indicated Resident 78's right leg ROM was impaired at the hip and the knee. The PT Eval indicated Resident 78's right knee was contracted in a bent position with knee extension measured at negative 80 degrees (normal range equals zero degrees). The PT Eval indicated a recommendation for Resident 78 to wear a knee extension splint on the right knee at all times to maintain joint integrity (strength, stability, and movement of the joint). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 78's Minimum Data Set (MDS, an assessment and care-screening tool), dated 2/18/2023, indicated Resident 78 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 78 required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene and total dependence with transfers. The MDS indicated Resident 78 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg and no functional ROM limitations in both arms. A review of Resident 78's PT Discharge Summary, dated 4/18/2023, indicated Resident 78 required set-up assistance with transfers. The PT Discharge Summary indicated a Restorative Nursing Program was not indicated at the time of discharge. The PT Discharge Summary indicated the reason for discharge from PT services was highest practical level achieved. A review of Resident 78's MDS, dated [DATE], indicated Resident 78 was cognitively intact. The MDS indicated Resident 78 required moderate assistance for dressing, toilet hygiene, and personal hygiene and partial/moderate assistance with transfers. The MDS indicated Resident 78 had functional limitations in ROM in one leg and no functional ROM limitations in both arms. During a concurrent observation and interview on 5/1/2024 at 1:20 pm, in Resident 78's room, Resident 78 was observed lying in bed with both knees bent. Resident 78's right leg was observed to be amputated below the level of the knee and was resting on a pillow with the knee fully bent. No splint was observed on Resident 78's right leg. Resident 78 tried to straighten both knees but could not. Resident 78 stated he was unable to straighten both knees and needed help with leg exercises because both of his legs felt very stiff. Resident 78 stated he never had a splint for the right leg, had not received help with leg exercises for about a year, and required assistance from staff getting into a wheelchair, getting dressed and toileting. During an interview on 4/30/2024 at 3:04 pm, with the Director of Rehabilitation (DOR) who was also a physical therapist, the DOR stated most residents in the facility were either on skilled therapy services and/or RNA services to maintain and improve their level of function and prevent any declines. The DOR stated any resident in the facility who was identified as having less than normal ROM in the arms and/or legs should be on skilled therapy services or in the RNA program to prevent functional declines and contractures. During a concurrent interview and record review on 5/1/2024 at 2:43 pm, with the DOR, Resident 78's PT records was reviewed. The DOR confirmed Resident 78 was evaluated by PT on 2/14/2023 and discharged from PT services on 4/18/2023. The DOR confirmed Resident 78's leg left ROM was WFL which meant Resident 78's leg ROM was not within normal range but had sufficient ROM to perform activities of daily living (ADLs, basic activities such as dressing and toileting) and transfers. The DOR confirmed Resident 78 had a right knee contracture, was lacking 80 degrees of right knee extension, and recommended a right knee extension splint to be worn at all times to maintain joint integrity. The DOR stated he did not remember if a right knee splint was ever issued to Resident 78 as recommended by PT on the PT Eval on 2/14/2023. The DOR stated he did not recall why Resident 78 was discharged from PT services and why he did not recommend RNA services upon discharge to maintain Resident 78's mobility and ROM. The DOR stated the facility did not have a monitoring system in place to detect changes in a resident's ROM and mobility and depended on the residents, nursing, or other direct care staff to inform the rehabilitation department if a resident's ROM and/or mobility declined. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/1/2024 at 2:57 pm, in Resident 78's room, the DOR assessed Resident 78's mobility and ROM of both legs. Resident 78 was observed lying in bed with both knees bent. Resident 78 tried to extend the left knee but could not. The DOR tried to straighten Resident 78's left knee but could not. The DOR assessed Resident 78's right knee and stated Resident 78's right knee was contracted in a bent position. The DOR bent and straightened Resident 78's right knee minimally. The DOR measured Resident 78's left knee and stated Resident 78's left knee ROM was negative 48 degrees or lacking 48 degrees of motion to attain a fully straight position. Resident 78 sat up at the edge of the bed without assistance. While at the edge of the bed, the DOR placed a gait belt (safety device worn around the waist that can be used help safely transfer a person from one surface to another or while walking) around Resident 78's waist and moved Resident 78's wheelchair to the left side of the bed. The DOR grabbed Resident 78's gait belt and assisted Resident 78 onto the wheelchair. Resident 78 sat in the wheelchair for two minutes and transferred back to bed with the DOR's assistance. During a concurrent interview and record review on 5/1/2024 at 3:25 pm, Resident 78's PT notes and PT Eval dated 2/14/2023 was reviewed. The DOR confirmed Resident 78 had a decline in left knee ROM and mobility. The DOR stated Resident 78's left knee felt very stiff. The DOR stated he was unable to straighten Resident 78's left knee and the knee joint felt hard when trying to straighten the leg. The DOR stated the PT Eval, dated 2/14/2023 indicated Resident 78's left leg ROM was WFL and did not indicate any ROM limitations. The DOR stated Resident 78's right leg was contracted and had minimal ROM. The DOR stated Resident 78 could have benefited from a right knee extension splint to protect the knee joint and to ensure Resident 78's knee ROM did not worsen. The DOR stated either the rehabilitation department or the RNA applied splints to the residents once recommended by therapy. The DOR stated the RNA did not apply the right knee splint as recommended by PT since RNA services were never ordered for Resident 78. The DOR reviewed the PT notes and stated there was no documented evidence to indicate Resident 78 received or wore a right knee splint as recommended by PT on 2/14/2023. The DOR stated Resident 78 required set-up assistance for transfers at the time of discharge from PT on 4/18/2023 and now required contact guard assistance (touching assistance, minimal physical contact provided to the resident by staff for safety and/or stabilization) for transfers to and from a wheelchair which was a functional decline. The DOR stated nursing should have notified the rehabilitation department when they noticed Resident 78's left knee was losing ROM and/or when he required more assistance for transfers but did not. The DOR stated the rehabilitation department was unaware Resident 78 had a functional decline because they were never notified by nursing and there was no other routine screening or monitoring systems in place to check for declines. The DOR confirmed Resident 78 did not have treatment and services in place to maintain and prevent a decline in ROM and mobility after discharge from PT services on 4/18/2023. The DOR stated if residents did not receive treatment and services to maintain ROM and mobility such as rehab services, RNA services, and/or splints, it could potentially lead to a functional decline and contracture development. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/2/2024 at 11:14 am, with the MDS Director (MDSD), Resident 78's MDS dated [DATE] and 2/1/2024 and PT notes was reviewed. The MDSD confirmed Resident 78 was identified as having mobility deficits and functional ROM limitations in one leg both upon admission and during the most recent annual assessment. The MDSD stated if mobility and functional ROM deficits were identified on the MDS, the resident should have been given treatment and services such as PT, Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) and/or RNA services to maintain and prevent a decline. The MDSD reviewed Resident 78's clinical record and confirmed Resident 78 did not have any treatment or services in place to maintain mobility and ROM after discharge from PT services on 4/18/2023. The MDSD stated Resident 78 was at high risk for contracture development and a functional decline due to his diagnosis of a right below knee amputation and decreased mobility and should have been on therapy or RNA services to address the decline in ROM and mobility identified in the MDS but was not. The MDSD stated if residents did not receive treatment and services to maintain ROM and mobility, it could potentially lead to a contracture development and a decline in function. During an interview on 5/2/2024 at 2:52 pm, with the the Director of Nursing (DON), the DON stated the facility provided therapy and/or RNA services to ensure residents maintained their current level of function and did not have a decline in function, mobility, and ROM. The DON stated the rehabilitation department assessed residents for splinting needs and communicated the recommendation to nursing or RNA to ensure the recommended splint was applied for contracture management. The DON stated if residents did not receive treatment and services to maintain ROM and mobility such as therapy, RNA services, and splints, it could potentially lead to a functional decline, increased weakness, muscle atrophy (decrease in size or wasting away of a body part of tissue), and contractures. The DON stated the facility did not have any policies and procedures for maintaining a resident's ROM and mobility and contracture management. During a review of the facility's policy and procedure (P/P) titled, Use of Assistive Devices, revised June 2023, the P/P indicated the facility would provide assistive devices such as orthotic or prosthetic equipment for those residents who required them to maintain or improve function and/or dignity. The P/P indicated the nursing, dietary, social services, and therapy departments would work together to ensure availability of devices such as ordering and/or replacement. 2. A review of Resident 29's Admission Record indicated Resident 29 was admitted to the facility on [DATE] and readmitted the resident on 8/11/2022 with diagnoses including Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), right sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body), and muscle weakness. A review of Resident 29's MDS, dated [DATE], indicated Resident 29 had moderate cognitive impairment. The MDS indicated Resident 29 required set-up assistance for eating, partial/moderate assistance for upper body dressing, transfers, and walking, and maximal/substantial assistance for toilet hygiene, lower body dressing, and rolling to both sides. The MDS indicated Resident 29 had functional ROM limitations in one arm and one leg. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 29's PT Discharge Summary, dated 11/10/2023, indicated the reason for discharge from PT services was Maximum Potential Achieved, referred for RNP. The PT Discharge Summary indicated Resident 29's prognosis (likely outcome or course of a disease, illness, or problem) to maintain his current level of function was excellent with participation in RNP. The PT Discharge Summary indicated the physical therapist established and recommended a Restorative Ambulation Program for RNA to ambulate with Resident 29 using a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking), as tolerated, once daily, five times a week. A review of Resident 29's February 2024 RNA Documentation Survey Report, indicated for RNA to ambulate with Resident 29 using a FWW, five times a week, as tolerated. The squares on the Documentation Survey Report indicated NA on the following days: 2/4/2024, 2/12/2024, 2/13/2024, 2/14/2024, 2/15/2024, 2/16/2024, 2/17/2024, 2/21/2024, 2/22/2024, 2/23/2024, and 2/25/2024. A review of Resident 29's March 2024 RNA Documentation Survey Report, indicated an for RNA to ambulate with Resident 29 using a FWW, five times a week, as tolerated. The squares on the Documentation Survey Report indicated NA on the following days: 3/5/2024, 3/6/2024, 3/7/2024, 3/8/2024, 3/9/2024, 3/11/2024, 3/12/2024, 3/13/2024, 3/14/2024, 3/16/2024, 3/18/2024, 3/22/2024, 3/23/2024, and 3/24/2024. A review of Resident 29's April 2024 RNA Documentation Survey Report, indicated for RNA to ambulate with Resident 29 using a FWW, five times a week, as tolerated. The squares on the Documentation Survey Report indicated NA on the following days: 4/3/2024, 4/5/2024, 4/6/2024, 4/7/2024, 4/10/2024, 4/12/2024, 4/14/2024, 4/23/2024, 4/26/2024, and 4/27/2024. The square on the Documentation Survey Report on 4/9/2024 was blank. During a concurrent observation and interview on 5/1/2024 at 8:46 am, in Resident 29's room, Resident 29 was observed lying in bed. Resident 29 stated staff assisted him with walking exercises two times a week. Resident 29 stated he was able to walk using a FWW with assistance but was unable to walk far distances due to fatigue and left knee pain. During an interview on 4/30/2024 at 3:04 pm, with the DOR, the DOR stated the rehabilitation department referred residents to the RNA program to ensure the residents maintained their current level of function after discharge from therapy services. The DOR stated the licensed therapist established an ambulation and/or exercise program for the resident prior to discharge from therapy services, discussed and trained the RNAs in the established program, and updated the resident's care plan and nursing task to reflect the type of exercises and frequency of the program for the RNAs to carry out. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/2/2024 at 10:14 am, with the Director of Staff Development (DSD), Resident 29's RNA Documentation Survey Reports for the months of February 2024, March 2024, and April 2024 was reviewed. The DSD reviewed Resident 29's RNA Documentation Survey Reports for the months of February 2024, March 2024, and April 2024 and confirmed Resident 29 had RNA tasks for RNA to provide RNA ambulation exercises five times a week. The DSD stated a blank square and NA (Not Applicable) on the RNA Documentation Survey Report indicated the resident was not seen for RNA treatment that day. The DSD confirmed Residents 29 missed 8 days of scheduled RNA services for the month of February, 8 days of scheduled RNA services for the month of March, and four days of scheduled RNA services for the month of April. The DSD stated she did not know why Resident 29 did not receive RNA treatments five times a week per PT's established ambulation program and task. The DSD stated it was important for RNA to provide services as indicated per the RNA task and established RNA program because missed sessions could place residents at risk for a functional decline. The DSD stated most of the RNA referrals were from the rehabilitation department to maintain the resident's current level of function after discharge from therapy services. During an interview on 5/2/2024 at 2:52 pm, with the DON, the DON stated the purpose of the RNA program was to maintain a resident's current level of function. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function, mobility, and ROM. A review of the facility's policy and procedure (P/P), titled Restorative Nursing Programs, revised December 2021, indicated the facility provided maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. The P/P indicated the concept of the RNA program was to focus on achieving and maintain optimal physical, mental, and psychosocial functioning. The P/P indicated the interdisciplinary team would ensure the ongoing review, evaluation, and decision-making regarding services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences. The P/P indicated residents would receive services from RNAs when they were assessed to have a need for RNA services, which included passive or active ROM, amputation/prosthesis care, and training and skill practice in transfers or walking. The P/P indicated potential candidates for RNA services may be identified through one or more of the following processes including physical assessments, MDS assessments, specialized rehabilitation assessments, and in-house referrals. The P/P indicated the Restorative Nurse was responsible for maintaining a current list of residents who required RNA to ensure all elements of the resident's program were implemented.

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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** 47092 Based on observation, interview, and record review, the facility failed to accurately monitor and record the total amount of calories received via enteral feeding (nutrition that bypasses the mouth and delivers via the stomach) for one of three residents (Resident 2). This deficient practice had the potential to result in Resident 2 not receiving an adequate amount of calories which could potentially lead to weight loss. Findings: A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), gastrostomy ([g-tube] the creation of an artificial external opening into the stomach for nutritional support), and dysphagia (difficulty swallowing). A review of Resident 2's History and Physical (H&P), dated 1/5/2023, indicated Resident 2 did not have capacity to understand and make decisions. A review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/27/2024, indicated Resident 2 was moderately cognitively impaired (ability to think and reason). The MDS indicated Resident 2 was dependent (helper does all the effort) on staff for hygiene, toileting, dressing, bathing, and eating. A review of Resident 2' Physician Orders, dated 9/11/2023, indicated Resident 2 was to receive Jevity 1.2 (a type of liquid feeding) via enteral pump (a feeding pump that moves fluid at a controlled rate to an enteral site such as a g-tube) at an infused rate of 50 milliliters ([ml] a unit of measurement) per hour for 20 hours for a total of 1000 ml. The orders indicated to begin the feeding at 2 p.m. daily until the dose was delivered. A review of Resident 2's care plan for altered nutrition and hydration, undated, indicated to administer enteral feeding as ordered to prevent unintended weight loss or dehydration. During an observation on 4/29/2024 at 10:24 a.m., Resident 2 was observed asleep in bed with the enteral feeding connected to the resident but turned off. Resident 2's Jevity 1.2 bottle was dated hung on 4/28/2024 at 6 a.m., and with 700 ml out of 1500 ml left in the bottle. During an interview on 4/29/2024 at 1:22 p.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated he turned off Resident 2's enteral pump off around 10:00 a.m. LVN 2 stated Resident 2 received a total amount of 786 ml of Jevity 1.2 since 4/28/2024. LVN 2 stated he would start a new bottle of Jevity 1.2 at 2 p.m. as ordered. (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 observation on 4/30/2024 at 9:29 a.m., Resident 2 had Jevity 1.2 infusing at 50 ml per hour. Resident 2's Jevity 1.2 bottle was dated hung on 4/29/2024 at 3:35 p.m., and with 1000 ml out of 1500 ml left in the bottle. The enteral pump machine indicated Resident 2 received a total fed amount of 864 ml. During a concurrent observation and interview on 4/30/2024 at 11:00 a.m., with LVN 2, LVN 2 turned off Resident 2's enteral pump. LVN 2 stated Resident 2 received a total amount of 895 ml since 4/29/2024. LVN 2 stated he turned off the feeding pump because the order was to turn off the pump at 10 a.m. every day, and then restart the feeding again at 2 p.m. LVN 2 stated Resident 2 should be off feeding for a total of 4 hours. LVN 2 stated normally the pump was restarted at 2 p.m. but he changed the feeding on 4/29/2024 at 3:35 p.m. Resident 2's Jevity 1.2 bottle had a total of 950 ml out of 1500 ml left to be infused. During an observation on 5/1/2024 at 9:36 a.m., Resident 2's Jevity 1.2 bottle was dated hung 5/1/2024 at 2:00 a.m., and was currently infusing at 50 ml per hour, with a total of 957 ml given (total fed) and had a total of 750 ml out of 1500 ml left in the bottle. During a concurrent observation and interview on 5/1/2024 at 9:47 a.m., LVN 3, LVN 3 stated Resident 2's current feeding was hung at 2 a.m. from the previous shift, and that the current rate was 50 ml per hour, with approximately 750 ml of Jevity 1.2 left in the bottle. LVN 3 stated according to the time the bottle was hung, the rate of infusion, and the current time, Resident 2 should have received approximately 375 ml. LVN 3 stated per the total amount fed indicated on the machine, Resident 2 received 957 ml. LVN 3 stated she did not know why there was a discrepancy and was unsure of the total amount Resident 2 actually received. LVN 3 stated Resident 2's enteral pump total fed amount should be reset upon finishing the feeding dose. LVN 3 proceeded to turn off the enteral pump and stated it should be turned off at 10:00 a.m. everyday. During a concurrent observation and interview on 5/1/2024 at 9:56 a.m., with Registered Nurse (RN) 1, RN 1 stated the total volume fed on the enteral pump should match the order. RN 1 stated the total fed amount should only be cleared after Resident 2 had the full 1000 ml. RN 1 turned on Resident 2's enteral feeding and stated the total amount was 970 ml, but that it should be 1000 ml. RN 1 stated the nurses documented in the medication administration record (MAR) in real time when the feeding was administered. RN 1 stated the concern with the discrepancy of Resident 2's total fed amount on the enteral pump, the infusion rate, and the time the Jevity 1.2 bottle was started was that Resident 2 could lose weight from a lack of adequate nutrition. During an interview on 5/1/2024 at 10:13 a.m., with LVN 2, LVN 2 stated on 4/30/2024 at 2 p.m., he administered Resident 2's feeding. During an interview on 5/1/2024, at 10:46 a.m., with the Director of Nursing (DON), the DON stated for enteral feedings the order must be followed which included the type of formula, the rate of the feeding, the total number of hours to be infused, and the total volume fed. The DON stated the total fed amount and the rate of a feeding given via the enteral pump had to be set on the pump by the nurse, and after the total fed amount was complete it should be reset. The DON stated when nurses signed the Resident 2's MAR, it did not reflect the actual time given but the actual time given was the time indicated on the Jevity 1.2 bottle. (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 the facility's policy and procedure (P&P) titled Enteral Nutritional Therapy, undated, the P&P indicated documentation may include the date, time, type, and amount of feeding administered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 37) did not receive unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) when: 1. Lorazepam (brand name Ativan, used to act on the brain and nerves to produce a calming effect) was administered for behaviors not indicated in the physician order or resident's care plan. 2. Certified Nursing Assistant (CNA) observations were used for clinical justification in determining whether to attempt a gradual dose reduction (GDR, the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for Resident 37's lorazepam order. 3. Resident 37's attending physician did not document the risk benefit analysis for continued administration of lorazepam beyond 14 days. These deficient practices placed Residents 37 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication or intervention) related to psychotherapeutic medication use. Findings: 1. A review of Resident 37's Admission Record indicated Resident 37 was originally admitted to the facility on [DATE], and was most recently readmitted on [DATE]. Resident 37's admitting diagnoses included metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and history of falling. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care-planning/care-screening tool), dated 4/2/2024, indicated Resident 37 had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 37 did not exhibit any hallucinations, delusions, or behavioral symptoms. A review of Resident 37's care plan, dated 5/4/2023, indicated Resident 37 had anxiety (feeling of unease, excessive worry). The staff's interventions indicated to monitor for repetitive motions and administer anti-anxiety medication as ordered. A review of Resident 37's medical record titled Documentation Survey Report, dated 1/1/2024 to 1/31/2024, indicated Resident 37 did not exhibit repetitive motion for the entire month of 1/2024. A review of Resident 37's EMAR, dated 1/1/2024 to 1/31/2024, indicated Resident 37 received lorazepam 1 mg a total of 39 times from 1/1/2024 to 1/31/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 37's medical record titled Documentation Survey Report, dated 2/1/2024 to 2/29/2024, indicated Resident 37 did not exhibit repetitive motion for the entire month of 2/2024. A review of Resident 37's EMAR, dated 2/1/2024 to 2/29/2024, indicated Resident 37 received lorazepam 1 milligram (mg, unit of measurement) a total of 13 times from 2/1/2024 to 2/29/2024. A review of Resident 37's medical record titled Documentation Survey Report, dated 3/1/2024 to 3/31/2024, indicated Resident 37 did not exhibit repetitive motion for the entire month of 3/2024. A review of Resident 37's EMAR, dated 3/1/2024 to 3/31/2024, indicated Resident 37 received lorazepam 1 mg a total of one (1) time from 3/1/2024 to 3/4/2024. A review of Resident 37's active physician orders, dated 3/4/2024 to current, indicated Resident 37's lorazepam orders were continued at 1 mg every six (6) hours as needed (PRN) for anxiety for another 90 days. A review of Resident 37's EMAR, dated 3/1/2024 to 3/31/2024, indicated Resident 37 received lorazepam 1 mg a total of 14 times from 3/4/2024 to 3/31/2024. A review of Resident 37's medical record titled Documentation Survey Report, dated 4/1/2024 to 4/30/2024, indicated Resident 37 did not exhibit the behavior of repetitive motion for the entire month of 4/2024. A review of Resident 37's EMAR, dated 4/1/2024 to 4/30/2024, indicated Resident 37 received lorazepam 1 mg a total of 23 times from 4/1/2024 to 4/31/2024. During an interview on 5/1/2024 at 1:58 p.m., with the Director of Staff Development (DSD), the DSD stated certified nursing assistants (CNAs) and licensed nurses documented resident behaviors at least once every shift, or as needed. The DSD stated these behaviors were stored in the resident's electronic health record (EHR) and documented on the resident's electronic medication administration record (EMAR). During a concurrent interview and record review, on 5/1/2024 at 4:15 p.m., with the Director of Nursing (DON), the DON reviewed Resident 37's discontinued and current physician orders for administration of lorazepam. The DON stated that the physician orders indicated lorazepam was to be administered for anxiety. The DON stated the specific behavioral manifestation of anxiety was not indicated in the physician orders. The DON stated the specific behavioral manifestation would be identified in Resident 37's care plan. During an interview on 5/2/2024 at 1:04 p.m., with the DON, the DON stated Resident 37's lorazepam dose should only be administered when the indicated behavior of repetitive motion was observed. A review of the facility's policy and procedure (P&P) titled Psychotropic Medication Management, dated 12/2017, indicated the facility policy was that psychotropic medications should only be used when necessary to minimize or eliminate medical symptoms and promote/maintain a Resident's highest practicable mental, physical, and psychosocial well-being. The P&P further indicated observed or reported behaviors are to be documented in the EHR [electronic health record]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility (P&P) titled Medication Administration, dated 10/15/2019 and revised on 10/22/2023, the P&P indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. 2. A review of Resident 37's care plan, dated 5/4/2023, did not indicate revisions to the targeted behaviors for administration of lorazepam, and still indicated to administer lorazepam for repetitive motions. A review of Resident 37's record titled Psychotropic Behavior Summary GDR Form, indicated Resident 37's lorazepam orders were being reviewed on 6/7/2023. The record indicated Resident 37 exhibited a total of 173 mood/behavior from May 2023 to June 2023. The record did not specify the specific mood or behaviors, and did not specify whether they were observed or documented by a CNA or licensed nurse. The record indicated Resident 37's physician did not attempt a GDR for Resident 37's lorazepam, and indicated [Resident 37's physician] would like to continue [lorazepam] for 90 more days [due to] persistent behaviors. A review of Resident 37's medical records titled Documentation Survey Report, dated 5/2023 and 6/2023, indicated Resident 37 did not exhibit the behavior of repetitive motion during the months of 5/2023 and 6/2023. A review of Resident 37's discontinued physician orders, dated 6/7/2023 to 9/6/2023, indicated Resident 37's lorazepam orders were continued at 1 mg every six (6) hours as needed for anxiety for 90 days. A review of Resident 37's care plan, dated 5/4/2023, did not indicate revisions to the targeted behaviors for administration of lorazepam, and still indicated to administer lorazepam for repetitive motions. A review of Resident 37's record titled Psychotropic Behavior Summary GDR Form, indicated Resident 37's lorazepam orders were being reviewed on 9/6/2023. The record further indicated Resident 37 exhibited 66 mood/behavior episodes from July 2023 to September 2023. The record did not specify the specific mood or behaviors, and did not specify whether they were observed or documented by a CNA or licensed nurse. The record indicated Resident 37's physician did not attempt a GDR for Resident 37's lorazepam, and indicated As per [Resident 37's physician], medication to continued [for] 90 more days. A review of Resident 37's discontinued physician orders, dated 9/6/2023 to 12/5/2023, indicated Resident 37's lorazepam orders were continued at 1 mg every six (6) hours PRN for anxiety for another 90 days. A review of Resident 37's medical records titled Documentation Survey Report, dated 7/2023, 8/2023, and 9/2023, indicated Resident 37 did not exhibit the behavior of repetitive motion during the months of 7/2023, 8/2023, and 9/2023. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 37's record titled Psychotropic Behavior Summary GDR Form, indicated Resident 37's lorazepam orders were being reviewed on 12/5/2023. The record further indicated Resident 37 exhibited 145 mood/behavior episodes from October 2023 to December 2023. The record did not specify the specific mood or behaviors, and did not specify whether they were observed or documented by a CNA or licensed nurse. The record indicated Resident 37's physician did not attempt a GDR for Resident 37's lorazepam, and indicated [Resident 37's physician] notified that [Resident 37] scheduled for GDR, informed of behaviors and frequency [with] new order to continue [lorazepam] for another 90 days. A review of Resident 37's discontinued physician orders, dated 12/5/2023 to 3/4/2024, indicated Resident 37's lorazepam orders were continued at 1 mg every six (6) hours PRN for anxiety for another 90 days. A review of Resident 37's medical records titled Documentation Survey Report, dated 10/2023, 11/2023, and 12/2023, indicated Resident 37 did not exhibit the behavior of repetitive motion during the months of 10/2023, 11/2023, and 12/2023. A review of Resident 37's care plan, dated 5/4/2023, did not indicate a revision to the targeted behaviors for administration of lorazepam. During a concurrent interview and record review, on 5/1/2024 at 2:58 p.m., with the Social Services Director (SSD), the SSD reviewed Resident 37's undated medical record titled Psychotropic Behavior Summary GDR Form. The SSD stated the form was used to review any psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) Resident 37 was receiving. The SSD stated the number of behavior/mood episodes documented on the form included any behaviors documented, not just the specific behavior indicated for administration of the medication being reviewed. The SSD stated she also did not differentiate between behaviors documented by the CNAs or the licensed nurses. During a concurrent interview and record review, on 5/1/2024 at 4:15 p.m., with the DON, the DON reviewed Resident 37's medical records titled Psychotropic Behavior Summary GDR Form, dated from 2023 to 2024, and Resident 37's care plan for anxiety, dated 5/4/2023. The DON stated the findings on the form were presented to Resident 37's physician to determine if a gradual dose reduction (GDR) was appropriate and to identify any unnecessary medications Resident 37 might be receiving. The DON stated a GDR was a safe way to determine if Resident 37 could tolerate a lower dose of lorazepam. The DON stated it was not in the CNAs scope of practice to assess residents, and stated CNA observations were not supposed to be used as clinical justification for the continued use of lorazepam. The DON further stated that the behaviors documented on Resident 37's records titled Psychotropic Behavior Summary GDR form, dated from 2023 to 2024, were not specific to the behaviors Resident 37's lorazepam was ordered for. The DON stated the lorazepam was only supposed to be administered when Resident 37 displayed repetitive motion. The DON stated there was a risk for irreversible side effects and complications related to psychotropic use in elderly residents and residents with dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/2024 at 10:31 a.m., with the facility's Consultant Pharmacist (CP), the CP stated lorazepam should only be administered for the indicated behavior. The CP stated Resident 37 met the criteria for an elderly patient (age 65 or older) and stated lorazepam dosage in the elderly should not exceed two (2) milligrams a day per the manufacturer's guidelines. The CP stated there was potential for Resident 37 to experience respiratory depression, sedation, and risk for falls related to lorazepam use at doses beyond the manufacturer's guidelines. The CP stated psychotropics should be administered at the least amount required to be effective, which was why GDRs were important. An attempt was made to reach Resident 37's physician on 5/2/2024 at 12:42 p.m. but no answer was received. A review of the facility P&P titled Psychotropic Medication Management, dated 12/2017, indicated the resident's care plan should include behavioral manifestations which prompted need for medication and observed or reported behaviors, effectiveness of non-drug approaches, and monitoring of medication side effects are to be documented in the EHR [electronic health record]. A review of the facility document titled Job Description/Performance Evaluation for CNAs, dated 11/13/2017, indicated CNAs were required recognize and adhere to capabilities within the CNA scope of practice. The job description did not include assessments of residents. 3. A review of Resident 37's discontinued physician orders, dated 6/7/2023 to 9/6/2023, indicated lorazepam 1 mg every six (6) hours PRN for anxiety for 90 days. A review of Resident 37's discontinued physician orders, dated 9/6/2023 to 12/5/2023, indicated lorazepam 1 mg every six (6) hours PRN for anxiety for 90 days. A review of Resident 37's active physician orders, dated 3/4/2024 to current, indicated lorazepam 1 mg every six (6) hours PRN for anxiety for 90 days. During a concurrent interview and record review, on 5/1/2024 at 4:15 p.m., with the DON, the DON reviewed Resident 37's physician progress notes. The DON stated Resident 37's physician did not document a risk/benefit analysis related to Resident 27's continued lorazepam use beyond the federal guideline of 14 days. An attempt was made to reach Resident 37's physician on 5/2/2024 at 12:42 p.m. but no answer was received. During a review of the facility P&P titled Psychotropic Medication Management, dated 12/2017, indicated clinically necessary PRN psychotropic drug orders are limited to 14 days. If the prescribing practitioner determines a need for continued PRN use beyond the original 14 days, it is accompanied by supporting documentation in the electronic health record (EHR) including the rational for continued use and duration. The P&P further indicated medications prescribed outside federal guidelines are to be supported by documented evidence from the practitioner evaluating risks versus benefits of use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to: 1. Ensure expired Ozempic (once-weekly injection to manage blood glucose levels) was removed and discarded for one out of three residents (Resident 51) medications reviewed in two of two inspected medication carts (Middle Station Medication Cart). 2. Ensure medication remaining at the facility after two of two residents (Resident 55 and 88) was discharged from the facility was removed from active supply, marked discontinued and securely stored until destroyed in accordance with the facility's Policy and Procedure (P&P) titled, Discontinued Medications, dated ,d+[DATE]. These deficient practices increased the risk that Residents 51 could have received medication that had become ineffective or toxic due to improper storage or labeling, which had the potential to lead to health complications related to Diabetes (a group of disease that result in too much sugar in the blood), hospitalization or death. For Resident 55 and Resident 88, these deficient practices had the potential for inadvertent (accidental) administration to Resident 55 and 88, misuse, and medication errors. Findings: 1. A review of Resident 51's Admission Record (a document containing demographic and diagnostic information), dated [DATE], indicated that the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 51's diagnoses included Type 2 diabetes mellitus (a medical condition characterized by the inability to control blood sugar) with hypoglycemia (low blood sugar) without coma and Type 2 diabetes mellitus with chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 51's History and Physical (H&P), dated [DATE], indicated the resident had the capacity to understand and make decisions. A review of Resident 51's Order Summary Report, dated [DATE], indicated an order for Ozempic (semaglutide) 0.25 milligrams (MG, unit of measurement) subcutaneous (SQ, an injection in which a needle is inserted just under the skin) injection. Inject 0.25 mg SQ one time a day every Thursday for weight loss, order date [DATE]. During a concurrent interview and medication cart inspection on [DATE] at 10:05 a.m. with Licensed Vocational Nurse (LVN) 4, observed Resident 51's Ozempic pen with an open date of [DATE] inside of Middle Station Medication Cart. LVN 4 stated that Resident 51 received Ozempic 0.25 mg once a week on Thursdays. (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 review on [DATE] at 10:09 a.m., with LVN 4, the manufacturer's information packet for Ozempic was reviewed. The manufacturer's information packet indicated, once used, it (Ozempic) can be stored for 56 days at room temperature between 59 degrees Fahrenheit (F, a scale for measuring temperature) and 86 degrees F or in a refrigerator between 36 degrees F and 46 degrees F. The manufacturer's information packet indicated Ozempic would expire 56 days after the pen's first use and should be properly disposed of, even if there was medicine remaining in the pen. During a concurrent interview and record review on [DATE] at 10:11 a.m. with LVN 4, LVN 4 reviewed Resident 51's Medication Administration Record (MAR, a written record of all medications given to a resident) for the month of ,d+[DATE]. LVN 4 stated that Resident 51 was documented to have received a dose of Ozempic 0.25 mg last on [DATE] which was over 56 days from first use on [DATE] , and expired on [DATE]. LVN 4 stated the medication was no longer any good and should have been discarded and reordered for the resident. During an interview on [DATE] at 4:17 p.m., with the Director of Nursing (DON), the DON stated he was notified of Ozempic's shortened expiration date but that he was not aware that it expired after 56 days. A review of the facility's Policy and Procedure (P&P) titled, Storage of Medication, dated ,d+[DATE], indicated, outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication, and reordered from the pharmacy, if a current order exists. The P&P indicated medication storage conditions are monitored on a monthly basis by the consultant pharmacist and corrective action taken if problems are identified. 2a. During a concurrent observation and interview on [DATE] at 9:51 a.m. with LVN 4, Middle Station Medication Cart was inspected, inside of Middle Station Medication Cart was multiple bubble packs (a specific type of packaging used primarily for unit-dose packaging of medications) of medications labeled for Resident 55 and Resident 88 mixed in with current residents' medications. LVN 4 stated Resident 55 and Resident 88 were both transferred to the hospital and not currently in the facility. LVN 4 stated Resident 55 was on Bedhold (the right of an individual to resume nursing facility residency after he or she has been away from the facility due to hospitalization or therapeutic leave) since [DATE] and Resident 88 was on bedhold since [DATE]. A review of Resident 55s Admission Record, dated [DATE], indicated that the resident was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 55's diagnoses included Type 2 diabetes mellitus, hyperlipidemia (high cholesterol), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), and hypertension (high blood pressure). A review of the facility's form titled, Situation, Background, Assessment, Recommendation (SBAR, a reliable consistent process to facilitate concise, clear, focused communication) COC (Change of Condition) 911 Transfer, dated [DATE], indicated Resident 55 experienced an episode of hypoglycemia and was transferred out of the facility to a general acute care hospital (GACH) on [DATE] at 1:09 a.m. with orders for a 7 (seven) day bedhold (the right of an individual to resume nursing facility residency after he or she has been away from the facility due to hospitalization or therapeutic leave). (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 medication cart inspection on [DATE] at 9:51 a.m. with LVN 4, of the Middle Station Medication Cart, the following bedhold medications for Resident 55 was observed inside of the medication cart mixed with current residents' medications that include but not limited to: a. Two different blood pressure medications Coreg and Nifedipine. b. Ciprofloxacin (an antibiotic). c. Two different medications for diabetes (a group of disease that result in too much sugar in the blood) Glipizide, an oral pill and Insulin Lispro(a hormone that lowers the level of glucose [a type of sugar] in the blood), an injectable insulin. d. Atorvastatin (a medication to lower cholesterol). e. Eliquis (a blood thinner). f. Two prescription eye drops, used to lower pressure in the eye, Lumigan and Brimonidine. g. Pentoxifylline (improves the flow of blood through blood vessels). 2b. During a review of Resident 88s Admission Record, dated [DATE], the admission record indicated that the resident was admitted on [DATE], diagnoses included, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease ([COPD] a group of diseases that cause airflow blockage and breathing-related problems), Acute Respiratory Failure (a serious lung condition that causes low blood oxygen) with Hypoxia (low levels of oxygen in the body), Unspecified Traumatic Brain Injury (damage to the brain), and Osteoarthritis (the swelling and tenderness of one or more joints). During a review of Resident 88's document titled Notice of Transfer or Discharge, dated [DATE] indicated, the resident was discharged from the facility. During a medication cart inspection on [DATE] at 9:51 a.m. with LVN 4, of the Middle Station Medication Cart, the following bedhold medications for Resident 88 was observed inside of the medication cart mixed with current residents' medications that include but not limited to: a. Norco (Hydrocodone and acetaminophen combination is used to relieve pain severe enough to require opioid treatment). b. Metoprolol (used to treat high blood pressure, chest pain [angina], and heart failure). c. Atorvastatin (used to lower cholestorol). d. Levetiracetam (used to treat seizures). e. Ipratropium and albuterol (combination medication used to help control the symptoms of lung diseases). f. Trelegy (is a prescription medicine used long term to treat breathing conditions) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Montelukast (helps to reduce inflammation and may be used to prevent asthma attacks). During an interview on [DATE] at 3:19 p.m. with LVN 4, LVN 4 stated there were no markings on the medication bubble packs for Resident 55 or Resident 88 to indicate the resident was transferred out of the facility. LVN 4 stated no one instructed her on how or where to store bedhold medications. LVN 4 stated she stored the medications inside of the medication cart until she was sure the resident(s) was not coming back. LVN 4 stated medications remaining in the medication cart when the resident was not in the facility could create a potential for medication errors and the possiblilty for another resident to receive the discharged resident's medication and a potential drug diversion for controlled medications. During an interview on [DATE] at 3:38 p.m. with the DON, the DON stated the facility's licensed nurse must give to the DON controlled medications as soon as possible when medication orders were changed, discontinued, and when residents were discharged out of the facility or expired (passed away). The DON stated once the resident left the facility, the licensed nurses must remove all the medications from the medication cart and store them in a designated location in the medication room and upon return would review the orders with the physician current orders for any changes or if able to continue the bedhold medications. During an interview on [DATE] at 4:10 p.m. with the DON, the DON stated that Resident 55 and Resident 88's medications should not be inside of the medication cart, only current residents medications. The DON stated Resident 55 and Resident 88's bedhold medications should have been removed and stored in the medication room. The DON stated the facility did not have a policy and procedure specific for handling bedhold medications. During a review of the facility's P&P titled, Discontinued Medications, dated ,d+[DATE], indicated when medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued and destroyed. The P&P indicated medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to honor one out of three residents' food preferences (Resident 65). This deficient practice had the potential for Resident 65 experience discomfort due to indigestion. Findings: A review of Resident 65's Admission Record indicated Resident 65 was admitted to the facility on [DATE]. Resident 65's diagnoses included gastro-esophageal reflux disease ([GERD] a digestive disease in which the stomach acid or bile irritates the food pipe lining), constipation, and nausea with vomiting. A review of Resident 65's History and Physical (H&P), dated 1/10/2023, indicated Resident 65 had the capacity to understand and make decisions. A review of Resident 65's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/6/2024, indicated Resident 65 was cognitively intact (ability to think and reason). A review of Resident 65's GERD care plan, dated 1/27/2023, indicated Resident 65's health goals was to remain free from discomfort or complications related to GERD by avoiding foods or beverages that irritate the esophageal (the muscular tube through which food passes from the throat to the stomach) lining such as alcohol, chocolate, caffeine, acidic or spicy foods, and fried or fatty foods. A review of the facilities recipe for Spanish rice, dated 5/1/2024, indicated the recipe for Spanish rice included green and black peppers. During a concurrent observation and interview on 4/30/2024 at 8:30 a.m., with Resident 65, Resident 65 was observed awake, alert, and oriented, sitting up in bed. Resident 65 stated she did not like the facility's food. During a concurrent observation and interview on 4/30/2024 at 12:39 p.m., with Resident 65, observed Resident 1's lunch meal tray. [NAME] peppers in Resident 1 was observed picking out the green peppers served in the Spanish rice before eating. Resident 65 stated there were too much green peppers in her food which might damage her inflamed stomach. Resident 65 stated two months ago she had informed the Dietary Staff Manager (DSM) that bell peppers irritated her stomach due to chronic gastritis (inflammation of the stomach) and caused discomfort due to producing a lot of gas. Resident 65 stated the DSM told her they could not cook special food items for her because there were a lot of residents. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/2024 at 2:35 p.m., with the DSM, the DSM stated Resident 65 had spoken to her a few months ago regarding not wanting any bell peppers or spicy foods because it hurts the resident's stomach. The DSM stated she updated Resident 65's food preferences, which was a printed paper slip that was placed on her tray. The DSM stated the dietary aide and cook work together by calling out diets and preferences before plating during tray line. The DSM stated the Spanish rice Resident 65 received 4/29/2024 did have bell peppers in it and should have been replaced with an alternative to honor Resident 65's food preferences and prevent digestive irritation. During an interview on 5/2/2024 at 9:34 a.m., with Cook 1, Cook 1 stated during tray line they ensured the diet and preferences match the food given and have alternatives to ensure the resident received the right food. Cook 1 stated Resident 65's diet slip did not specify no bell peppers or peppers. Cook 1 stated the diet slip only stated no spicy foods and she did not consider bell peppers a spicy food. During a concurrent interview and record review on 5/2/2024 at 9:55 a.m. with the DSM, the DSM stated Resident 65's dietary preferences on file stated no spicy food and did not specify no bell peppers. The DSM stated generally people would not consider bell peppers spicy. A review of the facility policy and procedure (P&P) titled Resident Food Preferences, dated 2/2009, indicated the purpose of the policy is to satisfy the resident's taste and appetites by determining and providing their food preferences at meals. The P&P indicated dining and food staff are to: a. Within 48 hours of admission to the facility the Food and Dining Services Manager will inquire as to the resident's specific food preferences, dislikes, and food allergies, which will be documented on tray tickets. b. Be made aware of all preferences and food allergies, and the food and dining services staff will avoid serving products that contribute to food allergies and make every attempt to meet the resident's food preferences.

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Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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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. 47092 Based on observation and interview, the facility failed to ensure all food items stored in the kitchen and dry food storage room were labeled and dated, and failed to ensure safe food preparation practices in the kitchen were followed. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness for residents who received food from kitchen. Findings: During the initial tour of the facility's kitchen on 4/29/2024 at 8:30 a.m., the following was observed: 1. In the refrigerator, there were 10 glasses of milk,10 glasses of juice, one medium sized plastic container of cooked beans, and one medium sized container of apple sauce without a date, and three cartons of milk open without a date. 2. In the refrigerator, there was one large size box of margarine and three plastic bags of uncooked sausages without a date. 3. On top of the kitchen table, there was two medium sized containers with previously cooked rice without a date. 4. In the dry storage room, there was one big sized container with dry uncooked beans unlabeled and without a date. During a concurrent observation and interview on 4/29/2024 at 9:00 a.m. with Cook 1, in the kitchen, Cook 1 stated she did not know when the milk, juice, cooked beans, and apple sauce were prepared. Cook 1 stated dates were necessary to know when food was prepared and when the food should be discarded before expiration. Cook 1 stated the box of margarine and bags of sausage were delivered to the facility last week. Cook 1 stated she did not remember the date. Cook 1 stated she should have labeled the margarine and sausage bag with the delivery date and use by date. Cook 1 stated she was busy and forgot. Cook 1 stated the rice was cooked that morning and should have been dated. Cook 1 stated she usually labeled all dry food containers with a use by date in the dry storage room, but did not label and date the dry beans container. During an interview on 4/30/2024 at 11:25 a.m. with the Dietary Staff Manager (DSM), the DSM stated all foods should be labeled and dated, when in storage for infection control, food safety and to prevent cross contamination of food and to provide good quality and safe food to our residents. A review of facility's Policy and Procedure (P&P) titled Food Safety in Receiving and Storage, effective 2/09, indicated food containers will be labeled with the name of the contents and dated with the date it was transferred to the container.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to provide Occupational Therapy (OT, provides services to increase and/or maintain a person's capability to participate in everyday life activities) services to one of six sampled residents (Resident 78) who had activities of daily living (ADL, basic activities such as eating, dressing, toileting) and functional mobility (ability to move around and perform daily tasks) concerns. This deficient practice prevented Resident 78 from receiving skilled therapy services to maintain or achieve the highest practicable level of function. Findings: A review of Resident 78's Admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including an acquired absence of the right leg below the knee (amputation of the right leg below the level of the knee), right knee contracture (shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints), and chronic left ankle ulcer (sore that forms on the skin or the lining of an organ that does not heal properly) with necrosis (death of cells or tissue through disease or injury) of the muscle. A review of Resident 78's Order Summary Report, dated 2/13/2023, indicated for Resident 78 was to receive an occupational therapy (OT) evaluation and treatment. A review of Resident 78's Minimum Data Set (MDS, an assessment and care-screening tool), dated 2/18/2023, indicated Resident 78 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 78 required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene and total dependence with transfers. The MDS indicated Resident 78 had functional limitations in range of motion (ROM, limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg and no functional ROM limitations in both arms. A review of Resident 78's OT Evaluation and Plan of Treatment dated 2/14/2023, indicated Resident 78 was referred to OT due to a decline in strength, balance, activity tolerance, and safety awareness impacting functional performance. The document indicated Resident 78's prior level of function (functional abilities prior to the condition causing the need for rehabilitation services) was independent in functional mobility and activities of daily living (ADLs, basic activities such as eating, toileting, and dressing). The document indicated Resident 78 required minimal assistance (MIN-A, helper provides 1-25% assistance to complete the task) for hygiene, grooming and upper body dressing, and maximal assistance (required 51-75% physical assistance to perform tasks) for lower body dressing, toileting, and toilet transfers. The document indicated Resident 78 had good rehabilitation potential and was very motivated to return to his prior level of function. The document indicated Resident 78 was at risk for a further decline and immobility (state of not being able to move around) without skilled OT services. The document indicated Resident 78 would receive OT services five times a week for eight weeks. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 78's OT Discharge Summary dated 4/18/2023, indicated Resident 78 required standby assistance (presence of another person within close proximity for safety during performance of an activity) for toileting, set-up/clean up assistance for hygiene/grooming and upper body dressing, moderate assistance (helper provides 26-50% assistance to complete the task) for upper and lower bathing, and MIN-A for lower body dressing. The discharge summary indicated Resident 78 was discharged per Physician or Case Manager. During a concurrent observation and interview on 5/1/2024 at 1:20 pm, in Resident 78's room, Resident 78 was observed lying in bed with both knees bent. Resident 78's right leg was observed to be amputated below the level of the knee and was resting on a pillow with the knee fully bent. Resident 78 tried to straighten both knees but could not. Resident 78 stated he was unable to straighten both knees and needed help with leg exercises because both of his legs felt very stiff. Resident 78 stated he had not received help with leg exercises for about a year and required assistance getting into a wheelchair, getting dressed and toileting. During an interview on 4/30/2024 at 3:04 p.m. with the Director of Rehabilitation (DOR), the DOR stated the facility was responsible for providing the care and services the residents needed, including rehabilitation services regardless of payment source. The DOR stated if insurance coverage ran out and a resident still had skilled therapy needs, the therapist should notify the DOR who would in turn notify the case manager to request re-authorization (process of giving someone the ability to access a resource) to continue therapy services from insurance. The DOR stated the facility should explore alternate means of providing services as needed while waiting for re-authorization or if re-authorization was denied. During a concurrent interview and record review on 5/2/2024 at 12:15 p.m. with Occupational Therapist 1 (OT 1), Resident 78's OT records were reviewed. OT 1 confirmed Resident 78 was evaluated by OT on 2/14/2023 and was discharged from OT services on 4/18/2023. OT 1 stated Resident 78 was discharged from OT services per physician or case manager which meant insurance coverage ended. OT 1 stated the physician did not discontinue OT services. OT 1 stated she was informed Resident 78 no longer had insurance coverage for skilled therapy services and discharged Resident 78 from OT services despite Resident 78 having skilled OT needs. OT 1 stated Resident 78 made good progress in therapy, continued to require assistance with ADLs and functional mobility, and could have benefitted from continued skilled OT services once insurance ended. OT 1 stated she should have informed the DOR, case manager, or business office to request re-authorization or explore alternate ways of obtaining services but did not. OT 1 stated if residents who benefitted or required skilled therapy services did not receive them, it could lead to a functional decline. During an interview on 5/2/2024 at 1:32 p.m. with the DOR, the DOR stated he was unaware and did not recall being informed Resident 78 continued to require skilled OT services after discharge from OT on 4/18/2023. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/2/2024 at 1:52 p.m. with the Social Services Director (SSD), who was also the facility's case manager, the SSD stated residents in the facility who required skilled therapy should receive the services regardless of the payment source. The SSD stated if a resident had skilled therapy needs and insurance coverage ended, the therapist should inform the DOR and the case manager so she can collaborate with the team and the insurance carrier to request re-authorization, inform the resident and family of the appeal process, or explore alternate means of providing the service. The SSD stated she was never informed Resident 78 had continued skilled OT needs once insurance coverage ended. During an interview on 5/2/2024 at 2:52 p.m. with the Director of Nursing (DON), the DON stated the facility was responsible for providing the care and services the residents in the facility needed regardless of payment source. The DON stated if insurance coverage ended and a resident still had skilled therapy needs, the facility should request for insurance re-authorization, put the resident on an RNA program in the meantime, and discuss alternative ways to provide the service. The DON stated if residents who required skilled therapy services did not receive them, it could negatively affect the discharge plan since the resident would not make progress towards established goals and potentially lead to a functional decline. The DON stated the facility did not have policies on Rehabilitation Services, maintaining ADLs, and maintaining mobility. During an interview on 5/2/2024 at 4:12 p.m. with the Administrator (ADM), the ADM stated the facility was responsible for providing the care and services the residents needed regardless of payment source. The ADM stated if insurance coverage ended and a resident still had skilled therapy needs, the facility should find ways to ensure the resident gets his or her needs met such as requesting re-authorization, exploring different insurance coverage plans, and looking for alternate ways of providing the services.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to ensure one out of three Residents (Resident 74) understood and received the arbitration agreement in a language (Spanish) Resident 74 could understand when entering a binding contract. This deficient practice had the potential to result in harm for Resident 74 by waiving his right to a jury trial when taking legal action without his knowledge. Findings: A review of Resident 74's Admission Record indicated Resident 74 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 74's diagnoses included stage renal disease (is the final, permanent stage of kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own) and dependence on renal dialysis (is the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). A review of Resident 74's History and Physical (H&P), dated 12/5/2023, indicated Resident 74 had capacity to understand and make decisions. A review of Resident 74's Arbitration Agreement, dated 5/30/2023, indicated Resident 74 signed the arbitration agreement in English, on 5/30/2023. During an interview on 5/2/2024, at 9:10 a.m., with the Admission Coordinator (ADMC), the ADMC stated Resident 74's arbitration agreement should have been in Spanish since Resident 74 only spoke Spanish. During a concurrent observation and interview on 5/2/2024 at 10:18 a.m., with Resident 74, Resident 74 was awake and alert, and stated he only speaks, reads, and writes in Spanish. Resident 74 stated he did not remember signing an arbitration agreement and was probably out of it when he signed that day. During an interview on 5/2/2024, at 1:14 p.m., with the Administrator (ADM), the ADM stated arbitration was explained to residents by the ADMC, was an optional form, and should be presented in a language the resident understands. A review of facility policy and procedure (P&P) titled Binding Arbitration Agreement, dated 5/2023, indicated the facility must ensure the resident or representative acknowledges that he/she understands the agreement, and in a language the resident or representative understands.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility did not ensure enhanced barrier precautions (EBPs, an infection control intervention used to reduce transmission of multidrug-resistant organisms [MDROs, organisms resistant to at least one or more classes of antimicrobial agents]) were implemented for 16 of 16 sampled residents (Residents 59, 70, 94, 46, 25, 74, 92, 71, 48, 38, 40, 69, 26, 2, 62, 247). This deficient practice increased the risk for spread of MDROs to vulnerable facility residents, and the potential incidence of preventable infection. Findings: 1. A review of Resident 59's Admission Record indicated Resident 59 was originally admitted to the facility on [DATE], and most recently readmitted Resident 59 on 7/13/2023. Resident 59's admitting diagnoses included cellulitis (a common and potentially serious bacterial skin infection) of the right lower leg and a pressure ulcer (PU, injury to skin and underlying tissue resulting from prolonged pressure) above the tailbone. A review of Resident 59's medical record titled Skin & Wound Evaluation, dated 4/27/2024, indicated Resident 59 had a Stage II PU (a type of PU that extends below the surface of the skin) measuring 5.8 centimeters (cm, unit of measurement) in length and 4.6 cm in width. A review of Resident 59's active physician orders indicated Resident 59 did not have orders for EBP. During an observation on 4/29/2024 at 12:10 p.m., outside of Resident 59's room, no signage was observed indicating Resident 59 was on EBP. No personal protective equipment (PPE, protective garments or equipment designed to protect the wearer's body from infection) was observed outside of or near Resident 59's room. During an observation on 4/30/2024 at 10:59 a.m., outside of Resident 59's room, no signage was observed indicating Resident 59 was on EBP. No personal protective equipment (PPE, protective garments or equipment designed to protect the wearer's body from infection) was observed outside of or near Resident 59's room. 2. A review of Resident 70's Admission Record indicated Resident 70 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 70's admitting diagnoses included local infection of the skin and underlying tissue, diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy) with skin complications, and surgical amputation of toes from the left and right foot. A review of Resident 70's medical record titled Skin & Wound Evaluation, dated 4/30/2024, indicated Resident 70 had a surgical incision to the left foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 70's active physician orders indicated Resident 70 did not have orders for EBP. During an observation on 4/29/2024 at 12:10 p.m., outside of Resident 70's room, no signage was observed indicating Resident 70 was on EBP. No personal protective equipment was observed outside of or near Resident 70's room. During an observation on 4/30/2024 at 10:59 a.m., outside of Resident 70's room, no signage was observed indicating Resident 70 was on EBP. No personal protective equipment was observed outside of or near Resident 70's room. 3. A review of Resident 94's Admission Record indicated Resident 94 was admitted to the facility on [DATE]. Resident 94's admitting diagnoses included end stage renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and extended spectrum beta lactamase (ESBL, an enzyme created by certain MDROs, making the organism harder to treat with antibiotics) resistance. A review of Resident 94's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 3/28/2024, indicated Resident 94 was receiving dialysis treatment and had intravenous (IV, any method used to access the bloodstream through the veins) access. A review of Resident 94's active physician orders indicated Resident 94 did not have orders for EBP. During an observation on 4/30/2024 at 11:03 a.m., outside of Resident 94's room, no signage was observed indicating Resident 94 was on EBP. No personal protective equipment was observed outside of or near Resident 94's room. During an observation on 5/2/2024 at 9:26 a.m., outside of Resident 94's room, no signage was observed indicating Resident 94 was on EBP. No personal protective equipment was observed outside of or near Resident 94's room. 4. A review of Resident 46's Admission Record indicated Resident 46 was admitted to the facility on [DATE]. Resident 46's admitting diagnoses included a Stage IV PU (a type of PU with full thickness tissue loss, with exposed bone, tendon, or muscle). A review of Resident 46's medical record titled Skin & Wound Evaluation, dated 4/25/2024, indicated Resident 46 had a Stage IV PU measuring 0.8 cm in length and 1.4 cm in width. The record further indicated Resident 46's PU had light, serosanguineous (clear, blood-tinged) exudate (fluid produced by a wound as it heals). A review of Resident 46's active physician orders indicated Resident 46 did not have orders for EBP. During an observation on 4/30/2024 at 11:03 a.m., outside of Resident 46's room, no signage was observed indicating Resident 46 was on EBP. No personal protective equipment was observed outside of or near Resident 46's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/2/2024 at 9:26 a.m., outside of Resident 46's room, no signage was observed indicating Resident 46 was on EBP. No personal protective equipment was observed outside of or near Resident 46's room. 5. A review of Resident 25's Admission Record indicated Resident 25 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 25's admitting diagnoses included failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments) and quadriplegia (complete or partial inability to move both arms and both legs). A review of Resident 25's MDS, dated [DATE], indicated Resident 25 had a feeding tube (a tube inserted through the wall of the abdomen directly into the stomach, used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation). A review of Resident 25's active physician orders indicated Resident 25 did not have orders for EBP. The orders also indicated Resident 25 was receiving daily nutrition through her feeding tube. During an observation on 4/30/2024 at 11:38 a.m., outside of Resident 25's room, no signage was observed indicating Resident 25 was on EBP. No personal protective equipment was observed outside of or near Resident 25's room. During an observation on 5/2/2024 at 8:25 a.m., outside of Resident 25's room, no signage was observed indicating Resident 25 was on EBP. No personal protective equipment was observed outside of or near Resident 25's room. 6. A review of Resident 74's Admission Record indicated Resident 74 was originally admitted Resident on 12/4/2022, and most recently readmitted on [DATE]. Resident 74's admitting diagnoses included ESRD, dependence on renal dialysis, and infection and inflammatory reaction due to peritoneal dialysis catheter (a flexible tube inserted into the abdomen that remains in place to remove waste products from the blood). A review of Resident 74's MDS, dated [DATE], indicated Resident 74 was receiving dialysis treatment. A review of Resident 74's care plan, dated 12/11/2023, indicated Resident 74 was at risk for infection at dialysis access site: right upper chest PermaCath (a catheter for dialysis, that is placed into the blood vessel in your neck or upper chest and ends in the right side of the heart, that can remain in place up to 12 months). During an observation on 5/2/2024 at 8:26 a.m., outside of Resident 74's room, no signage was observed indicating Resident 74 was on EBP. No personal protective equipment was observed outside of or near Resident 74's room. During an observation, on 5/2/2024 at 9:02 a.m., in Resident 74's room, observed Resident 74's PermaCath. No signage was observed indicating Resident 74 was on EBP. No personal protective equipment was observed outside of or near Resident 74's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A review of Resident 92's Admission Record indicated Resident 92 was admitted to the facility on Resident 92 on 3/14/2024. Resident 92's admitting diagnoses included inability to move the left side of her body following a cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and dysphagia (difficulty swallowing). A review of Resident 92's physician orders indicated Resident 92 did not have orders for EBP. Resident 92's physician orders further indicated Resident 92 received IV fluids. During a concurrent observation and interview, on 4/29/2024 at 10:47 a.m., with Resident 92's family member (FM 1), at Resident 92's bedside, observed an IV access to Resident 92's right arm. FM 1 stated Resident 92 was receiving fluids intravenously. During an observation on 4/30/2024 at 11:34 a.m., there was no signage was observed indicating Resident 92 was on EBP. No personal protective equipment was observed outside of or near Resident 92's room. Resident 92 was observed lying in bed with IV access to her right arm. 8. A review of Resident 71's Admission Record indicated Resident 71 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 71's admitting diagnoses included inability to move the right side of her body following a cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and dysphagia (difficulty swallowing) following cerebral infarction. A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had a feeding tube. A review of Resident 71's active physician orders indicated Resident 71 did not have orders for EBP. The orders also indicated Resident 71 was receiving daily nutrition through a feeding tube. During an observation on 4/30/2024 at 11:38 a.m., outside of Resident 71's room, no signage was observed indicating Resident 71 was on EBP. No personal protective equipment was observed outside of or near Resident 71's room. During an observation on 5/2/2024 at 8:27 a.m., outside of Resident 71's room, no signage was observed indicating Resident 71 was on EBP. No personal protective equipment was observed outside of or near Resident 71's room. 9. A review of Resident 48's Admission Record indicated Resident 48 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 48's admitting diagnoses included gangrene (dead tissue caused by an infection or lack of blood flow), ESRD, and dependence on renal dialysis. A review of Resident 48's active physician orders indicated Resident 48 did not have orders for EBP. During an observation on 4/30/2024 at 11:35 a.m., outside of Resident 48's room, no signage was observed indicating Resident 48 was on EBP. No personal protective equipment was observed outside of or near Resident 48's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/2/2024 at 8:28 a.m., outside of Resident 48's room, no signage was observed indicating Resident 48 was on EBP. No personal protective equipment was observed outside of or near Resident 48's room. Inside Resident 48's room, observed PermaCath to Resident 48's right upper chest. 10. A review of Resident 38's Admission Record indicated Resident 38 was admitted to the facility on [DATE]. Resident 38's admitting diagnoses included neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). A review of Resident 38's MDS, dated [DATE], indicated Resident 38 had an indwelling urinary catheter (a flexible tube inserted into the bladder, that remains in place for draining urine). A review of Resident 38's physician orders indicated Resident 38 did not have orders for EBP. Resident 38's physician orders further indicated Resident 38 had a Foley catheter (a type of indwelling urinary catheter). During an observation on 4/30/2024 at 11:37 a.m., outside of Resident 38's room, no signage was observed indicating Resident 38 was on EBP. No personal protective equipment was observed outside of or near Resident 38's room. During an observation on 5/2/2024 at 8:27 a.m., outside of Resident 38's room, no signage was observed indicating Resident 38 was on EBP. No personal protective equipment was observed outside of or near Resident 38's room. 11. A review of Resident 40's Admission Record indicated Resident 40 was admitted to the facility on [DATE]. Resident 40's admitting diagnoses included neuromuscular dysfunction of bladder. A review of Resident 40's MDS, dated [DATE], indicated Resident 40 had an indwelling urinary catheter. A review of Resident 40's physician orders indicated Resident 40 did not have orders for EBP. Resident 40's physician orders further indicated Resident 40 had a Foley catheter. During an observation on 4/30/2024 at 11:40 a.m., outside of Resident 40's room, no signage was observed indicating Resident 40 was on EBP. No personal protective equipment was observed outside of or near Resident 40's room. During an observation on 5/2/2024 at 8:27 a.m., outside of Resident 40's room, no signage was observed indicating Resident 40 was on EBP. No personal protective equipment was observed outside of or near Resident 40's room. 12. A review of Resident 69's Admission Record indicated Resident 69 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 69's admitting diagnoses included chronic kidney disease (longstanding disease of the kidneys leading to renal failure), extended spectrum beta lactamase resistance, neuromuscular dysfunction of bladder, and dysphagia with a feeding tube. A review of Resident 69's MDS, dated [DATE], indicated Resident 69 had an indwelling urinary catheter and a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056144	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 69's physician orders indicated Resident 69 did not have orders for EBP. Resident 69's physician orders further indicated Resident 69 had a suprapubic catheter (a type of indwelling urinary catheter that is inserted into the bladder through the abdominal wall) and was receiving nutrition through his feeding tube daily. During an observation on 4/29/2024 at 9:40 a.m., inside Resident 69's room, Resident 69 was observed lying in bed, with nutrition infusing into his feeding tube via machine, and Resident 69's catheter was observed hanging on the bed, draining urine. Outside of Resident 69's room, no signage was observed indicating Resident 69 was on EBP. No personal protective equipment was observed outside of or near Resident 69's room. During an observation on 4/30/2024 at 11:36 a.m., outside of Resident 69's room, no signage was observed indicating Resident 69 was on EBP. No personal protective equipment was observed outside of or near Resident 69's room. During an observation on 5/2/2024 at 8:28 a.m., outside of Resident 69's room, no signage was observed indicating Resident 69 was on EBP. No personal protective equipment was observed outside of or near Resident 69's room. 13. A review of Resident 26's Admission Record indicated Resident 26 was admitted to the facility on [DATE]. Resident 26's admitting diagnoses included an unstageable PU (a type of full thickness PU where the depth of the wound or is completely obscured by eschar [dead tissue] in the wound bed). A review of Resident 26's medical record titled Skin & Wound Evaluation, dated 4/28/2024, indicated Resident 26 had a wound to her left foot, measuring 7.3 cm in length and 7.2 cm in width. The record further indicated the wound had light, serous [clear, liquid part of blood] drainage. A review of Resident 26's physician orders indicated Resident 26 did not have orders for EBP. During an observation on 4/29/2024 at 9:50 a.m., outside of Resident 26's room, no signage was observed indicating Resident 26 was on EBP. No personal protective equipment was observed outside of or near Resident 26's room. During an observation on 4/30/2024 at 11:31 a.m., outside of Resident 26's room, no signage was observed indicating Resident 26 was on EBP. No personal protective equipment was observed outside of or near Resident 26's room. 14. A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 2's admitting diagnoses included dysphagia with a feeding tube. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a feeding tube. A review of Resident 2's physician orders indicated Resident 2 did not have orders for EBP. Resident 2's physician orders further indicated Resident 29 was receiving nutrition through her feeding tube daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/29/2024 at 10:24 a.m., outside of Resident 2's room, no signage was observed indicating Resident 2 was on EBP. No personal protective equipment was observed outside of or near Resident 2's room. During an observation on 4/29/2024 at 1:22 p.m., in Resident 2's room, observed Licensed Vocational Nurse (LVN) 2 providing care to Resident 2 and handling Resident 2's feeding tube. LVN 2 was not wearing PPE. Outside of Resident 2's room, no signage was observed indicating Resident 2 was on EBP. No personal protective equipment was observed outside of or near Resident 2's room. During an observation on 5/2/2024 at 9:28 a.m., outside of Resident 2's room, no signage was observed indicating Resident 2 was on EBP. No personal protective equipment was observed outside of or near Resident 2's room. 15. A review of Resident 62's Admission Record indicated Resident 62 was admitted to the facility on [DATE]. Resident 62's admitting diagnoses included pancytopenia (a condition in which there is a lower-than-normal number of red and white blood cells and platelets in the blood, increasing infection risk), ESRD, and dependence on renal dialysis. A review of Resident 62's care plan, dated 8/23/2023, indicated Resident 62 had risk for infection due to her PermaCath to her right upper chest area. A review of Resident 62's physician orders indicated Resident 62 did not have orders for EBP. During an observation on 5/1/2024 at 12:15 p.m., outside of Resident 62's room, no signage was observed indicating Resident 62 was on EBP. No personal protective equipment was observed outside of or near Resident 62's room. During an observation on 5/2/2024 at 8:59 a.m., outside of Resident 62's room, no signage was observed indicating Resident 62 was on EBP. No personal protective equipment was observed outside of or near Resident 62's room. In Resident 62's room, observed Resident 62 with a PermaCath on her right upper chest. 16. A review of Resident 247's Admission Record indicated Resident 247 was admitted to the facility on [DATE]. Resident 247's Admission Record did not have any admitting diagnoses indicated. A review of Resident 247's care plan, dated 4/26/2024, indicated Resident 247 had ESRD and was receiving dialysis treatment. The care plan indicated Resident 247 had risk for infection related to the PermaCath to the right upper chest area. A review of Resident 247's physician orders indicated Resident 247 did not have orders for EBP. During a concurrent observation and interview, on 4/29/2024 at 2:15 p.m., with Resident 247, Resident 247 stated that he recently started dialysis. Resident 247 then showed his PermaCath to his right upper chest area. During an observation on 5/2/2024 at 8:55 a.m., outside of Resident 247's room, no signage was observed indicating Resident 247 was on EBP. No personal protective equipment was observed outside of or near Resident 247's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/2/2024 at 9:00 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated EBP was used to prevent spread of MDROs. The IPN stated that EBP required staff to wear a gown and gloves while performing high contact activities such as showering residents, changing bed linens, handling indwelling medical devices, and providing wound care. The IPN stated indwelling medical devices included urinary catheters, feeding tubes, and PermaCath dialysis catheters. The IPN stated that EBP was not currently being implemented for any facility residents. The IPN reviewed the facility policy and procedure (P&P) titled Enhanced Barrier Precautions, and stated it was dated 3/2023. The IPN stated that according to the P&P, EBP was supposed to be implemented for all facility residents with wounds and indwelling medical devices. The IPN stated the purpose of implementing EBP was infection prevention and stated that not implementing EBP could increase the risk for infection in the facility. A review of the facility P&P titled Enhanced Barrier Precautions, dated 3/2023, indicated it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The P&P indicated MDROs included ESBL, and indicated PPE was supposed to be available immediately near or outside of the resident's room. The P&P indicated an order for enhanced barrier precautions will be obtained for residents with any of the following: a. Wounds (e.g., chronic wounds such as pressure ulcers and unhealed surgical wounds) and/or indwelling medical devices (e.g.,urinary catheters and feeding tubes). b. Infection or colonization with a MDRO.