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	05/08/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47679 Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled residents' (Resident 45) call light was within reach. This deficient practice had the potential to result in a delay and the inability for Resident 45 to obtain care and services from the facility's staff. Findings: During a review of Resident 45's Admission Record (Face Sheet), the Face Sheet indicated Resident 45 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 45's diagnoses included cognitive communication deficit (difficulties with communication due to problems with thinking and processing information, rather than just speech or language issues), generalized muscle weakness (feeling weak throughout the body), and dementia (a progressive state of decline in mental abilities). During a review of Resident 45's Minimum Data Set ([MDS], a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 45's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 45 required moderate assistance (helper does less than half the effort) with oral hygiene and personal hygiene and was dependent on staff's assistance with toileting, bathing, and lower body dressing. During a review of Resident 45's care plan titled, At Risk for Falls, dated 4/4/2025, the care plan indicated to minimize and manage Resident 45's risk for falls. The staff interventions indicated to keep the call light within Resident 45's reach. During a review of Resident 45's care plan titled, Communication Problem Related to Cognitive Communication Deficit, dated 4/7/2025, the care plan indicated Resident 45 would be able to make basic needs known daily. The staff interventions indicated to provide a safe environment and to have the call light within Resident 45's reach. During a review of Resident 45's care plan titled, Alteration in Musculoskeletal Status, dated 4/10/2025, the care plan indicated staff to anticipate Resident 45's needs and to ensure Resident 45's call light was within reach and responded promptly. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/5/2025 at 11:41 a.m. and 1:04 p.m., inside Resident 45's room, Resident 45 was observed laying in bed. Resident 45's call light hung behind Resident 45's bed and Resident 45 unable to reach it. During a concurrent observation and interview on 5/6/2025 at 10:42 a.m., with Certified Nursing Assistant (CNA) 2, inside Resident 45's room, Resident 45 was observed laying in bed. Resident 45's call light was clipped to the overhead light and Resident 45 unable to reach it. CNA 2 stated Resident 45's call light was not within reach. CNA 2 stated since the call light was outside of Resident 45's reach, Resident 45 would not be able to call for assistance. CNA 2 stated when she assisted Resident 45 inside his room and fixed his bed, the call light was moved out of the way. CNA 2 stated she forgot to put the call light within reach before leaving the room. During an interview on 5/7/2025 at 10:49 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated call lights were used by the residents to call for assistance. LVN 1 stated when a resident was in bed, the call light would be clipped to the pillowcase or the bed sheet to ensure the call light would not fall onto the floor and would be within the resident's reach. LVN 1 stated Resident 45 used the call light when he needed assistance. LVN 1 stated if Resident 45's call light was not within his reach, Resident 45 was at risk, not only for a delay in his needs being attended to, but at risk for falls if Resident 45 tried to get out of bed to signal for a staff member. During an interview on 5/7/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated call lights were used by the residents to ask for assistance. The DON stated when a resident was in their room, especially in bed, their call light had to be within their reach in case they needed assistance. The DON stated due to Resident 45's call light not within his reach, Resident 45 was at risk of his needs being not being met and Resident 45 may take it upon himself to do the tasks on his own, putting Resident 45 at risk of falling and sustaining an injury. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 10/2022, the P&P indicated, Staff will ensure the call light is within reach of resident and secured, as needed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to promptly notify the physician and the responsible party (RP) of a significant change in condition (COC), related to decline in mobility and ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) for one of six sampled residents (Resident 72). This deficient practice had the potential to result in a delay in medical assessment and treatment for Resident 72 and placing the resident at risk of significant decline in functional status, including total dependency for mobility, and increased dependency in ([ADLs]- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). Cross Reference F688 Findings: During a review of Resident 72's Admission Record (Face Sheet),the Face Sheet indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included dementia, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (loss of muscle strength). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 6/10/2024, the MDS indicated Resident 72's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 72 required moderate (helper does less than half the effort) assistance from staff for ADLs. The MDS indicated Resident 72 required moderate assistance from staff for sitting to standing and transfer from a bed to a chair. The MDS indicated Resident 72 was not assessed for walking due to medical conditions or safety concerns. During a review of Resident 72's care plan titled Resident with self-care deficit ., initiated 6/10/2024, the care plan indicated the facility would monitor, document, and report any changes for self-care deficit and decline in Resident 72's function. During an observation on 5/5/2025 at 11:47 a.m., in Resident 72's room, Resident 72 was observed lying in bed, asleep. During an observation on 5/7/2025 at 10:22 a.m., in the hallway, Resident 72 was observed sitting on the wheelchair asleep. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/6/2025 11:25 a.m., with Resident 72's RP 1, RP 1 stated he visited Resident 72 daily since the resident's admission to the facility. RP 1 stated Resident 72 was able to walk independently and sometimes used a walker (mobility aid). RP 1 stated he noticed over the past four months, Resident 72 increasingly began to spend more time in bed and was sleeping more; however, this change was not discussed with RP 1 by the facility. RP 1 stated he wanted the facility to get Resident 72 out of bed more often and provide therapy. During a concurrent interview and record review on 5/8/2025 at 9:15 a.m., with Occupational Therapy Assistant (OTA) 1, Resident 72's occupational therapy treatment encounter notes, dated 6/6/2024 to 9/12/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on 6/6/2024, and Resident 72 required moderate assistance from staff for ADLs. OTA 1 stated Resident 72 received OT services from 6/6/2024 to 9/12/2024 and the resident achieved maximum potential (highest level of functional abilities). OTA 1 stated Resident 72 was discharged from therapy on 9/12/2024 with an order for the Restorative Nursing Assistance ([RNA]- certified nursing aide program that helps residents to maintain or improve their physical function) program. OTA 1 stated she was not aware of the resident's current ADLs status. OTA 1 stated if there was a significant change of condition related to Resident 72's increased dependency in ADLs, licensed staff should have notified the physician timely to prevent delays in care and services. During a concurrent interview and record review on 5/8/2025 at 9:25 a.m., with Physical Therapy (PT) 1, Resident 72's physical therapy treatment encounter notes, dated 6/6/2025 to 7/31/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on dated 6/6/2024 and Resident 72 was able to ambulate (walk) five feet using a two-wheeled walker (a mobility aid). PT 1 stated Resident 72 received PT services from 6/6/2024 to 7/30/2024 and reached a high level of mobility (ambulate independently). PT 1 stated Resident 72 was discharged from therapy on 7/31/2024 and did not require the RNA program. PT 1 stated Resident 72 had no need for a wheelchair during PT treatment and/or upon discharge from PT services. PT 1 stated Resident 72 was not referred again for PT after being discharged on [DATE]. PT 1 stated he was not aware Resident 72 was now wheelchair bound. PT 1 stated if there was a change of condition related to the decline in a resident's mobility, the nurses were responsible for notifying the physician immediately for an order and referral for therapy. During a concurrent observation and interview on 5/8/2025 at 10:00 a.m., in Resident 72's room, with Certified Nursing Assistant (CNA) 3, CNA 3 was observed transferring Resident 72 from a shower chair to the bed using a mechanical lift (a device used to assist in lifting transferring residents with limited mobility). CNA 3 stated Resident 72 was no longer able to stand up on her feet or walk and now required staff assistance for transfers. CNA 3 stated Resident 72 was able to stand and walk when first admitted to the facility but no longer could due to a decline in mobility and increased need for physical support. During a concurrent interview and record review on 5/8/2025 at 10:15 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 72's Electronic Medical Records (EMR) were reviewed. The EMR indicated Resident 72 was able to stand and walk short distances with a walker upon admission to the facility but now required a wheelchair. LVN 2 stated there was no documented evidence in the EMR to reflect a timely resident assessment and/or physician notification. LVN 2 stated Resident 72's decline in mobility and ADLs should have been assessed, and the physician should have been notified to prevent delays of medical assessment, care, and treatment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 10:25 a.m., with the MDS Nurse (MDSN), Resident 72's MDS dated [DATE] and 12/4/2024 were reviewed. Resident 72's MDS dated [DATE] indicated Resident 72 was able to walk at least 10 to150 feet with moderate assistance. Resident 72's MDS dated [DATE] indicated Resident 72 was not able to walk at least 10 feet due to medical condition or safety concerns. The MDSN stated this change reflected a significant decline in functional mobility and required reassessment and care plan revision. The MDSN stated Resident 72's physician should have been notified of the significant change of condition so resident would be evaluated and referred to therapy for services and treatment. During a concurrent interview and record review on 5/8/2025 at 2:20 p.m., with the Director of Nursing (DON), Resident 72's EMR was reviewed. The DON stated staff were to communicate a change of condition with the physician as needed. The DON stated he was not able to find documented evidence that the facility reassessed Resident 72 and addressed her functional status decline and/or timely physician notification. The DON stated the facility could have done better in notifying Resident 72's physician timely. The DON stated this could have placed Resident 72 at risk for delayed interventions, care and services, and further physical decline. During a telephone interview on 5/9/2025 at 3:04 p.m., with Resident 72's physician, the physician stated he was not aware of Resident 72's significant change of condition related to decline in mobility and increased dependency with ADLs. During a review of the facility's policy and procedure (P&P) titled Change of Condition, dated 2016, the P&P indicated the facility would provide treatment and services to address residents' changes. The P&P indicated if there were residents with a change of condition the facility would: 1. Document assessment findings and communications as soon as practical. 2. Notify physician and responsible party of assessment findings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool), for two of six sampled residents (Residents 9, and 3) was accurately coded to reflect Residents 9 and 3's oral and/or dental status. This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 9 and 3's dental status and had the potential to negatively affect residents' care plan and delivery of necessary care and services. Findings: a. During a review of Resident 9's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 10/10/2024, the MDS indicated Resident 9's cognitive (the ability to think and process information) skills for daily decision making was moderately impaired. The MDS indicated Resident 9 required moderate (helper does less that half effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 9 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 5/5/2025 at 9:35 a.m., in Resident 9's room, with Resident 9, Resident 9 was observed sitting on a wheelchair eating breakfast. Resident 9 stated it was hard to chew because he did not have his natural teeth. Resident 9 stated his dentures were broken. During a concurrent interview and record review on 5/6/2025 at 10:15 a.m., with the MDS Nurse (MDSN), Residents 9's MDS, dated [DATE] section oral/dental was reviewed. The MDS indicated Resident 9's oral/dental status assessment was coded incorrectly. The MDS Nurse stated the MDS did not reflect the resident's actual oral and/or dental status. The MDSN stated Resident 9 had dentures and did not have his natural teeth. The MDS Nurse stated the MDS should have been coded correctly. The MDSN stated inaccuracy in the MDS assessment had the potential to result in not meeting the resident's care needs and services. b. During a review of Resident 3's Face Sheet, the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included dementia, DM, dysphagia, and muscle weakness (loss of muscle strength). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 required maximal (helper does more than half the effort) assistance from staff for ADLs. The MDS indicated Resident 3 was assessed as not having any oral and/or dental issues. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/6/2025 at 8:22 a.m., in Resident 3's room, with Resident 3, Resident 3 was observed sitting up in bed. Resident 3's breakfast plate on the top of the resident's bedside table. Resident 3 stated she did not have any natural teeth and was not able to chew food. Resident 3 stated her dentures felt loose and shifted during meals. During a concurrent interview and record review on 5/6/2025 at 10:22 a.m., with the MDSN, Resident 3's MDS, dated [DATE] section oral/dental status was reviewed. The MDS indicated Resident 3 was assessed as not having any oral/dental issues. The MDSN stated Resident 3's MDS oral/dental status was coded incorrectly as it did not reflect the resident's actual oral and/or dental status. The MDSN stated the inaccurate coding had the potential to impact residents' oral health monitoring, nutritional interventions, and placed the residents at risk for delayed care needs and services. During a review of the facility's policy and procedure (P&P) titled Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) process verification of MDS, undated, the P&P indicated MDS accuracy would be completed by the facility's Interdisciplinary Team and ensure accuracy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to provide care and services to maintain good grooming and personal hygiene for one of 11 residents (Resident 7) by failing to keep Resident 7's fingernails clean and neat. This failure had the potential to result in a negative impact on Resident 7's quality of life and self-esteem. This failure also had the potential for the development of infection. Findings: During an observation on 5/5/2025 at 11:50 a.m., in the activity room, observed Resident 7's fingernails were long with yellow and brown substance underneath. During an observation on 5/6/2025 at 8:15 a.m., in Resident 7's room, observed Resident 7's fingernails were long with yellow and brown substance underneath. During an observation on 5/7/2025 at 1:31 p.m., in the facility's hallway, observed Resident 7's fingernails long with yellow and brown substance underneath. During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was originally admitted to the facility on 3/28/2017 and readmitted on [DATE]. Resident 7's diagnoses included ulcerative colitis (a chronic inflammatory bowel disease [IBD] that caused inflammation and ulcers in the lining of the large intestine) and dementia (a progressive state of decline in mental abilities). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 7's cognitive (the ability to think and process information) skills for daily living was intact. The MDS indicated Resident 7 required setup assistance with eating; moderate assistance (helper did less than half the effort) with oral hygiene; maximal assistance (helper did more than half the effort) with personal hygiene; and was dependent (helper did all the effort) with toileting hygiene, showering/ bathing self, and chair/bed-to-chair transferring. The MDS indicated Resident 7 used a walker and wheelchair for mobility. During a review of Resident 7's History and Physical (H&P), dated 1/15/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's care plan titled Self-care deficit as evidenced by: needs assistance with ADLs (activities of daily living, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), revised on 8/6/2024, the care plan indicated the goal was to keep Resident 7 clean, dry, and well-groomed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/7/2025 at 1:32 p.m., with Certified Nursing Assistant (CNA 1), in the facility hallway, observed Resident 7's fingernails were long with yellow and brown substance underneath. CNA 1 stated Resident 7's fingernails needed to be cleaned. CNA 1 stated Resident 7's long fingernails was a hygiene problem and could cause an infection. CNA 1 stated the CNAs were responsible for making sure residents' fingernails were clean. CNA 1 stated staff checked on residents constantly for cleanliness. During a concurrent interview and picture review on 5/7/2025 at 1:46 p.m. with the Infection Preventionist Nurse (IPN), the pictures dated 5/5/2025 at 11:52 a.m., 5/6/2025 at 8:15 a.m., and 5/7/2025 at 1:31 p.m. were reviewed. The pictures showed Resident 7's fingernails long with yellow and brown substance underneath. The IPN stated Resident 7's fingernails were dirty and needed to be cleaned. The IPN stated that when Resident 7 was eating, Resident 7's fingernails might transmit bacteria into her body. The IPN stated when Resident 7 touched any surface it would transmit the bacteria and put other residents at risk for infection. The IPN stated all nursing staff were responsible to ensure residents' fingernails were clean because of infection control. During a review of the facility's policy and procedure (P&P) titled Bath, Bed, undated, the P&P indicated fingernail care was part of the bath and staff were to be certain that nails were clean. During a review of the facility's Job Description for CNA, revised on 11/13/2017, the Job Description indicated the CNAs would provide assistance with nail care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents' (Residents 33, 70, and 32) low air loss mattresses (LALM, a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) were accurately set to their weight. This deficient practice had the potential to cause the avoidable development and/or worsening of pressure ulcers (PU, localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and the complications associated with impaired skin integrity. Findings: a. During a review of Resident 70's Admission Record (Face Sheet), the Face Sheet indicated Resident 70 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the right dominant side following a cerebral infarct (also known as stroke, a loss of blood flow to a part of the brain), respiratory failure (when the lungs do not work well enough to get enough oxygen into the blood) with hypoxia (low oxygen level in the body's tissues), and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's Minimum Data Set ([MDS], a resident assessment tool), dated 2/11/2025, the MDS indicated Resident 70's cognition (process of thinking) was severely impaired. The MDS indicated Resident 70 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. The MDS indicated Resident 70 was at risk of developing PUs and used a pressure reducing device for the bed. During a review of Resident 70's History and Physical (H&P), dated 5/4/2024, the H&P indicated Resident 70 did not have the capacity to understand and make decisions. During a review of Resident 70's Order Summary Report, dated 1/29/2025, the Order Summary Report indicated Resident 70 could have a LALM in place for skin integrity maintenance. During a review of Resident 70's Braden Scale for Predicting Pressure Sore (Ulcer) Risk, dated 5/4/2025, the Braden Scale indicated Resident 70 was at moderate risk for developing PUs. During an observation on 5/5/2025 at 9:51 a.m., 5/5/2025 at 1 p.m., 5/5/2025 at 3:49 p.m., and 5/6/2025 at 7:51 a.m., in Resident 70's bedroom, Resident 70 was observed lying on a LALM. The LALM was set for a resident that weighed 350 pounds (lbs, a unit of measuring weight). During a concurrent observation and interview on 5/7/2025 at 8:51 a.m., with Treatment Nurse (TN) 1, in Resident 70's bedroom, Resident 70 was observed lying on the LALM with the weight setting on the pump set to 350 lbs. TN 1 stated Resident 70's LALM was set at the highest weight setting. TN 1 stated the LALM was supposed to be set according to Resident 70's weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8:53 a.m., with TN 1, Resident 70's Weight, dated 5/3/2025, was reviewed. TN 1 stated Resident 70 weighed 123 lbs. TN 1 stated Resident 70 did not have any PUs and the LALM was used to maintain Resident 70's skin integrity and to prevent the development of PUs. TN 1 stated the LALM was used to distribute Resident 70's weight to decrease the amount of pressure directed on body areas. TN 1 stated a 350 lb setting on the LALM was too high for Resident 70 and the LALM would be too firm. TN 1 stated this put Resident 70 at risk of developing PUs if the setting on the LALM continued to be incorrectly set. b. During a review of Resident 33's Admission Record (Face Sheet), the Face Sheet indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction, stage three pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region (area at the bottom of the spine and the buttocks), and essential hypertension (elevated blood pressure not due to another medical condition). During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 33's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 33 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. The MDS indicated Resident 33 was at risk of developing PUs. The MDS indicated Resident 33 had an unhealed unstageable PU (unable to stage the PU due to the wound bed covered with slough [dead tissue, usually cream or yellow color] or eschar [dry, black, hard dead tissue]). The MDS indicated Resident 33 had a pressure-reducing device in bed. During a review of Resident 33's H&P, dated 3/10/2025, the H&P indicated Resident 33 did not have the capacity to understand or make decisions. During a review of Resident 33's Order Summary Report, dated 12/17/2024, the Order Summary Report indicated Resident 33 could have a LALM in place. During a review of Resident 33's Braden Scale for Predicting Pressure Sore Risk, dated 3/11/2025, the Braden Scale indicated Resident 33 was at a high risk for developing PUs. During a review of Resident 33's Skin and Wound Evaluation, dated 5/5/2025, the Skin and Wound Evaluation indicated Resident 33 had a Stage Four PU (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) at the sacrococcygeal (region of the body where the lower spine and the tailbone meet). During an observation on 5/5/2025 at 10:43 a.m., 5/5/2025 at 1:05 p.m., 5/5/2025 at 3:52 p.m., and 5/6/2025 at 7:58 a.m., in Resident 33's room, Resident 33 was observed lying on a LALM. The LALM was set for a resident that weighed 350 lbs. During a concurrent observation and interview on 5/7/2025 at 9:06 a.m., with TN 1, inside Resident 33's room, Resident 33 was observed lying on the LALM with the weight setting on the pump set to 350 lbs. TN 1 stated Resident 33's LALM was set at the highest weight setting. TN 1 stated the LALM was supposed to be set according to Resident 33's weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/7/2025 at 9:08 a.m., with TN 1, Resident 33's Weight, dated 5/2/2025, was reviewed. TN 1 stated Resident 33 weighed 159lbs. RN 1 stated Resident 33 had a Stage Four PU and utilized the LALM to reduce the amount of pressure on her sacral area. TN 1 stated 350 lbs was too high for Resident 33 and the LALM should have been set according to Resident 33's weight. TN 1 stated this put Resident 33 at risk of developing new PUs and for her current stage four PU to worsen. During an interview on 5/7/2025 at 2:25 p.m., with the Director of Nursing (DON), the DON stated LALM were utilized to disperse the amount of pressure on the individual's body. The DON stated the LALM should be set close to the resident's weight to disperse the appropriate amount of pressure onto their body. The DON stated that when the LALM is set to a weight higher than the resident's weight, the LALM would become too firm. The DON stated when the LALM was not set correctly, the maximal potential to prevent the development or worsening of PUs would diminish. The DON stated Resident 70 did not have any existing PUs but was at risk of developing a PU or other skin breakdown due to the incorrect LALM setting. The DON stated Resident 33 had an existing PU and was at risk of healing progress to slow down and for the development of new PUs due to the incorrect LALM setting. 48343 c. During a review of Resident 32's Face Sheet, the Face Sheet indicated Resident 32 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN -high blood pressure). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 cognitive skills for daily living was intact. The MDS indicated Resident 32 was dependent on staff for activities of daily living (ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 32 was at risk of developing PUs/injury and used a pressure-reducing device for the bed. During a review of Resident 32's Order Summary Report, dated 5/28/2024, the Order summary Report indicated apply LALM every shift to maintain Resident 32's skin integrity. During a review of Resident 32's Braden Scale for Predicting Pressure Sore Risk, dated 3/4/2025, the Braden Scale indicated Resident 32 was chairfast (cannot walk safely and confined to a chair or wheelchair), was completely immobile (inability to change and control body position without assistance) and was at moderate risk for developing pressure sores. During a review of Resident 32's Weight and Vitals Summary, the Weight and Vitals Summary indicated Resident 32 weighed 157 lbs. on 4/29/2025 and 156 lbs. on 5/5/2025. During a concurrent observation and interview on 5/5/2025 at 9:50 a.m., in Resident 32's room, at Resident 32's bedside, Resident 32 was observed lying on a LALM. Resident 32 stated he was not able to move his body and was totally dependent on staff for repositioning and care. Resident 32 stated his mattress felt hard and he felt uncomfortable lying on his back. Resident 32's LALM was set at 230 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/5/2025 at 3:30 p.m., and 5/7/2025 at 1:20 p.m., at Resident 32's bedside, Resident 32 was observed lying on the LALM. Resident 32's LALM was set at 230 lbs. During a concurrent interview and record review, on 5/7/2025 at 1:25 p.m., with TN 1, Resident 32's Weight and Vitals Summary was reviewed. TN 1 stated Resident 32's Weight and Vitals Summary indicated Resident 32 weighed 157 lbs. on 4/29/2025 and 156 lbs. on 5/5/2025. During a concurrent observation and interview on 5/8/2025 at 1:33 p.m., at Resident 32's bedside, with TN 1, TN 1 stated Resident 32's LAML was set for 230 lbs. TN 1 stated this was setting and not the correct setting for the resident and stated it should be set for the 150-180 lb. setting. TN 1 stated it was important the resident's LALM would be set according to the resident's weight because if it was too soft, the resident would not get adequate support, and if it was too firm it could cause discomfort and increase the risk of PUs. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcer, Prevention of, undated, the P&P indicated to prevent skin breakdown and development of pressure ulcers use pressure reducing or relieving devices as necessary. During a review of the LALM's Operator's Manual titled, Drive Med Aire Plus Alternating Pressure and Low Air Loss Mattress Replacement System Operator's Manual, undated, the manual indicated to adjust the pressure of the mattress based on the patient's weight.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48343 Based on interview and record review, the facility failed to ensure a physician order for physical therapy ([PT]- healthcare specialty focuses on restoring, maintaining, and improving a resident ability to move and function) and occupational therapy ([OT]- a healthcare specialty that helps a resident improve the ability to perform daily activities) services were implemented timely for one of six sampled residents (Resident 72). This deficient practice had the potential to result in a significant decline in Resident 72's functional status, including total dependency for mobility, and increased dependency in activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). Findings: During a review of Resident Admission Record (Face Sheet), the Face Sheet indicated Resident 72 was admitted to the facility on [DATE]. Resident 72's diagnoses included dementia, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (loss of muscle strength). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 6/10/2024, the MDS indicated Resident 72's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 72 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The MDS indicated Resident 72 required moderate assistance from staff for sitting to standing and transfer from a bed to a chair. The MDS indicated Resident 72 was not assessed for walking due to medical conditions or safety concerns. During a review of Resident 72's care plan titled Resident with self-care deficit ., initiated 6/10/2024, the care plan indicated the facility would monitor, document, and report any changes for self-care deficit and decline in Resident 72's function. During a telephone interview on 5/6/2025 11:25 a.m., with Resident 72's Responsible Party (RP) 1, RP 1 stated he visited Resident 72 daily since the resident's admission to the facility. RP 1 stated Resident 72 was able to walk independently and sometimes used a walker (a mobility aid). RP 1 stated he noticed over the past four months Resident 72 increasingly spent more time in bed and was sleeping more than usual. RP 1 stated he wanted the facility to get Resident 72 out of bed more often and provide therapy. RP 1 stated Resident 72 was receiving therapy upon admission to the facility but the facility discontinued therapy services on 9/2024 and has not resumed them since. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 9:15 a.m., with Occupational Therapy Assistant (OTA) 1, Resident 72's OT treatment encounter notes, dated 6/6/2024 to 9/12/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on 6/6/2024 and Resident 72 required moderate assistance from staff for ADLs. OTA 1 stated Resident 72 received OT services from 6/6/2024 to 9/12/2024 and the resident achieved maximum potential (highest level of functional abilities). OTA 1 stated Resident 72 was discharged from therapy on 9/12/2024 with an order for the Restorative Nursing Assistance ([RNA]- certified nursing aide program that helps residents to maintain or improve their physical function) program. OTA 1 stated Resident 72 was not referred again for occupational therapy and she was not aware of the resident's current functional status. During a concurrent interview and record review on 5/8/2025 at 9:25 a.m., with Physical Therapist (PT) 1, Resident 72's PT treatment encounter notes, dated 6/6/2025 to 7/31/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on 6/6/2024 and Resident 72 was able to ambulate (walk) five feet using a two-wheeled walker (a mobility aid). PT 1 stated Resident 72 received PT services from 6/6/2024 to 7/30/2024 and reached a high level of mobility (ambulate independently). PT 1 stated Resident 72 was discharged from therapy on 7/31/2024 and did not require the RNA program. PT 1 stated Resident 72 had no need for a wheelchair during PT treatment and/or upon discharge from PT services. PT 1 stated Resident 72 was not referred again for PT services after being discharged on [DATE]. PT 1 stated he was not aware Resident 72 was now wheelchair bound. PT 1 stated if there was a decline in a resident's mobility, the nurses were responsible for notifying the physician for an order and referral for therapy. During a concurrent observation and interview on 5/8/2025 at 10:00 a.m., in Resident 72's room, with Certified Nursing Assistant (CNA) 3, CNA 3 was observed transferring Resident 72 from a shower chair to the bed using a mechanical lift (a device used to assist in lifting transferring residents with limited mobility). CNA 3 stated Resident 72 was no longer able to stand up on her feet or walk and required staff assistance for transfers. CNA 3 stated Resident 72 was able to stand and walk when first admitted to the facility but could no longer do so due to a decline in mobility and increased need for physical support. During a concurrent interview and record review on 5/8/2025 at 10:15 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 72's Nursing Progress Notes dated 1/3/2025 to 5/4/2025, and Physician Orders, dated 1/2025 to 5/2025, were reviewed. The nursing progress notes indicated there were no assessments related to mobility decline and/or a PT/OT revaluation and treatment. The Physician Orders indicated there were no active orders for PT/OT evaluation. LVN 2 stated Resident 72 was able to stand and walk short distances with a walker upon admission to the facility but now required a wheelchair. LVN 2 stated Resident 72's decline in mobility and ADLs should have been assessed and an order for a PT/OT evaluation and treatment obtained. LVN 2 stated it was the licensed nurses' responsibility to notify the physician but was not done. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 10:25 a.m., with the MDS Nurse (MDSN), Resident 72's MDS dated [DATE] and 12/4/2024 were reviewed. The MDS dated [DATE] indicated Resident 72 was able to walk at least 10 to150 feet with moderate assistance. Resident 72's MDS dated [DATE] indicated Resident 72 was not able to walk at least 10 feet due to medical condition or safety concerns. The MDSN stated the change from 10/10/2024 to 12/4/2024 reflected a significant decline in Resident 72's functional mobility and required reassessment and a care plan revision. The MDSN stated Resident 72's physician should have been notified of the significant change of condition so the resident would be evaluated and referred to therapy for services and treatment. The MDSN stated delays in services and treatment had the potential to place Resident 72 at risk for further mobility and ADL decline. During an interview on 5/8/2025 at 12:19 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated if the nurse received a written and signed order from the physician, the order would be indicated on the resident's order summary report and carried out immediately. RNS 1 stated if a PT/OT order was received the nurse would communicate with the rehabilitation department so the therapists would be aware and carry out the physician order. During a concurrent interview and record review on 5/8/2025 at 12:28 p.m., with RNS 1, Resident 72's Physician Order dated 10/23/2024 was reviewed. RNS 1 stated there was a written and signed physician's order dated 10/23/2024 which indicated Resident 72 required a PT/OT evaluation and wheelchair for mobility. RNS 1 stated there was no documented evidence indicating the order was carried out and/or communicated to the therapy department. RNS 1 stated not carrying out the PT/OT order timely placed Resident 72 at risk for delayed treatment, services, and for further functional and mobility decline. During a concurrent interview and record review on 5/8/2025 at 1:20 p.m., with PT 1, Resident 72's physician order dated 10/23/2024, was reviewed. The physician order indicated Resident 72 required a PT/OT evaluation for a wheelchair. PT 1 stated he was not aware of the order. PT 1 stated if residents required therapy nurses were responsible for obtaining a physician order and communicating the order to the rehabilitation department. PT 1 stated he was not aware Resident 72 had an order for a PT/OT evaluation and wheelchair until after the concern was brought to the rehabilitation department on 5/8/2025. PT 1 stated nurses should have notified the rehabilitation department that there was a physician order for a PT/OT evaluation and treatment so Resident 72 would be assessed and provided with necessary services and treatment as necessary and prevent further mobility decline. During an interview on 5/8/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated the physician's orders should be completed and implemented immediately after they were received. The DON stated the facility staff overlooked Resident 72's physician order for a PT/OT evaluation for a wheelchair, which resulted in delayed care and treatment. The DON stated this could place Resident 72 at risk for mobility and ADL decline. During a review of the facility's policy and procedure (P&P) titled Physician Orders and Telephone Orders, dated 1/2004, the P&P indicated physician's orders would be obtained prior to the initiation of any treatment. The P&P indicated all orders must be complete and carried out without any questions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Ambulation, undated, the P&P indicated facility would provide assistance, assess resident's function, maintain residents' optimal ambulation function, and would assist resident to achieve maximum function. During a review of the facility's P&P titled Range of Motion Exercises, undated, the P&P indicated the facility's responsibilities were to improve or maintain resident's mobility, muscle strength and prevent complications of immobility. During a review of the facility's Registered Nurse (RN) Job Description, undated, the job description indicated RNs duties included but not limited to take, transcribe, and carry out complete orders. The job description indicated RNs would complete appropriate referrals to other departments, including therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure a two-person assist when utilizing the electric stand-up lift (battery-powered device to provide assistance from a sitting to standing position) for one of two sampled residents (Resident 64). This deficient practice had the potential to result in Resident 64 becoming unsteady on the electronic stand-up lift resulting in a fall and/or injury. Findings: During an observation on 5/5/2025 at 1:27 p.m., inside Resident 64's room, Certified Nursing Assistant (CNA) 4 entered Resident 64's room with the electric stand-up lift. CNA 4 did not have another staff member in Resident 64's room to operate the electronic stand-up lift. CNA 4 transferred Resident 64 from the wheelchair to the bed using the electronic stand-up lift alone. During a review of Resident 64's Admission Record (Face Sheet), the Face Sheet indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included multiple sclerosis (a disease that causes breakdown of the protective covering of nerves) and generalized muscle weakness (feeling weak throughout the body). During a review of Resident 64's Minimum Data Set ([MDS], a resident assessment tool), dated 3/10/2025, the MDS indicated Resident 64's cognition (process of thinking) was severely impaired. The MDS indicated Resident 64 required maximal assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, moving from a sit to stand position, and from a chair/bed-to-chair transfer. During a review of Resident 64's History and Physical (H&P), dated 3/6/2025, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a review of Resident 64's care plan titled Self-Care Deficit ., dated 3/5/2025, the care plan indicated staff interventions were to provide a two-person physical assistance with bed mobility and transfers. During a review of the facility's In-Service titled, Hoyer Lift/Standing Machine/Transfers, dated 2/26/2024, the In-Service indicated participants would be able to properly transfer residents from one surface to another with assistance from other nursing staff personnel. The In-service indicated CNA 4 received and understood the In-Service education. During an interview on 5/5/2025 at 1:32 p.m., with CNA 4, CNA 4 stated she used the electric stand-up lift to transfer Resident 64 from his wheelchair to bed. CNA 4 stated she was alone with Resident 64 during the transfer. CNA 4 stated when operating the electric stand-up lift, two people were required to ensure a safe patient-transfer. CNA 4 stated a second person to assist in the transfer was required in case Resident 64 fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 9:46 a.m., with the Director of Staff Development (DSD), the DSD stated two nursing personnel were required to safely operate the electric stand-up lift. The DSD stated the CNAs were educated through in-service training. The DSD stated having a second person there to assist in the transfer was essential for the safety of the residents and the CNA. The DSD stated while operating the electric stand-up lift, Resident 64 could have become unsteady and tip over to either side, causing him to fall. The DSD stated it could also be unsafe for the CNA operating the electric stand-up lift if the CNA tried to catch Resident 64 on their own. During an interview on 5/7/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated a two-person assist was required when operating the electric stand-up lift. The DON stated one person would operate the stand-up lift, while the second person would provide stand-by assistance and stability to the resident. The DON stated during Resident 64's transfer from the wheelchair to the bed, CNA 4 was responsible for having a second person to assist. The DON stated a one-person assist placed Resident 64 at risk for falling during the transfer which could result in a serious injury. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 10/2022, the P&P indicated, The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51859 Based on observation, interview, and record review, the facility failed to provide one of two residents (Resident 80), who required hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), a dialysis emergency kit (e-kit) at bedside. This failure had the potential for Resident 80 to receive delayed intervention in managing dialysis site complications such as bleeding. Findings: During a review of Resident 80's Admission Record, dated 1/15/2025, the admission record indicated the facility admitted Resident 80 on 1/15/2025 with diagnoses including, but not limited to, chronic kidney disease (CKD - a condition that causes gradual loss of kidney function over a period of time) with dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN - high blood pressure). During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2025, the MDS indicated Resident 80's cognition was intact. The MDS indicated Resident 80 required partial assistance from staff with activities such as dressing, personal hygiene, toileting use, and transfer mobility. During an observation on 5/5/2025 at 10:35 a.m., in Resident 80's room, there was no e-kit pinned to the wall, on the nightstand, or inside the bedside drawer. During an observation on 5/5/2025 at 11:36 a.m., in Resident 80's room, there was no e-kit pinned to the wall, on the nightstand, or inside the bedside drawer. During a concurrent observation and interview on 5/5/2025 at 1:05 p.m., in Resident 80's room, there was no e-kit pinned to the wall, on the nightstand, or inside the bedside drawer. Resident 80 stated he had not seen an e-kit inside his room. During a review of Resident 80's Physician Orders, dated 1/16/2025, physician orders indicated Resident 80 was to receive hemodialysis every Monday, Wednesday, and Friday. During a review of Resident 80's Order Summary Report indicated checking dialysis e-kit at bedside and restocking the e-kit as needed. During a review of Resident 80's care plan, dated 1/17/2025, the care plan indicated Resident 80 was at high risk for bleeding due to hemodialysis. The care plan indicated the goal was for Resident 80 would have no massive blood loss while awaiting medical assistance. The care plan indicated an intervention for meeting the goal included ensuring that an e-kit was available at all times in the event of bleeding. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 1:29 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated a complication the staff would monitor for a resident on hemodialysis was bleeding. LVN 1 stated an e-kit contained tape, gauze, and a clamp. LVN 1 stated an e-kit should always be at Resident 80's bedside and the e-kit should be checked daily to make sure the e-kit was stocked with all the necessary supplies. LVN 1 stated Resident 80 could hemorrhage (excessive bleeding or blood loss) if there was no e-kit at the bedside. During an interview on 5/8/2025 at 8:44 a.m. with the Director of Nursing (DON), the DON stated having an e-kit at Resident 80's bedside at all times would make it easier for staff to access the supplies needed to intervene immediately to manage bleeding. The DON stated if there was no e-kit available at Resident 80's bedside and Resident 80 began to bleed, there would be a delay in intervention to manage bleeding. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis, dated 12/2022, indicated . The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include .Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices .

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure a resident's physician (Physician 1) conducted an initial comprehensive assessment (a thorough evaluation of person's health, including their physical, mental, and social factors) for one of six sampled residents (Resident 45) after Resident 45 was readmitted to the facility. This deficient practice resulted in the delay of a comprehensive assessment of Resident 45's health and status, which could negatively affect the delivery of necessary care and services for Resident 45. Findings: During a review of Resident 45's Admission Record (Face Sheet), the Face Sheet indicated Resident 45 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 45's diagnoses included cognitive communication deficit (difficulties with communication due to problems with thinking and processing information, rather than just speech or language issues), generalized muscle weakness (feeling weak throughout the body), and dementia (a progressive state of decline in mental abilities). During a review of Resident 45's Minimum Data Set ([MDS], a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 45's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 45 required moderate assistance (helper does less than half the effort) with oral hygiene and personal hygiene and was dependent on staff's assistance with toileting, bathing, and lower body dressing. During a review of Resident 45's Census List, dated 4/8/2024 through 4/4/2025, the Census List indicated Resident 45 was discharged from the facility on 2/5/2025 and was readmitted to the facility on [DATE]. During a concurrent interview and record review on 5/8/2025 at 9:58 a.m., with the Medical Records Director (MRD), Resident 45's History and Physical (H&P), dated 3/28/2025, was reviewed. The MRD stated the H&P was completed when Resident 45 was hospitalized . The MRD stated once she received residents' records, either from the general acute care hospital (GACH) or from their physician, the records were scanned into the resident's electronic health record (eHR). The MRD stated Physician 1 would email or fax the completed H&Ps and she would scan into the resident's eHR. The MRD stated Resident 45 did not have an H&P after the resident's admission to the facility scanned into the eHR. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 3:06 p.m., with the Director of Nursing (DON), the DON stated when a resident was admitted to the facility, their attending physician was supposed to physically see the resident within 30 days. The DON stated the physician would review hospital records, conduct a comprehensive assessment to establish a baseline (an individual's current health at a specific point of time, serving as a reference point for tracking changes and progress over time), and review orders and medications. The DON stated the physician would complete an H&P and provide the document to the facility. The DON stated an H&P was essential to create a baseline of the resident's health status and use as a reference if the resident experienced any changes. The DON stated the H&P was used by the nursing staff to reference prior to interacting with the resident and help guide the care provided to the resident. The DON stated Resident 45 had an H&P completed while he was hospitalized , however, Resident 45's health condition could change from his admission to the GACH to the resident's readmission back to the facility. The DON stated a completed H&P would show that Physician 1 came to personally assess Resident 45 comprehensively. The DON stated due to the delay of a comprehensive assessment of Resident 45's health and status, Resident 45 was at risk of experiencing a negative effect in the delivery of necessary care and services from the facility's staff. During a review of the facility's policy and procedure (P&P) titled, Physician Documentation, dated 1/2004, the P&P indicated, The resident shall be under the continuing supervision of a physician who evaluates the resident as needed and at least every 30 days unless there is an alternate schedule with medical justification by the attending physician. The P&P indicated the physician would provide a current History and Physical Examination within five days prior to admission or within 72 hours following the resident's admission.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 51859 Based on interview and record review, the facility failed to follow up on an order for consultation with an Ear, Nose, and Throat (ENT - medical doctor who specializes in the medical and surgical treatment of conditions affecting the ears, nose, throat, head, and neck region) doctor for Resident 82. This failure had the potential to result in worsening left ear pain and left ear hearing loss for Resident 82. Findings: During a review of Resident 82's Admission Record, dated 1/22/2025, the admission record indicated the facility admitted Resident 82 on 1/22/2025 with diagnoses including, but not limited to, end stage renal disease (ESRD - irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), hypertension (HTN - high blood pressure), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During an interview on 5/5/2025 at 10:55 a.m., with Resident 82, in the resident's room, Resident 82 stated she could not hear well in her left ear and had been experiencing pain in her left ear over a month ago, especially at nighttime. Resident 82 stated she could not open her mouth too wide or chew on the left side because of the left ear pain. Resident 82 stated she was told by staff that a specialist would be coming to examine her but had been waiting for more than a month for the consultation. During a review of Resident 82's progress note, dated 3/19/2025, the progress note indicated Resident 82 first experienced left ear pain on 3/19/2025. The progress note indicated Resident 82 complained of hearing from headphones sounding distant in the left ear. During a review of Resident 82's Order Summary Report, dated 4/6/2025, the order summary report indicated Resident 82 was to receive ENT consultation and treatment as needed for left ear pain. During a review of Resident 82's medical records, dated from 1/22/2025 to 5/6/2025, the resident's medical records indicated no documentation of an ENT consultation being followed up by nursing staff, social services department, or administration. During an interview on 5/7/2025 at 1:55 p.m., with the Social Services Director (SSD), the SSD stated there had not been any follow-up calls made to the ENT doctor about the ENT consultation for Resident 82 after the consultation was ordered by Resident 82's primary care physician in April. The SSD stated if Resident 82 did not receive an ENT consultation as ordered, Resident 82's condition could worsen. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 8:57 a.m., with the Director of Nursing (DON), the DON stated the facility would not be meeting the needs of Resident 82 if the resident did not receive the ENT consultation. The DON stated Resident 82's activities of daily living (ADLs) would be affected by the resident's ear pain and would have hearing loss if the resident did not receive the ENT consultation as ordered. During a review of the Job Description for Social Worker, on 5/8/2025 at 11:00 a.m., indicated Understands in the MDS process and accurately assesses, documents and provides interventions for assigned case load . Effectively communicates with residents and families .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to administer hydralazine (antihypertensive medication used to treat high blood pressure [BP]) within the ordered parameters (specific instructions that dictate whether the medication is safe to administer) for one of five sampled residents (Resident 33). This deficient practice had the potential to result in Resident 33 becoming hypotensive (low blood pressure) that could cause altered level of consciousness ([ALOC], a state of reduced alertness or inability to arouse), confusion, nausea, vomiting, and weakness. Findings: During a review of Resident 33's Admission Record (Face Sheet), the Face Sheet indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side following a cerebral infarction and essential hypertension (elevated blood pressure not due to another medical condition). During a review of Resident 33's Minimum Data Set ([MDS], a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 33's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 33 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. During a review of Resident 33's History and Physical (H&P), dated 3/10/2025, the H&P indicated Resident 33 did not have the capacity to understand or make decisions. During a review of Resident 33's Order Summary Report, dated 5/8/2025, the Order Summary Report indicated to give hydralazine 25 milligrams (mg, a unit of measurement) by mouth, every eight hours for hypertension. Hold (not to give) the medication if the systolic blood pressure ([SBP], the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was less than 110 millimeters of mercury (mm Hg, unit of pressure measurement) or if the diastolic blood pressure ([DBP], the bottom number of a blood pressure reading, representing the force of blood against artery walls when the heart is resting between beats) was less than 60 mm Hg. During a review of Resident 33's care plan titled, The Resident has Hypertension, dated 3/6/2024, the care plan indicated staff interventions were to give antihypertensive medications as ordered. During a concurrent interview and record review on 5/7/2025 at 10:53 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 33's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 through 4/30/2025 and 5/1/2025 through 5/31/2025, were reviewed. The MARs indicated Resident 33 was administered hydralazine 25 mg outside the parameters on the following dates: 1. 4/1/2025 at 6 a.m. with a BP of 133/56 mm Hg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. 4/12025 at 10 p.m. with a BP of 108/58 mm Hg. 3. 4/2/2025 at 6 a.m. with a BP of 133/58 mm Hg. 4. 4/7/2025 at 10 p.m. with a BP of 116/58 mm Hg. 5. 4/8/2025 at 6 a.m. with a BP of 110/53 mm Hg. 6. 4/8/2025 at 10 p.m. with a BP of 118/59 mm Hg. 7. 4/9/2025 at 6 a.m. with a BP of 119/57 mm Hg. 8. 4/14/2025 at 6 a.m. with a BP of 119/52 mm Hg. 9. 4/14/2025 at 10 p.m. with a BP of 129/59 mm Hg. 10. 4/15/2025 at 10 p.m. with a BP of 121/58 mm Hg. 11. 4/16/2025 at 6 a.m. with a BP of 128/57 mm Hg. 12. 4/20/2025 at 10 p.m. with a BP of 118/58 mm Hg. 13. 4/21/2025 at 6 a.m. with a BP of 130/56 mm Hg. 14. 4/22/2025 at 6 a.m. with a BP of 119/57 mm Hg. 15. 4/24/2025 at 6 a.m. with a BP of 117/50 mm Hg. 16. 4/28/2025 at 6 a.m. with a BP of 122/52 mm Hg. 17. 4/28/2025 at 10 p.m. with a BP of 115/59 mm Hg. 18. 4/29/2025 at 6 a.m. with a BP of 121/57 mm Hg. 19. 4/29/2025 at 10 p.m. with a BP of 118/59 mm Hg. 20. 4/30/2025 at 6 a.m. with a BP of 122/58 mm Hg. 21. 5/4/2025 at 10 p.m. with a BP of 126/56 mm Hg. 22. 5/5/2025 at 6 a.m. with a BP of 112/53 mm Hg. 23. 5/5/2025 at 10 p.m., with a BP of 127/53 mm Hg. 24. 5/6/2025 at 6 a.m. with a BP of 120/58 mm Hg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 1 stated prior to administering blood pressure medications, the licensed nurse was responsible for following all hold parameters. LVN 1 stated from 4/1/2025 through 5/6/2025, Resident 33 received hydralazine 25 mg 24 times when Resident 33 was not supposed to due to Resident 33's BP meeting the hold parameters. LVN 1 stated administering hydralazine to Resident 33 outside of the hold parameters put Resident 33 at risk of becoming hypotensive (low blood pressure), alerted level of consciousness, nausea, and vomiting. During an interview on 5/7/2025 at 2:34 p.m., with the Director of Nursing (DON), the DON stated hold parameters were ordered by the residents' physician to ensure safe medication administration. The DON stated Resident 33's hold parameters were not followed and put Resident 33 at risk for her heart to compensate (when the body works to maintain a normal state despite having a problem) for the low blood pressure by increasing her heart rate, making her heart work harder. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, updated 11/2021, the P&P indicated, Medications are administered in accordance with written orders of the attending physician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure residents' food preferences were respected and alternatives were provided for one of six sampled residents (Resident 42). This deficient practice had the potential to result in decreased meal intake, and alter Resident 42's nutritional status. Findings: During a review of Resident 42's Admission Record (Face Sheet), the Face Sheet indicated Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 42's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 42's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 42 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 42's History and Physical (H&P), dated 1/12/2025, the H&P indicated Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's Order Summary Report, dated 3/8/2025, the Order Summary Report indicated the facility would provide Resident 42 with choices for the snack of the day. During a review of Resident 42's care plan with titled [Resident 42] was at risk for altered nutrition and hydration ., date initiated 1/13/2025, the care plan indicated staff interventions were to honor Resident 42's food and fluid preferences. During an interview on 5/5/2025 at 2:35 p.m., in Resident 42's room, Resident 42 stated he did not like the meals he was currently receiving and stated he did not like grilled chicken or fish. Resident 42 stated he was not offered substitutes or snacks. During a concurrent observation and interview on 5/7/2025 at 1:11 p.m., in Resident 42's room, Resident 42's lunch tray was observed. Resident 42's lunch tray had a plate with grilled fish, a scoop of white rice, and a carton of Ensure (nutritional supplement). Resident 42 stated he did not want to eat the fish because it was grilled and did not look appetizing. Resident 42 stated the Ensure contained milk and he did not like milk. Resident 42 stated he preferred to have boiled beef and toast. Resident 42 stated staff told him boiled beef was not an option. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 1:36 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated CNA staff were responsible for completing and submitting the substitute request form to the kitchen if a resident requested something different from what was being served. CNA 3 stated the option for boiled beef was not provided to residents. During a concurrent observation, interview, and record review on 5/7/2025 at 1:44 p.m., in Resident 42's room, with the Dietary Supervisor (DS), Resident 42's lunch tray and diet ticket (a document that listed a resident's dietary needs, including allergies, preferences, and restrictions) was observed. The DS stated Resident 42's lunch plate contained grilled fish and a carton of Ensure. The DS stated Resident 42's diet ticket indicated Resident 42 would be provided with boiled meats and the resident disliked milk. The DS stated it was not appropriate to provide grilled fish and Ensure which contained milk ingredients. The DS stated it was important to honor Resident 42's food preferences. The DS stated dislike of food may affect Resident 42's meal intake and place the resident at risk for malnutrition (lack of proper nutrition). During a review of the facility's policy and procedure (P&P) titled Resident food preferences, dated 2/2009, the P&P indicated the facility would satisfy residents' tastes and shall provide food substitutions to meet resident food preferences.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to follow the renal diet (specialized diet designed to help people with kidney disease or kidney failure to manage their condition) menu for one of four sampled residents (Resident 21). This deficient practice had the potential to result in the buildup of waste products that Resident 21's kidneys could not filter. Findings: During a review of Resident 21's Admission Record (Face Sheet), the Face Sheet indicated Resident 21 was admitted to the facility on [DATE]. Resident 21's diagnoses included spina bifida (a condition that occurs when the spine and spinal column do not form properly), end stage renal disease ([ESRD], irreversible kidney failure), and neuromuscular dysfunction of the bladder (also known as neurogenic bladder, when damage to the brain, spinal cord, or nerves disrupts the communication between the brain and the bladder, leading to a loss of bladder control). During a review of Resident 21's Minimum Data Set ([MDS], a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 21's cognition (process of thinking) was intact. The MDS indicated Resident 21 required setup assistance with eating and oral hygiene and required moderate assistance (helper does less than half the effort) with toileting, bathing, and upper body dressing. The MDS indicated Resident 21 was on a therapeutic diet (diet ordered to manage problematic health conditions) During a review of Resident 21's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's Order Summary Report, dated 5/8/2025, the Order Summary Report indicated to give Resident 21 a renal diet, regular texture for food items and thin consistency for fluids, for ESRD. During a review of Resident 21's care plan titled Resident at Risk for Altered Nutrition, Hydration, and Weight Fluctuations, dated 2/21/2025, the care plan indicated staff interventions to serve Resident 21 the diet as ordered. During an interview on 5/5/2025 at 1:10 p.m. with Resident 21, Resident 21 stated he was on a renal diet, however, would sometimes receive the wrong menu items during mealtimes. Resident 21 stated he understood since he was on the renal diet, receiving unapproved items could affect his kidneys. During an observation on 5/7/2025 at 12:30 p.m., inside Resident 21's room, Resident 21 received his lunch tray. The meal tray ticket indicated to serve Resident 21 a double portion of protein with every meal per Resident 21's request. Observed two pieces of crusted fish on Resident 21's plate. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/7/2025 at 1:21 p.m., with the Dietary Supervisor (DS), the facility's Menu and Diet Spreadsheet, dated 5/7/2025, were reviewed. The DS stated the protein on the lunch menu served on 5/7/2025 was Italian crusted fish. The DS stated many of the therapeutic diets allowed for the Italian crusted fish to be served, however, according to the Diet Spreadsheet, the residents on the renal diet were served baked fish instead. The DS stated unlike the Italian crushed fish that was seasoned and with other ingredients to make the fish crispy, the baked fish would have simple seasonings such as garlic and onion powder. During a concurrent interview and picture review on 5/7/2025 at 1:28 p.m. with the DS, a picture of Resident 21's lunch tray dated 5/7/2025 at 12:30 p.m., was reviewed. The DS stated according to the photo of Resident 21's lunch tray on 5/7/2025, Resident 21 was served the incorrect fish based on Resident 21's renal diet order. The DS stated Resident 21 received a double portion of protein with every meal, per Resident 21's request. The DS stated not only did Resident 21 receive the incorrect fish, but he was also served a double portion of the fish. The DS stated she was responsible for checking the plates prior to the food carts leaving the kitchen and the nursing staff passing the meals to the residents. The DS stated serving the incorrect meal to Resident 21 put him at risk for issues with his nutrition and could affect his laboratory results and the resident's kidneys which could ultimately affect his dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During an interview on 5/7/2025 at 2:45 p.m., with the Director of Nursing (DON), the DON stated when a therapeutic diet, like the renal diet, was not followed, the resident's health condition could be affected. The DON stated Resident 21 had ESRD and received dialysis due to his kidney failure. The DON stated with ESRD, diet is the number one factor in maintaining healthy laboratory levels. The DON stated ESRD affected many bodily systems and organs. The DON stated serving the incorrect diet to Resident 21 could make his condition worse. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, dated 2/2009, the P&P indicated, The facility prepares and serves all special diets as planned.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49900 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices for 84 out of 84 residents when: 1. The inside gasket of the kitchen ice machine was not clean. 2. One container of gelatin mix powder was not labeled with use-by date and content. 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 (any illness resulting from eating contaminated/spoiled foods) in all residents. Findings: 1. During a concurrent observation and interview on 5/6/2025 at 9:56 a.m. with the Dietary Supervisor (DS), in the kitchen, the inside gasket of the ice machine was observed with yellow and white buildup. The DS stated the buildup was water residual and should not be inside the ice machine. The DS stated the buildup could cause contamination that could make residents sick. The DS stated the residents might experience nausea, vomiting, and diarrhea. The DS stated she was responsible for ensuring the ice machine was cleaned, and the maintenance was responsible for cleaning the inside of the ice machine. During an interview on 5/7/25 at 3:21 p.m. with the Maintenance Manager (MM), the MM stated he was responsible for cleaning the inside of the kitchen ice machine once a month, and he cleaned and disinfected it on 4/28/2025 and 5/6/2025. The MM stated he removed all the yellow buildup on the rubber part inside the ice machine because it was not supposed to be there. 2. During a concurrent observation and interview on 5/6/2025 at 9:40 a.m. with the DS, in the kitchen's dry storage room, observed a container of gelatin mix powder was not labeled with the use-by date and contents. The DS stated the gelatin container did not have the received and use-by date. The DS stated the container should have a use-by date, and the DS was responsible for ensuring it was labeled. The DS stated the unopened gelatin could be stored on the shelf for 10 months. The DS stated the gelatin's expiration date was not visible, and the risk was that staff could have used it without knowing. The DS stated it could cause food born illness in residents, and residents could experience nausea, vomiting, and diarrhea. During a review of the facility's Policy and Procedure (P&P) titled, Ice Machine Sanitation, dated 2/2019, the P&P indicated Maintain sanitary and clean ice machines .Ice machines are properly maintained. During a review of the facility's P&P titled, Food and Dining Services, dated 2/2019, the P&P indicated Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters .All food storage bins or containers should be maintained in clean condition and labeled with the contents.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to label and properly store food brought by family/ visitors for three out of three residents (Residents 40, 66, and 52) in accordance with the facility's Policy and Procedure (P&P) titled, Use and storage for foods brought in by family or visitors. These deficient practices had the potential to result in food borne illnesses (any illness resulting from eating contaminated/spoiled foods) for Residents 40, 66, and 52, with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and could lead to other serious medical complications and hospitalization . Findings: 1. During a review of Resident 40's Admission Record, the admission record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (ESRD -irreversible kidney failure). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 40's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 40 required setup assistance for eating; maximal assistance (helper did more than half the effort) for oral hygiene; and was dependent (helper did all the effort) for toileting hygiene, showering/ bathing self, personal hygiene, and chair/bed-to-chair transferring. The MDS indicated Resident 40 had impairments to the extremities (arms/legs) and used a wheelchair for mobility. During a review of Resident 40's History and Physical (H&P), dated 1/1/2025, the H&P indicated Resident 40 had the capacity to understand and make decisions. During an observation on 5/5/2025 at 11:10 a.m., in Resident 40's room, observed an unlabeled, opened ranch dressing bottle stored at the resident's bedside. The bottle indicated refrigerate after opening. During a concurrent observation and interview on 5/5/2025 at 1:23 p.m. with Resident 40, in Resident 40's room, observed the unlabeled, opened ranch dressing bottle at the bedside. Resident 40 stated the ranch dressing bottle belonged to him. During a concurrent observation and interview on 5/6/2025 at 8:11 a.m. with Resident 40, in Resident 40's room, observed the unlabeled, opened ranch dressing bottle at the bedside. Resident 40 stated he opened the bottle a while ago but did not remember exactly when. Resident 40 stated the staff did not offer to store the opened bottle in the refrigerator. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and pictures review on 5/6/2025 at 2:29 p.m. with the Infection Preventionist Nurse (IPN), pictures of Resident 40's unlabeled and opened ranch dressing bottle, dated 5/5/2025 at 11:10 a.m. and 5/6/2025 at 8:12 a.m., were reviewed. The pictures showed an opened, unlabeled ranch dressing bottle at Resident 40's bedside. The bottle indicated to refrigerate after opening. The IPN stated the ranch dressing was perishable (something that was likely to spoil, decay, or go bad quickly.) The IPN stated the opened ranch dressing needed to be stored in the refrigerator if the label indicated as such. 2. During a review of Resident 66's Admission Record, the admission record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included dementia (a progressive state of decline in mental abilities) and DM. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition was severely impaired. The MDS indicated Resident 66 required setup assistance with eating; moderate assistance with oral hygiene and personal hygiene; maximal assistance with toileting hygiene, showering/ bathing self, and chair/ bed-to-chair transferring. During a review of Resident 66's H&P, dated 10/23/2024, the H&P indicated Resident 66 had the capacity to understand and make decisions. During a review of Resident 66's care plan titled, Oral/Dental Health Problems, revised on 11/12/2024, the care plan indicated the goal was for Resident 66 to be free of infection. During an observation on 5/5/2025 at 11:12 a.m., in Resident 66's room, observed two bottles of lemonade with a label indicating keep refrigerated at the bedside. The lemonade bottles were not labeled with the resident's name or date. During an observation on 5/6/2025 at 9:36 a.m., in Resident 66's room, observed two bottles of lemonade with a label indicating keep refrigerated at the bedside. The lemonade bottles were not labeled with the resident's name or date. During a concurrent observation and interview on 5/6/2025 at 1:34 p.m. with Resident 66, in Resident 66's room, observed two bottles of lemonade at the resident's bedside. The lemonade bottles were not labeled with the resident's name or date. Resident 66 stated she did not know how long she had the lemonade bottles at the bedside. During a concurrent observation and interview on 5/6/2025 at 1:34 p.m. with Certified Nursing Assistant (CNA) 5, in Resident 66's room, observed two bottles of lemonade at the bedside. CNA 5 stated she did not know how long Resident 7 had the lemonade at the bedside. During a concurrent interview with the IPN and picture review of Resident 66's lemonade bottles, the pictures dated 5/5/2025 at 11:16 a.m., 5/5/2025 at 1:25 p.m., and 5/6/2025 at 9:36 a.m. were reviewed. The pictures showed two unlabeled and undated bottles of lemonade at the bedside. The IPN stated if the lemonade's manufacture label indicated to keep refrigerated, the lemonade needed to be refrigerated. The IPN stated bacteria could grow causing the lemonade to cause infection. The IPN stated the risks for residents were upset stomach, nausea, vomiting, and diarrhea. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 52's Admission Record, the admission record indicated Resident 52 was admitted to the facility on [DATE]. Resident 52's diagnoses included DM and local skin infection. During a review of Resident 52's MDS dated [DATE], the MDS indicated Resident 52's cognition was intact. The MDS indicated Resident 52 required setup assistance with eating; supervision with oral hygiene and personal hygiene; moderate assistance with toileting hygiene and chair/bed-to-chair transferring; and maximal assistance with showering/ bathing self. During a review of Resident 52's H&P, dated 1/12/2025, the H&P indicated Resident 52 had the capacity to understand and make decisions. During an observation on 5/5/2025 at 1:06 p.m., in Resident 52's room, observed an opened jar of jalapenos at the bedside. The jar was unlabeled with the resident's name and undated. During a concurrent observation and interview on 5/5/2025 at 9:58 a.m. with Resident 52, in Resident 52's room, observed an opened jar of jalapenos at the bedside. The jar was unlabeled and undated. Resident 52 stated he got the jar of jalapenos the day before (5/4/2025). During a concurrent observation and interview on 5/6/2025 at 8:04 a.m. with Resident 52, in Resident 52's room, observed an opened jar of jalapenos at the bedside. Resident 52 stated he ate some of the jalapenos 5/5/2025. Resident 52 stated none of the staff offered him to store the jalapenos in the refrigerator. During an interview on 5/6/2025 at 12:40 p.m. with the Dietary Supervisor (DS), the DS stated the facility did not have a refrigerator to store residents' food items. The DS stated the facility informed families that they may bring food to residents but would not allow any leftover food because there was no refrigerator and also for infection control purposes. The DS stated residents should finish food that was brought in by families or visitors within four hours. The DS stated nurses were responsible for ensuring residents finish the food brought in by families or visitors and no perishable food was left at the bedside. The DS stated perishable food items included milk, yogurt, cheese, processed meat, ham, turkey, and salad dressings. The DS stated if the manufacture label indicated to keep the food item refrigerated, the item needed to be stored in the refrigerator. The DS stated the purpose of storing food in the refrigerator was to prevent food poisoning. The DS stated residents might experience nausea, vomiting, diarrhea, and fever if they have food poisoning. During a concurrent observation and interview on 5/6/2025 at 1:44 p.m. with CNA 5, in Resident 52's room, observed an opened, unlabeled and undated jar of jalapenos at the bedside. CNA 5 stated there was no label of the resident's name or date on the jar of jalapenos. CNA 5 stated the facility's policy for outside food was to have residents eat the food that family bought right away. CNA 5 stated she would label the outside food items with markers and write the date and time the item was received and the resident's name. CNA 5 stated she would throw away the food items if there was no label and it had been at the bedside for more than two days. CNA 5 stated the food could have been spoiled with bacteria. CNA 5 stated it was dangerous to residents, and residents might have stomachaches and diarrhea. CNA 5 stated she needed to throw away the food items at the bedside that were labeled to keep refrigerated. CNA 5 stated staff were responsible for ensuring food was stored properly by doing rounds constantly. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/2025 at 2:29 p.m. with the IPN, the IPN stated the facility's policy for outside food was to bring the portion of food the resident would eat because they did not want the food to be cold or left at room temperature. The IPN stated the facility discouraged left-over food because it could make residents sick. The IPN stated the purpose of keeping food in the refrigerator was to maintain the temperature to prevent food from going bad. The IPN stated bacteria would grow when the food went bad, and it could cause infection among residents. The IPN stated the risks for residents were upset stomach, nausea, vomiting, and diarrhea. During a review of the facility's P&P titled, Use and storage of foods brought in by family or visitors, revised on 8/2023, the P&P indicated, Prepared food items brought in by family or visitor must be labeled and dated. Facility may refrigerate labeled/dated prepared items in designated unit or pantry refrigerator. The P&P further indicated improperly stored items would be discarded if not removed by resident and or resident representative.

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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** 48343 Based on interview and record review, the facility failed to ensure a physician order for physical therapy ([PT]- healthcare specialty focuses on restoring, maintaining, and improving a resident ability to move and function) and occupational therapy ([OT]-a healthcare specialty that helps a resident improve the ability to perform daily activities) evaluation and a wheelchair was carried out for one of six sampled residents (Resident 72). This deficient practice resulted in delayed treatment and services for Resident 72 and placed the resident at higher risk for further functional and mobility decline. Cross Reference F688 Findings: During a review of Resident Admission Record (Face Sheet), the Face Sheet indicated Resident 72 was admitted to the facility on [DATE] with diagnoses which included dementia, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (loss of muscle strength). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 6/10/2024, the MDS indicated Resident 72's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 72 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The MDS indicated Resident 72 required moderate assistance from staff for sitting to standing and transfer from bed to chair. The MDS indicated Resident 72 was not assessed for walking due to medical conditions or safety concerns. During a review of Resident 72's care plan titled Resident with self-care deficit ., initiated 6/10/2024, the care plan indicated the facility would monitor, document, and report any changes for self-care deficit and declines in Resident 72's function. During a telephone interview on 5/6/2025 11:25 a.m., with Resident 72's Responsible Party (RP) 1, RP 1 stated he visited Resident 72 daily since the resident's admission to the facility. RP 1 stated Resident 72 was able to walk independently and sometimes used a walker (a mobility aid). RP 1 stated he noticed over the last four months Resident 72 increasingly began to spend more time in bed and was sleeping more. RP 1 stated he wanted the facility to get Resident 72 out of bed more often and provide therapy. RP 1 stated Resident 72 was receiving therapy upon admission to the facility but the facility discontinued therapy services on 9/2024. (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 5/8/2025 at 9:15 a.m., with Occupational Therapy Assistant (OTA) 1, Resident 72's occupational therapy treatment encounter notes, dated 6/6/2024 to 9/12/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on 6/6/2024 and Resident 72 required moderate assistance from staff for ADLs. OTA 1 stated Resident 72 received OT services from 6/6/2024 to 9/12/2024 and the resident achieved maximum potential (highest level of functional abilities). OTA 1 stated Resident 72 was discharged from therapy on 9/12/2024 with an order for the Restorative Nursing Assistance ([RNA]- certified nursing aide program that helps residents to maintain or improve their physical function) program. OTA 1 stated Resident 72 was not referred again for occupational therapy and she was not aware of the resident's current functional status. During a concurrent interview and record review on 5/8/2025 at 9:25 a.m., with Physical Therapist (PT) 1, Resident 72's physical therapy treatment encounter notes, dated 6/6/2025 to 7/31/2024, were reviewed. The notes indicated Resident 72's initial assessment was performed on 6/6/2024 and Resident 72 was able to ambulate (walk) five feet using a two-wheeled walker (a mobility aid). PT 1 stated Resident 72 received PT services from 6/6/2024 to 7/30/2024 and reached a high level of mobility (ambulate independently). PT 1 stated Resident 72 was discharged from therapy on 7/31/2024 and did not require the RNA program. PT 1 stated Resident 72 had no need for a wheelchair during PT treatment and/or upon discharge from PT services. PT 1 stated Resident 72 was not referred again for PT after being discharged on [DATE]. PT 1 stated he was not aware Resident 72 was now wheelchair bound. PT 1 stated if there was a decline in a resident's mobility, the nurses were responsible for notifying the physician for an order and referral for therapy. During a concurrent observation and interview on 5/8/2025 at 10:00 a.m., in Resident 72's room, with Certified Nursing Assistant (CNA) 3, CNA 3 was observed transferring Resident 72 from a shower chair to the bed using a mechanical lift (a device used to assist in lifting transferring residents with limited mobility). CNA 3 stated Resident 72 was no longer able to stand up on her feet or walk and now required staff assistance for transfers. CNA 3 stated Resident 72 was able to stand and walk when first admitted to the facility but can no longer due to a decline in mobility and increased need for physical support. During a concurrent interview and record review on 5/8/2025 at 10:15 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 72's Electronic Medical Records (EMR) was reviewed. The EMR indicated Resident 72 was able to stand and walk short distances with a walker upon admission to the facility but now required a wheelchair. LVN 2 stated Resident 72's decline in mobility and ADLs should have been assessed and an order for PT/OT evaluation and treatment obtained. LVN 2 stated she was not aware if there was a current PT/OT order and was unable to locate an order in the EMR. During an interview on 5/8/2025 at 12:19 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated if the nurse received a written and signed order from the physician, the order would be put in resident's order summary report and carried out immediately. RNS 1 stated if a PT/OT order was received the nurse would communicate with the rehabilitation department so the therapists would be aware to carry out the order. (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 with RNS 1, Resident 72's EMR was reviewed. RNS 1 stated there was a written and signed physician's order dated 10/23/2024 which indicated Resident 72 required PT/OT evaluation and wheelchair for mobility. RNS 1 stated there was no documented evidence the order was carried out and/or communicated to the therapy department. RNS 1 stated not carrying out the PT/OT order timely placed Resident 72 at risk for delayed treatment, services, and for further functional and mobility decline. During a concurrent interview and record review on 5/8/2025 at 1:20 p.m., with PT 1, Resident 72's physician order dated 10/23/2024, was reviewed. PT 1 stated the physician order indicated Resident 72 required PT/OT evaluation for a wheelchair. PT 1 stated he was not aware of the order. PT 1 stated the nurses were responsible for getting an order from the physician and communicating with the rehabilitation department. PT 1 stated he was not aware Resident 72 had an order for a PT/OT evaluation and wheelchair until 5/8/2025. PT 1 stated the nurses should have notified the rehabilitation department that there was a physician order for a PT/OT evaluation and treatment so Resident 72 would be assessed and provided with necessary services and treatment as necessary. During an interview on 5/8/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated the physician's orders should be completed and implemented immediately after they were received. The DON stated the facility staff overlooked Resident 72's physician order for a PT/OT evaluation for a wheelchair, which resulted in delayed care and treatment. The DON stated this could place Resident 72 at risk for mobility and ADL decline. During a review of the facility's policy and procedure P&P titled Physician Orders and Telephone Orders, dated 1/2004, the P&P indicated physician's orders would be obtained prior to the initiation of any treatment. The P&P indicated all orders must be complete and carry out without any questions. During a review of the facility's Registered Nurse (RN) Job Description, undated, the job description indicated RNs duties included but not limited to take, transcribe, and carry out complete orders. The job description indicated RNs would complete appropriate referrals to other departments, including therapy.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to implement an effective infection prevention control program for three out of four sampled residents (Residents 21, 70, and 242) when the facility failed to: 1. Ensure Resident 21 did not reuse an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag. 2. Change Resident 70's oral suction (procedure involving the removal of secretions from the mouth using a suction device) cannister (container to collect fluids and secretions removed from the mouth). 3. Ensure Resident 242's indwelling urinary catheter drainage bag and tubing did not touch the floor. These deficient practices had the potential to result in the spread of bacteria through Resident 21 and 242's urinary catheter to result in a urinary tract infection ([UTI], an infection in the bladder/urinary tract). These deficient practices had the potential to result in Resident 70 developing a respiratory infection. Findings: a. During a review of Resident 21's Admission Record (Face Sheet), the Face Sheet indicated Resident 21 was admitted to the facility on [DATE]. Resident 21's diagnoses included spina bifida (a condition that occurs when the spine and spinal column do not form properly), end stage renal disease ([ESRD], irreversible kidney failure), and neuromuscular dysfunction of the bladder (also known as neurogenic bladder, when damage to the brain, spinal cord, or nerves disrupts the communication between the brain and the bladder, leading to a loss of bladder control). During a review of Resident 21's Minimum Data Set ([MDS], a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 21's cognition (process of thinking) was intact. The MDS indicated Resident 21 required setup assistance with eating and oral hygiene and required moderate assistance (helper does less than half the effort) with toileting, bathing, and upper body dressing. The MDS indicated Resident 21 had an indwelling urinary catheter During a review of Resident 21's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's Order Summary Report, dated 5/8/2025, the Order Summary Report indicated for Resident 21 to have an indwelling urinary catheter, 16 French (unit of measure of the diameter of the catheter) with 5 milliliter (mL, unit of fluid measurement) balloon, connected to a drainage bag for neurogenic bladder. (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 review of Resident 21's care plan titled, Resident with a Foley (indwelling urinary catheter) for Urinary Detention (the inability to fully or partially empty the bladder of urine), dated 3/3/2025, the care plan indicated staff were to maintain a closed drainage system (drainage tubing that is connected to a sterile collection container). During an observation on 5/5/2025 at 11:23 a.m., inside Resident 21's room, Resident 21 was not present in the room. A dignity bag (bag specifically designed to cover and conceal a urinary catheter drainage bag) with the urinary catheter drainage bag inside was tied to Resident 21's bed frame. The tip (end) of the drainage tubing, without a cap and exposed to air, was hanging outside of the dignity bag. During an interview on 5/5/2025 at 1:10 p.m., with Resident 21, Resident 21 stated when in bed, his urinary catheter was connected to the drainage bag on the side of the bed frame. Resident 21 stated when he transfers to his wheelchair, he would disconnect the urinary catheter from the drainage tubing then connect the urinary catheter to the drainage tubing of the leg bag (a sterile urine drainage bag designed to attach securely to the leg). Resident 21 stated once he returned to bed, he would disconnect the urinary catheter from the leg bag, then reconnect the urinary catheter to the drainage tubing at the side of his bed frame. Resident 21 stated the drainage bag tubing at the side of his bedframe would be reused daily and only changed once a month. Resident 21 stated the tip of the drainage tubing was not capped when he switched to the leg bag. Resident 21 stated the nursing staff were aware he switched from the two drainage bags. During an observation on 5/6/2025 at 1:47 p.m., inside Resident 21's room, Resident 21 was not present in the room. Resident 21's urinary catheter drainage bag was inside the dignity bag at the side of Resident 21's bed frame. The tip of the drainage bag, without a cap, was tucked inside the dignity bag. During an interview on 5/7/2025 at 7:37 a.m., with Resident 21, Resident 21 stated on 5/6/2025 he left the facility for his dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) appointment. Resident 21 stated prior to his appointment he switched to the leg bag and upon his return to the facility, he switched back to the same drainage bag in the dignity bag. During a concurrent observation and interview on 5/7/2025 at 11:14 a.m., with Treatment Nurse (TN) 1, inside Resident 21's room, Resident 21 was not present in the room. Resident 21's urinary catheter drainage bag was observed inside the dignity bag at the side of Resident 21's bed frame. The tip of the drainage bag, without a cap, was tucked into the dignity bag. TN 1 stated Resident 21's drainage bag should not be kept at the bedside once disconnected from Resident 21. TN 1 stated whenever Resident 21 switched from the drainage bag to the leg back, the disconnected tubing and drainage bag should be disposed. TN 1 stated once Resident 21 was ready to switch from the leg bag to the drainage bag, Resident 21 should have been provided with a new drainage bag. TN 1 stated the urinary drainage bag should not be kept at the bedside after being disconnected due to the high chance of bacteria entering through the tip of the drainage tubing. TN 1 stated if bacteria were to enter the tubing and was reconnected to Resident 21's urinary catheter, the bacteria would enter Resident 21's bladder and cause a UTI. (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 interview on 5/7/2025 at 1:42 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated urinary catheters can be disconnected from the drainage tubing and bag, however, those parts should never be reconnected. The IPN stated a new drainage tubing and bag should be connected to the urinary catheter to prevent bacteria from entering the urinary catheter. The IPN stated the urinary catheter was a direct passage to Resident 21's bladder and any bacteria introduced could cause Resident 21 to develop a UTI and experience symptoms such as burning during urination. During a review of the facility's policy and procedure (P&P) titled, Catheter Associated Urinary Tract Infection (CAUTI) Prevention, undated, the P&P indicated to change the indwelling catheter and/or drainage bag when the closed system is compromised. b. During a review of Resident 70's Admission Record (Face Sheet), the Face Sheet indicated Resident 70 was admitted to the facility on [DATE]. Resident 70's diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the right dominant side following a cerebral infarct (also known as stroke, a loss of blood flow to a part of the brain), respiratory failure (when the lungs do not work well enough to get enough oxygen into the blood) with hypoxia (low oxygen level in the body's tissues), and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70's cognition was severely impaired. The MDS indicated Resident 70 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right. The MDS indicated Resident 70 was receiving oxygen therapy. During a review of Resident 70's H&P, dated 5/4/2024, the H&P indicated Resident 70 did not have the capacity to understand and make decisions. During a review of Resident 70's Order Summary Report, dated 5/7/2025, the Order Summary Report indicated to suction Resident 70 four times a day and as needed for increased oral secretions. During a review of Resident 70's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 through 4/30/2025, the MAR indicated from 4/27/2025 through 4/30/2025, Resident 70 had oral secretions suctioned 13 times. During a review of Resident 70's MAR, dated 5/1/2025 through 5/31/2025, the MAR indicated from 5/1/2025 through 5/5/2025, Resident 70 had oral secretions suctioned 17 times. During an observation on 5/5/2025 at 9:51 a.m., inside Resident 70's bedroom, an oral suction cannister containing approximately 250 ml of clear fluid was on top of Resident 70's nightstand. The lid of the suction cannister was dated 4/27/2025 and the two suction tubing connected to the cannister were dated 5/4/2025. (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 interview on 5/7/2025 at 11:07 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 70 had the tendency to have oral secretions that required oral suctioning from the licensed nurse. LVN 1 stated after the suction cannister, and tubing were used, those items were to be disposed of daily. LVN 1 stated oral secretions had the potential to grow bacteria and the bacteria could enter Resident 70's respiratory system through the Yankauer suction tip (an oral suctioning tool). During an interview on 5/7/2025 at 1:44 p.m., with the IPN, the IPN stated once the suction tubing and suction cannister were used, the licensed nurse was responsible for disposing the used tubing and cannister and putting together a new set up for the following shift. The IPN stated Resident 70's suction cannister with oral secretions should not have been kept at the bedside from 4/27/2025 through 5/5/2025. The IPN stated Resident 70 was at risk for respiratory infection, which could manifest as a fever, cough, or increased secretions. During an interview on 5/7/2025 at 2:37 p.m., with the Director of Nursing (DON), the DON stated the facility did not have a policy that indicated when a used suction cannister and tubing were to be changed. The DON stated the best practice was to dispose and change the suction cannister and tubing after 24 hours. The DON stated secretions in the cannister and tubing at the bedside could grow bacteria that would be harmful to the residents and the staff. During a review of the facility's P&P titled, Infection Prevention Program Overview, undated, the P&P indicated the goal of the infection prevention program was to decrease the risk of infection to residents and personnel. 49900 c. During a review of Resident 242's Admission Record, the record indicated Resident 242 was admitted to the facility on [DATE]. Resident 242's diagnoses included candidal cystitis and urethritis (a fungal urinary tract infection [UTI] in the urinary bladder and/or urethra [tube-like structure that carried urine from the bladder to the outside of the body]) and dermatitis (inflammation of the skin). During a review of Resident 242's MDS, dated [DATE], the MDS indicated Resident 242's cognition was intact. The MDS indicated Resident 242 required setup assistance with eating and oral hygiene, and maximal assistance (helper did more than half the effort) with toileting hygiene, showering/ bathing self, and chair/bed-to-chair transferring. During a review of Resident 242's H&P, dated 4/13/2025, the H&P indicated Resident 242 had a chronic (lasting for a long time or recurring frequently) indwelling urinary catheter. During a review of Resident 242's care plan titled Enhanced Barrier Precautions, dated 4/17/2025, the care plan indicated the goal was for Resident 242 to be free of signs and symptoms of infection. During an observation on 5/5/2025 at 9:56 a.m. in Resident 242's room, Resident 242 was observed lying on the bed. Resident 242's urinary catheter bag and tubing were touching the floor. During an observation on 5/6/2025 at 8:06 a.m. in Resident 242's room, Resident 242 was observed lying on the bed. Resident 242's urinary catheter bag and tubing were touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/6/2025 at 10:12 a.m. in Resident 242's room, Resident 242 was observed lying on the bed. Resident 242's urinary catheter bag and tubing were touching the floor. During a concurrent interview and picture review of Resident 242's urinary catheter bag and tubing on 5/6/2025 at 2:29 p.m. with the IPN, the pictures dated 5/5/2025 at 9:56 a.m., 5/6/2025 at 8:06 a.m., and 5/6/2025 at 10:12 a.m. were reviewed. The pictures showed Resident 242's urinary catheter bag and tubing were touching the floor. The IPN stated the urinary catheter bag and tubing should be away from the floor to prevent microorganisms from entering the resident's body. The IPN stated it was a part of the infection control program. The IPN stated it put Resident 242 at risk of infection and Resident 242 might experience burning sensation, pain, and fever. The IPN stated everyone was responsible for ensuring the urinary catheter bag was off the floor by checking throughout the shift. During a review of the facility's P&P titled Catheter Associated Urinary Tract Infection (CAUTI) Prevention, undated, the P&P indicated, Keep the collection bag and tubing off the floor.