STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056148	A. Building B. Wing	03/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casitas Care Center	10626 Balboa Blvd. Granada Hills, CA 91344

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to provide dignity to a resident by failing to ensure an indwelling urinary catheter (a flexible tube inserted into the bladder [organ that stores urine] and left in place to continuously drain urine) collection bag (attached to the catheter tube for the purpose of collecting urine) was covered with a privacy bag (dignity bag- a bag that conceals urine in the collection bag) for one of one sampled resident (Resident 238). This deficient practice had the potential to affect the resident's sense of self-worth and self-esteem. Findings: During a review of Resident 238's Admission Record, the Admission Record indicated that the facility admitted the resident on 3/7/2025 with diagnoses including infection and inflammatory reaction (the body's response to injury or infection) due to urinary catheter, and malignant neoplasm of bladder (an uncontrolled growth of abnormal cells that form a tumor in the bladder, the organ that stores urine). During a review of Resident 238's Order Summary Report dated 3/7/2025, the Order Summary Report indicated an order to provide indwelling catheter care for the resident during every shift and as needed. During an observation on 3/8/2025 at 8:52 a.m., inside Resident 238's room, observed Resident 238's urinary catheter bag not covered with a privacy bag. During a concurrent observation and interview on 3/8/2025 at 8:54 a.m., with Registered Nurse 1 (RN 1) inside Resident 238's room, observed Resident 238's urinary catheter collection bag. RN 1 stated that Resident 238's urinary catheter collection bag was not covered with a privacy bag. RN 1 stated that urinary catheter collection bags are required to be covered with a privacy bag to promote dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/2025 at 9:10 a.m., with the Director of Nursing (DON), the DON stated that urinary catheter collection bags are required to be covered with a privacy bag. The DON stated Resident 238 was admitted to the facility on [DATE], and staff forgot to cover Resident 238's urinary catheter collection bag with a privacy bag. The DON stated the potential outcome is the lack of promoting a resident's dignity. During a review of the facility's Policy and Procedure (P&P) titled, Quality of Lift-Dignity, the P&P indicated that residents shall be treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered.

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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** 39550 Based on observation, interview, and record review, the facility failed to ensure call lights were within residents' reach while in bed for three of three sampled residents. (Resident 5, Resident 44, and Resident 45) This deficient practice had the potential to delay the provision of services and residents' needs not being met. Findings: a. During a review of Resident 5's Admission Record, the Admission Record indicated the facility readmitted the resident on 7/5/2023 with diagnoses including acute respiratory failure (results from acute or chronic impairment of gas exchange between the lungs and the blood) with hypoxia (a condition in which the body's tissues do not receive enough oxygen), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, often caused by damage to the brain) following unspecified cerebrovascular disease (a group of conditions that affect the blood vessels in the brain and spinal cord) affecting left non-dominant side. During a review of Resident 5's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 3/3/2025, the MDS indicated Resident 5 has moderately impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 5 required supervision or touching assistance from staff with eating, oral hygiene, personal hygiene. During an observation on 3/7/2025 at 7:18 p.m. in Resident 5's room, observed Resident 5 in bed while the call was on the floor. During an observation and concurrent interview on 3/7/2025 at 7:20 p.m. with the MDS Nurse (MDSN), observed Resident 5 in bed while Resident 5's call light was on the floor, out of Resident 5's reach. Observed the MDSN place the call light within Resident 5's reach next to her right hand and stated residents' call light should always be within reach for safety. b. During a review of Resident 44's Admission Record, the Admission Record indicated the facility admitted the resident on 5/28/2024 with diagnoses that included metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in the body's metabolism), urinary tract infection (UTI- an infection in the bladder/urinary tract), and abnormal posture. During a review of Resident 44's MDS dated [DATE], the MDS indicated Resident 44's has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 44 required setup or clean-up assistance with oral hygiene and required supervision or touching assistance from staff with toileting and personal hygiene. During a review of Resident 44's care plan for ADL (activities of daily living) self-care performance deficit initiated on 6/1/2024, the care plan indicated an intervention to keep call light within easy reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/7/2025 at 7:16 p.m. in Resident 44's room, observed Resident 44 in bed while Resident 44's call light on the floor and not within Resident 44's reach. During an observation and concurrent interview on 3/7/2025 at 7:26 p.m. with Certified Nursing Assistant 2 (CNA 2), observed Resident 44 in bed while Resident 44's call light was on the floor and not within Resident 44's reach. CNA 2 stated that residents' call light should be within reach for the resident's safety. c. During a review of Resident 45's Admission Record, the Admission Record indicated the facility readmitted the resident on 4/6/2023 with diagnoses that included Parkinsonism (clinical syndrome characterized by tremor, bradykinesia, rigidity, and postural instability). During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 45 was dependent with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 44's care plan for ADL self-care performance deficit revised on 2/10/2025, the CP indicated an intervention to keep call light within reach and answer in timely manner. During an observation on 3/8/2025 at 10:34 a.m. in Resident 45's room, observed Resident 45 in bed, with the call light hanging behind Resident 45's head of bed, and not within Resident 45's reach. During an observation and concurrent interview on 3/8/2025 at 10:57 a.m. with CNA 3, observed Resident 45 in bed, with the call light hanging behind Resident 45's head of bed, and not within Resident 45's reach. Observed CNA 3 place the call light within Resident 45's reach next to his left hand. CNA 3 stated that resident's call light should be within reach at all times so the resident can ask for help. CNA 3 stated she provided care to Resident 45 and forgot to place Resident 45's call light back within his reach. During an interview on 3/9/2025 at 5:15 p.m., with the Director of Nursing (DON), the DON stated that all residents' call light should always be within reach for their safety. During a review of the facility policy titled Call Light reviewed 1/3/2025, the policy indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member on a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed. Upon admission and as needed, resident call light shall be within reach.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to conduct an accurate Minimum Data Set (MDS- a resident assessment tool) assessment, reflecting a resident's status at the time of assessment for one of two sampled residents (Resident 62) by failing to indicate that the resident was receiving insulin (a hormone that works by lowering levels of glucose [sugar] in the blood) since his admission to the facility. This deficient practice had the potential to negatively affect Resident 62's plan of care and the delivery of necessary care and services. Findings: During a review of Resident 62's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/12/2025 with diagnoses including benign prostatic hypertension (BPH, enlarged prostrate [a gland] that makes it difficult to urinate), history of falling, and type two (2) diabetes mellitus (DM- a chronic condition that affects the way the body processes blood sugar). During a review of Resident 62's MDS dated [DATE], the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 62 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering and bathing, lower body dressing, and putting on/talking off footwear. The MDS further indicated that Resident 62 did not receive insulin injections during the last seven (7) days or since his admission. During a review of Resident 62's Order Summary Report dated 2/12/2025, the Order Summary Report indicated an order to administer insulin lispro (a rapid-acting insulin) subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) before meals and at bedtime. During a review of Resident 62's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/12/2025-2/17/2025, the MAR indicated that Resident 62 received insulin lispro from 2/13/2025 through 2/17/2025. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review on 3/9/2025 at 10:10 a.m., with MDS Coordinator 1 (MDSC 1), reviewed Resident 62's MAR dated 2/2025 and Resident 62's MDS dated [DATE]. MDSC 1 stated Resident 62 has a diagnosis of DM and on 2/12/2025 Resident 62's physician ordered insulin lispro to be administered per sliding scale. MDSC 1 stated Resident 62 received insulin lispro from 2/13/2025 through 2/17/2025. MDSC 1 stated Resident 62's MDS dated [DATE] was not coded for insulin use and it did not indicate that the resident has taken insulin since his admission to the facility. MDSC 1 stated that it was his mistake, and he (MDSC 1) has to make the correction for incorrect coding. MDSC 1 stated he (MDSC 1) did not conduct a correct MDS assessment for Resident 62's insulin use. MDSC 1 stated the potential outcome of an incorrect MDS assessment is the inability to make the correct care plan (a document that summarizes a resident's needs, goals, and care/treatment) for the resident, and lack of care. During an interview on 3/9/2025 at 3:25 p.m., with the Director of Nursing (DON), the DON stated the facility's MDS Coordinator is required to accurately complete each portion of the MDS assessment to reflect the resident's status at the time of the assessment. The DON stated Resident 62's MDS assessment dated [DATE] did not indicate that Resident 62 was receiving insulin since his admission to the facility. The DON stated that the potential outcome of an inaccurate MDS assessment is the development of an incorrect care plan for the resident. During review of the facility's Policy and Procedure (P&P) titled, Resident Assessments, last reviewed on 1/3/2025, the P&P indicated that the resident assessment coordinator is responsible for ensuring that the Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) conducts timely and appropriate resident assessments. The IDT uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. Assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident`s strengths and areas of decline. All persons who have completed any portion of MDS resident assessment form must sign the document attesting to the accuracy of such information. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to develop a baseline care plan (a document that summarizes a resident's needs, goals, and care/treatment) within 48 hours of admission and/or readmission for three of four sampled residents (Resident 21, 59, and 62) by failing to: 1. Develop a baseline care plan that addressed Resident 21 and 59's antibiotic (medication used to treat bacterial infections) use. 2. Develop a baseline care plan that addressed Resident 62's insulin (a hormone that works by lowering levels of glucose [sugar] in the blood) use. These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: 1.a. During a review of Resident 21's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 7/20/2017 and readmitted the resident on 2/20/2025 with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe) and gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach). During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool) dated 2/6/2025, the MDS indicated that Resident 21's cognition (a mental process of acquitting knowledge and understanding) was intact. The MDS indicated Resident 21 required setup or clean-up assistance with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. During a review of Resident 21's physician orders, dated 2/20/2025, the physician orders indicated a order for ertapenem sodium injection solution (Invanz [brand name]-is used to prevent and treat a wide variety of bacterial infections) reconstituted one (1) gram (GM- unit of measurement), use one (1) GM intravenously (into or within a vein) one time a day for urinary tract infection (UTI- an infection in any part of the urinary system) for seven (7) days. During a concurrent interview and record review on 3/9/2025 at 2:01 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 21's physician orders dated 2/20/2025 for Invanz and Resident 21's care plans dated 2/20/2025 to 3/9/2025. RN 1 stated that for any antibiotic order and antibiotic order upon admission, a baseline care plan should be initiated or created within 48 hours. RN 1 stated the baseline care plan would establish the goals of treatment and outline the interventions on how to meet the goals and in this case, for the antibiotic therapy, the goal is for the infection to resolve with no adverse reactions (undesired harmful effect resulting from a medication or other intervention). RN 1 stated that if there is no baseline care plan, then the staff would not know what to monitor as far as potential adverse reactions from the antibiotic and how to intervene promptly to ensure the safety of the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Baseline Care Plan, last reviewed on 1/3/2025, the policy indicated, A baseline plan of care to meet the resident's needs shall be developed admission .for each resident within forty-eight (48) hours of the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan . 1.b. During a review of Resident 59's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 10/17/2022 and readmitted the resident on 11/13/2024, with diagnoses including urinary tract infection and gastro-esophageal reflux disease. During a review of Resident 59's MDS dated [DATE], the MDS indicated that Resident 59's cognition was severely impaired. The MDS indicated Resident 59 is totally dependent on staff for oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. During a review of Resident 59's physician orders, dated 2/11/2025, the physician orders indicated the following orders: - Cefdinir (is used to treat bacterial infections in many different parts of the body) oral capsule 300 milligrams (mg- unit of measurement), give one (1) capsule via gastrostomy tube (G-tube- a tube inserted through the belly that brings nutrition and medication directly to the stomach) two times a day for G-tube site cellulitis for seven (7) days. - Sulfamethoxazole-Trimethoprim (Bactrim [brand name]- a combination antibiotic used to treat ear infections and urinary tract infections) 800-160 mg, give one (1) tablet via G-tube two times a day for G-tube cellulitis (common bacterial infection of the skin and underlying tissues) for seven (7) days. During a concurrent interview and record review on 3/8/2025 at 5:33 p.m., with RN 1, reviewed Resident 59's physician orders dated 2/11/2025 that included cefdinir and Bactrim and Resident 59's care plans dated 2/11/2025 to 3/8/2025. RN 1 stated that Resident 59 was readmitted from the hospital with these orders. RN 1 stated that Resident 59 was diagnosed with abdominal wall cellulitis, hence the antibiotic orders. RN 1 stated a baseline care plan should have been created to monitor Resident 59 while on antibiotic therapy. RN 1 stated the baseline care plan for antibiotic therapy would establish the goals of treatment and outline the interventions if a resident experiences adverse reactions from the antibiotic including notifying the physician promptly. RN 1 stated that without a care plan, staff would not be able to monitor or identify adverse reactions which could lead to serious complications such as an allergic reaction. During a review of the facility's policy and procedure titled, Baseline Care Plan, last reviewed on 1/3/2025, the policy indicated, A baseline plan of care to meet the resident's needs shall be developed for each resident within forty-eight (48) hours of admission .the baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan . 44309 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 62's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/12/2025 with diagnoses including benign prostatic hypertension (BPH, enlarged prostrate [a gland] that makes it difficult to urinate), history of falling, and type two (2) diabetes mellitus (DM- a chronic condition that affects the way the body processes blood sugar). During a review of Resident 62's MDS dated [DATE], the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 62 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering and bathing, lower body dressing, and putting on/talking off footwear. During a review of Resident 62's Order Summary Report dated 2/12/2025, the Order Summary Report indicated an order to administer insulin lispro (a rapid-acting insulin) subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) before meals and at bedtime. During a review of Resident 62's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/12/2025-2/17/2025, the MAR indicated that Resident 62 received insulin lispro from 2/13/2025 through 2/17/2025. During a concurrent interview and record review on 3/9/2025 at 10:10 a.m., with MDS Coordinator 1 (MDSC 1), reviewed Resident 62's baseline care plan signed 2/13/2025, MAR dated 2/2025, and medical diagnoses. MDSC 1 stated that he (MDSC 1) developed Resident 62's baseline care plan on 2/12/2025. MDSC 1 stated Resident 62 has a diagnosis of DM, and on 2/12/2025 Resident 62's physician ordered insulin lispro to be administered per sliding scale. MDSC 1 stated Resident 62 received insulin lispro from 2/13/2025 through 2/17/2025. MDSC 1 stated he did not indicate in Resident 62's baseline care plan that Resident 62 was taking insulin. MDSC 1 stated this was a mistake from his part. MDSC 1 stated that residents' base line care plans must be completed thoroughly reflecting all the pertinent information regarding residents within 48 hours of their admission to the facility. MDSC 1 stated the potential outcome of not thoroughly completing a resident's baseline care plan is the inability to meet the resident's immediate care needs and lack of care. During an interview on 3/9/2025 at 3:15 p.m., with the Director of Nursing (DON), the DON stated a resident's baseline care plan is required to be completed within 48 hours of resident's admission to the facility. The DON stated upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident accurately indicating the medications they are taking. The DON stated Resident 62's baseline care plan developed on 2/12/2025 was not completed thoroughly. The DON stated the potential outcome is the inability to meet the resident's immediate care needs and the delivery of necessary services to the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's Policy and Procedure (P&P) titled, Care Plans-Baseline, last reviewed on 1/3/2025, the P&P indicated that a baseline care plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. The Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) will review the healthcare practitioner's orders such as medications, dietary needs and routine treatments and implement a baseline care plan to meet the resident's immediate care needs, including but not limited to initial goals based on admission orders, and physician orders.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for four of four sampled residents (Resident 287, Resident 36, Resident 37, and Resident 20) by failing to:  1. Develop and implement a comprehensive person-centered care plan addressing Resident 287`s intravenous catheter (IV- a thin flexible tube inserted into a vein to allow for administration of fluids or medications). This deficient practice had the potential to result in Resident 287`s inadequate care of IV site. 2. Develop and implement a comprehensive person-centered care plan addressing Resident 36's Ceftriaxone Sodium (antibiotic used to treat bacterial infections) use. This deficient practice had the potential to result in complications due to Resident 36's use of antibiotics. 3. Develop and implement a comprehensive person-centered care plan addressing Resident 37's ability to safely use an electric kettle (a simple portable appliance that boils water quickly using electricity) in his room. This deficient practice had the potential to result in injuries. 4. Develop and implement a comprehensive person-centered care plan addressing Resident 20's inability to communicate due to a language barrier. This deficient practice had the potential to result in Resident 20`s inadequate care. Findings: 1. During a review of Resident 287's Admission Record, the Admission Record indicated that the facility initially admitted Resident 287 on 4/27/2024 and readmitted the resident on 3/3/2025 with diagnoses including pneumonitis (lungs tissue inflammation, swelling, and irritation), urinary tract infection (an infection in any part of the urinary system), and type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). During a review of Resident 287's Minimum Data Set (MDS - a resident assessment tool) dated 10/12/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 287 was dependent on assistance of two or more helpers for activities of daily living (ADL-activities related to personal care). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 287's History and Physical (H&P), dated 3/4/2025, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 287's Physician Orders, an order dated 2/21/2025 indicated to infuse 5% dextrose in water (D5W- intravenous sugar solution) one (1) Liter (L- 1000 milliliters) at 50 milliliters/hour (ml/hr.-infusion rate) every Tuesday and Monday via IV. During an observation on 3/7/2025, at 8:40 PM, Resident 287 was observed in his room in his bed with IV infusing, D5W at 50 ml/hour. During a concurrent interview and record review on 3/9/2025 at 2:30 PM, with MDS Coordinator 1(MDSN 1), Resident 287`s physician orders and care plans were reviewed. MDSC 1 stated Resident 287`s has a physician order for IV infusion of D5W. MDSC 1 stated licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s IV site monitoring. MDSC 1 stated the potential outcome of not developing a person-centered care plan with goals and interventions for a resident who has an IV is the lack of care and the inability to implement the specific services and monitoring the resident requires. 2. During a review of Resident 36's Admission Record, the Admission Record indicated that the facility initially admitted Resident 36 on 5/18/2023 and readmitted the resident on 1/29/2025 with diagnoses including dislocation of internal joint prosthesis (the displacement or misalignment of a prosthetic joint that has been surgically implanted to replace a damaged or diseased joint), urinary tract infection (an infection in any part of the urinary system), and essential hypertension (high blood pressure). During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/20/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 36 was requiring touch up or supervision assistance with eating and moderate - to - maximal assistance for other activities of daily living (ADL-activities related to personal care). During a review of Resident 36's Physician Orders, an order dated 1/30/2025 indicated to administer Ceftriaxone Sodium (antibiotic used to treat bacterial infections) one (1) gram (g) intravenously one time a day for urinary tract infection (UTI) until 02/202/2025. During a concurrent interview and record review on 3/9/2025 at 2:30 PM, with MDS Coordinator 1(MDSC 1), Resident 36`s physician orders and care plans were reviewed. MDSC 1 stated Resident 36`s has a physician order for Ceftriaxone IV infusion. MDSC 1 stated licensed staff did not develop a comprehensive care plan with person-centered interventions for the antibiotic administration. MDSC 1 stated the potential outcome of not developing a person-centered care plan with goals and interventions for a resident who was receiving antibiotic therapy is the lack of care and the inability to implement the specific services and monitoring for side effects. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 37's Admission Record, the Admission Record indicated that the facility initially admitted Resident 37 on 10/29/2019 with diagnoses including phlebitis of lower extremities (an inflammation that causes a blood clot [a clumps that occur when blood hardens from a liquid to a solid] to form in a vein[blood vessels that carry blood back to the [NAME]]), gangrene (the death of body tissue, typically due to a lack of blood flow), and type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). During a review of Resident 37's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/19/2024, the MDS indicated that the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 37 was required supervision or set up assistance for all activities of daily living (ADL-activities related to personal care). During a review of Resident 37's History and Physical (H&P), dated 3/4/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 3/8/2025, at 8:30 AM, observed Resident 37 in bed and an electric tea kettle under the chair. Resident 37 stated he likes to make his own tea by boiling water in the kettle. During an interview with on 3/8/2025, at 8:35AM with the Director of Nursing (DON), the DON stated that Resident 37 likes to make his own tea and is alert and oriented and had intact cognition. The DON stated that Resident 37 was not assessed for his ability to safely use an electrical equipment like tea kettle. The DON stated there is no care plan developed addressing Resident 37's use of an electric tea kettle. The DON stated that resident should have been assessed, and there should have been a care plan in place addressing use of an electric tea kettle to ensure resident safety. During an interview on 3/9/2025 at 4:00 PM, with the Director of Nursing (DON), the DON stated licensed staff are required to develop a person-centered care plan based on the residents` needs and identified problems. The DON stated licensed staff did not develop a care plan with goal and interventions for Resident 287`s IV site, for Resident 36's Ceftriaxone administration and for Resident 37's ability to safely use an electric kettle. The DON stated that the potential outcome of not developing care plans with goal and interventions is the inability to monitor to see if there are any decline/improvement in the resident`s condition and consequently providing inadequate care to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/3/2025, the P&P indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan is developed within seven (7) days of completion of the required MDS assessment and no more than 21 days after admission. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident`s problem areas and their causes, and relevant clinical decision making. 44309 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 20's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 10/25/2024, and readmitted on [DATE], with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cerebral infarction (stroke, loss of blood flow to a part of the brain). The admission records further indicated that Resident 20`s primary language was Korean.  During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 20 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 20`s preferred language was Korean.  During a review of Resident 20`s Activity Participation Review form dated 1/27/2025, the Activity Participation form indicated that Resident 20 speaks Korean and very little English. During a review of Resident 20's care plans, the care plans did not indicate a comprehensive care plan addressing Resident 20`s inability to communicate due to language barrier.  During a concurrent interview and record review on 3/8/2025 at 6:40 p.m., with the Infection Preventionist (IP), Resident 20`s care plans were reviewed. The IP stated that Resident 20`s preferred language is Korean. The IP stated Resident 20 does not speak or understand English. However, licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s inability to communicate effectively. The IP stated it is required to develop a person-centered care plan with goals and interventions to address how the facility is going to accommodate Resident 20`s inability to communicate. The IP stated the potential outcome of not developing a care plan for a resident who is unable to communicate in English is the absence of care and the resident`s inability to communicate her needs with the staff. During an interview on 3/9/2025 at 4:06 p.m., with the Director of Nursing (DON), the DON stated residents who do not speak and understand English, licensed staff are required to develop a person-centered care plan addressing the residents` communication skills, the language they speak, and the use of any communication tools. The DON stated licensed staff did not develop a care plan with goals and interventions for Resident 20`s inability to communicate due to a language barrier. The DON stated the potential outcome of not developing a person-centered care plan for a resident who does not speak and understand English is the lack of care and the inability to communicate effectively with the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/3/2025, the P&P indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan is developed within seven (7) days of completion of the required MDS assessment and no more than 21 days after admission. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident`s problem areas and their causes, and relevant clinical decision making.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44309 Based on interview and record review, the facility failed to update and revise a resident's care plan (a document that summarizes a resident's needs, goals, and care/treatment) after the resident's physician discontinued administration of Januvia (a medication that helps control blood sugar levels) on 10/25/2024, for one of two sampled residents (Resident 20). This deficient practice had the potential to result in confusion regarding the care and services Resident 20 received at the facility. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 10/25/2024 and readmitted the resident on 11/19/2024 with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type two diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), and cerebral infarction (stroke, loss of blood flow to a part of the brain). During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired. The MDS indicated that Resident 20 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 20's Order Summary Report dated 10/25/2024, the Order Summary Report indicated the order to administer Januvia 25 milligrams (mg-a unit of measurement) two tablets by mouth one time a day, was discontinued on 10/25/2024 at 9:22 p.m. During a review of Resident 20's Care Plan for DM, initiated on 10/26/2024, the care plan indicated that the resident is currently taking Januvia and an intervention to administer DM medications as ordered by the physician. During a concurrent interview and record review on 3/8/2025 at 6:30 p.m., with the Infection Preventionist (IP), reviewed Resident 20's care plan for DM dated 10/26/2024 and Resident 20's physician orders. The IP stated that Resident 20's physician order to administer Januvia was discontinued on 10/25/2024, however, Resident 20's care plan for DM still indicated that Resident 20 is taking Januvia. The IP stated Resident 20's care plan was not revised or updated to show that Januvia was discontinued on 10/25/2024. The IP stated licensed staff are required to revise a resident's care plan immediately after a medication is discontinued. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/9/2024 at 4:15 p.m., with the Director of Nursing (DON), the DON stated that licensed nurses did not review or revise Resident 20's care plan for DM after the physician discontinued Januvia on 10/25/2024. The DON stated residents' care plans are required to be reviewed and revised when the physician is changing their medication. The DON further stated that residents' care plans need to reflect the correct medications that residents are taking and the current interventions that are being implemented. The DON stated the potential outcome of not updating/revising a resident's care plan is the inability to provide appropriate care and services to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans Comprehensive Person-Centered, last reviewed on 1/3/2025, the P&P indicated that care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 44309 Based on observation, interview, and record review, the facility failed to provide a resident with a communication board (a device that can help patients communicate with care providers and family using symbols, photos, or illustrations) for one of two sampled residents (Resident 20) whose primary and preferred language was not English. This deficient practice has the potential to prevent the resident from communicating with the staff and had the potential to delay receiving care/treatment the resident needed. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 10/25/2024 and readmitted the resident on 11/19/2024 with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type two diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), and cerebral infarction (stroke, loss of blood flow to a part of the brain). The Admission Record further indicated that Resident 20's primary language was Korean (foreign language). During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 20 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 20's preferred language was Korean. During a review of Resident 20's Activity Participation Review form dated 1/27/2025, the Activity Participation Review form indicated that Resident 20 speaks Korean and very little English. During a concurrent observation and interview on 3/8/2025 at 1:02 p.m., inside Resident 20's room, with Certified Nursing Assistant 1 (CNA 1), observed CNA 1 sitting next to Resident 20 and assisting her with her lunch. CNA 1 stated Resident 20 speaks Korean. CNA 1 stated that she is unable to communicate with Resident 20 and she uses hand gestures to get her point across. CNA 1 stated a communication board with pictures and signs is required for residents who do not speak English. CNA 1 started looking for a communication board/device at Resident 20's bedside, however, CNA 1 did not find one. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/9/2025 at 2:39 p.m., with the Director of Social Services (DSS), the DSS stated that when she (DSS) performs residents' initial social service assessments upon their admission to the facility, she determines if the residents are able to comfortably communicate in English or not. The DSS stated that for the residents who are not able to communicate their needs in English, she (DSS) recommends the placement of a communication board/device at the residents' bedside. The DSS stated that Resident 20 speaks Korean and requires a communication board at her bedside to be able to make her needs known. The DSS stated she (DSS) did place a communication board/device at Resident 20's bedside, however, for some reason the board was removed. The DSS stated that the potential outcome of not having a communication board available and accessible to a resident who is not able to communicate effectively in English is insufficient care. During an interview on 3/9/2025 at 4:00 p.m., with the Director of Nursing (DON), the DON stated staff are required to provide a communication board or device to the residents who do not speak English in the language that they speak. The DON stated Resident 20 was not provided a communication device/board in Korean. The DON stated the potential outcome of not providing a communication board/device to the residents who do not speak English is the inability to communicate with residents accurately and understand their needs. During a review of the facility's Policy and Procedure (P&P) titled, Translation and/or Interpretation of Facility Services, last reviewed on 1/3/2025, the P&P indicated that when encountering limited English proficiency (LEP) individuals, staff members will conduct initial assessment and notify the staff person in charge of the language access program. The facility shall provide written translation of vital information pertaining to health services translation of information that is not available in written translation shall be provided in a timely manner and at no cost to the resident through the following means: communication devices, a staff member/or family/RP (resident representative), a staff interpreter who is trained and competent in the skill of interpreting, contracted interpreter service, and telephone interpretation service. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADL- activities related to personal care), Supporting, last reviewed on 1/3/2025, the P&P indicated that appropriate care and services with be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with communication including speech, language, and any functional communication system.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to provide religious services to one of one sampled resident (Resident 10) investigated under Activities. This deficient practice violated the resident's right to have access and receive religious services which had the potential to affect the resident's sense of self-esteem and self-worth. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated that the facility admitted the resident on 6/20/2023 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and anemia (blood has a lower than normal number of red blood cells). During a review of Resident 10's Annual Minimum Data Set (MDS - a resident assessment tool) dated 6/21/2024, the MDS indicated in Section F that participating in religious services or practice is somewhat important to Resident 10. During a review of Resident 10's Quarterly MDS dated [DATE], the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired and was partially dependent on staff for shower, dressing and personal hygiene. During a concurrent observation and interview on 3/7/2025 at 7:31 p.m., observed Resident 10 sitting in bed with an open bible. Resident 10 stated that she wants to attend a church service but has not attended in a long time. Resident 10 stated the facility did not offer any religious service and that she just does her own bible study. Resident 10 stated no pastor nor priest have visited her in her room. During a concurrent interview and record review on 3/9/2025 at 1:09 p.m., with the Activity Director (AD), reviewed Resident 10's Activity Participation Log for 1/2025 and 2/2025. The AD stated that Resident 10 has not participated in any religious activities for the months reviewed and there is no documentation that she was offered or invited to attend any religious service. The AD stated that on admission, residents are assessed regarding their religious practices or interests and inform them of the scheduled religious services in the facility. The AD stated that she doesn't know why there is no documented attendance for Resident 10 in any of the religious services. The AD stated that she understands and recognizes the spiritual needs of the residents especially in their condition and advanced age. The AD stated that it is the right of the resident to practice their own religion, and the facility will facilitate in providing for religious activities. During a concurrent observation and interview on 3/9/2025 at 1:30 p.m., with the AD, observed the presence of a bible on Resident 10's bed. The AD asked Resident 10 if she would like to attend religious services and observed Resident 10's face lit up and smiled and Resident 10 stated that she wants to attend as long somebody will look after her stuff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Activity Programs-Staffing, last reviewed on 1/3/2025, the policy indicated, The activity director/coordinators responsibilities include: ensuring that the activity goals and approaches reflected in the residents' care plans are individualized to match the skills, abilities and interests/preferences of each resident .sufficient activity personnel are on duty to meet the needs of the residents and the functions of the activity programs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39550 Based on observation and interview, the facility failed to provide a safe environment for three out of six residents (Resident 70 and Resident 37) investigated under the care area of accidents when: 1. The facility failed to place a landing mat to Resident 70's right side of the bed while Resident 70 was in bed as indicated in the care plan and physician's order. This deficient practice placed the resident at risk for avoidable pain and/or injury in an event of Resident 70 experiencing an actual fall. 2. The facility allowed Resident 37 to keep an electric tea kettle in his room. This deficient practice had the potential to result in injuries to Resident 37. Findings: 1. During a review of Resident 70's Admission Record, the Admission Record indicated the facility admitted the resident on 2/23/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), encounter for palliative care (person and family-centered treatment, care and support for people living with a life-limiting illness), and unspecified sequelae of cerebral infarction (loss of blood flow to a part of the brain). During a review of Resident 70's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/5/2025, the MDS indicated Resident 70 had severely impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS also indicated Resident 70 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 70's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 70 was at risk for falls. During a review of Resident 70's physician's order dated 2/13/2025 at 10:56 a.m., the physician order indicated an order for one right side landing pad every shift less restrictive measures of fall and injury. During a review of Resident 70's care plan titled Resident 70 is risk for unavoidable falls with injury related to generalized weakness, impaired mobility, cerebral infarction with right hemiparesis and hemiplegia initiated on 2/26/2024 indicated under interventions: right side landing pads. During an observation on 3/7/2025 at 7:35 p.m., in Resident 70's room, observed Resident 70 in bed. Observed a landing mat under Resident 70's bed. (continued on next page)

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Casitas Care Center	10626 Balboa Blvd. Granada Hills, CA 91344

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/7/2025 at 7:46 p.m., with Registered Nurse 2 (RN 2) in Resident 70's room, observed Resident 70 in bed and Resident 70's landing mat under Resident 70's bed. RN 2 stated that Resident 70's landing mat should be placed on Resident 70's right side as indicated in the physician's order. RN 2 stated that the Certified Nursing Assistant (CNA) placed the landing mat under Resident 70's bed when the CNA assisted Resident 70 for dinner. RN 2 further stated that Resident 70's landing mat should have been placed back on Resident 70's right side because the resident is at risk for falls. During an interview with the Director of Nursing (DON) on 3/8/2025 at 5:05 p.m., the DON stated Resident 70's landing mat should have been on Resident 70's right side of bed to minimize injury if a fall were to occur. During a review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, review date 1/3/2025, the policy and procedure indicated based on previous evaluations and current data, the nursing staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and try to minimize complications from falling. In conjunction with the attending physician, licensed staff will identify and implement relevant intervention (e.g., low position, floor pad, .) to try to minimize serious consequences of falling. 47883 2. During a review of Resident 37's Admission Record, the Admission Record indicated that the facility initially admitted Resident 37 on 10/29/2019 with diagnoses including phlebitis of lower extremities (an inflammation that causes a blood clot [a clumps that occur when blood hardens from a liquid to a solid] to form in a vein[blood vessels that carry blood back to the [NAME]]), gangrene (the death of body tissue, typically due to a lack of blood flow), and type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). During a review of Resident 37's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/19/2024, the MDS indicated that the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 37 was required supervision or set up assistance for all activities of daily living (ADL-activities related to personal care). During a review of Resident 37's History and Physical (H&P), dated 3/4/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 3/8/2025, at 8:30 AM, surveyor observed Resident 37 in his room in his bed and a tea kettle under the chair. Resident 37 stated he likes to make his own tea by boiling water in the kettle. During an interview with on 3/8/2025, at 8:35AM with the Director of Nursing (DON), the DON stated that Resident 37 liked to make his own tea and is alert and oriented and had intact cognition. The DON stated that Resident 37 was not assessed for his ability to safely use an electrical equipment like tea kettle. The DON stated there is no care plan developed addressing Resident 37's use of an electric tea kettle. The DON stated that resident should have been assessed, and there should have been a care plan in place addressing use of an electric tea kettle to ensure resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with on 3/8/2025, at 4:15 AM with the Maintenance Director (MD), the MD stated that he was not aware that Resident 37 is using electrical kettle to boil a water in his room. The MD stated that Resident 37 may not have any electrical appliances in the room because it placed the resident at risk for accidents. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, last reviewed on 1/3/2025, the P&P indicated: Our facility strives to make the environment as free from accident hazards as possible. During a review of the facility's Policy and Procedure (P&P) titled, Electrical Appliances, last reviewed on 1/3/2025, the P&P indicated: Resident may not maintain any electrical appliances within their living area, unless approved, in writing, by the Administrator, or his/her designee.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44309 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 62) with an indwelling catheter (a hollow tube inserted into the bladder [organ that stores urine] to drain or collect urine) received proper care and services by failing to monitor the resident for signs and symptoms of urinary tract infection (UTI- an infection in the bladder/urinary tract) and pain associated with the catheter as indicated in the resident's care plan (a document that summarizes a resident's needs, goals, and care/treatment). This deficient practice had the potential to result in Resident 62 receiving inadequate care and monitoring at the facility. Findings: During a review of Resident 62's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/12/2025 with diagnoses including benign prostatic hypertension (BPH, enlarged prostrate [a gland] that makes it difficult to urinate), obstructive uropathy (a blockage in the urinary tract that prevents urine from draining normally), and reflux uropathy (when urine flows backward into the kidneys). During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool) dated 2/17/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 62 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering and bathing, lower body dressing, and putting on/talking off footwear. The MDS further indicated that Resident 62 had an indwelling catheter. During a review of Resident 62's Order Summary Report dated 2/13/2025, the Order Summary Report indicated an order to provide indwelling catheter care for the resident during every shift and as needed. During a review of Resident 62's care plan for indwelling catheter initiated on 2/13/2025, the care plan indicated a goal that the resident will remain free from catheter related trauma through the review date. The care plan indicated interventions to monitor and document the resident's fluid intake and urine output as per facility's policy, monitor and document for pain/discomfort due to catheter, and to monitor/record and report to the physician any signs and symptoms of UTI such as pain, burning, blood tinged urine, urinary frequency (the need to urinate many times during the day), foul smelling (having an extremely unpleasant smell) urine, fever, chills, altered mental status (a change in mental function), and change in behavior and eating patterns. During a review of Resident 62's Treatment Administration Record (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) for 2/13/2025-2/28/2025, the TAR did not indicate any documented evidence that licensed staff monitored Resident 62 for pain due to the presence of an indwelling catheter, and signs and symptoms of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/8/2025 at 4:00 p.m., with MDS Coordinator 1 (MDSC 1), reviewed Resident 62's care plan for indwelling catheter initiated on 2/13/2025 and TAR dated 2/2025. MDSC 1 stated that Resident 62's indwelling catheter care plan interventions are to monitor and document for pain/discomfort due to presence of the catheter, and to monitor/record and report to the physician any signs and symptoms of UTI such as pain, burning, blood-tinged urine and urinary frequency. MDSC 1 stated there is no documentation regarding this monitoring anywhere in the resident's chart. MDSC 1 stated that licensed staff are required to monitor Resident 62 for pain due to presence of the indwelling catheter, and signs and symptoms of infection and document their monitoring in Resident 62's medical record as indicated in Resident 62's care plan. MDSC 1 stated that the potential outcome of not implementing a resident's care plan intervention is the inability to provide appropriate care and services to the resident. During an interview on 3/9/2025 at 3:30 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to monitor the residents for complications associated with urinary catheter. The DON stated licensed staff are required to monitor and document in the resident's medical record their monitoring and observations such as a kinked (a tubing that has an unwanted, sharp bend or crease, which can obstruct or restrict fluid flow) or accidently removed catheter, urine color, presence of pain/discomfort, and signs and symptoms of UTI such as burning, blood-tinged urine, urinary frequency, foul smelling urine, fever and chills. The DON stated licensed staff did not document anywhere in Resident 62's chart regarding implementing the interventions of monitoring for Resident 62's indwelling catheter. The DON stated the potential outcome of not monitoring a resident's indwelling catheter is the risk of infection and the inability to provide appropriate care and services to the resident. During review of the facility's Policy and Procedure (P&P) titled, Catheter Care-Urinary, last reviewed on 1/3/2025, the P&P indicated that the purpose of this procedure is to prevent catheter-associated UTI. Review the resident's care plan to assess for any special needs of the resident. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Observe the resident for complications associated with urinary catheters. If the resident indicates that his or her bladder is full or that he or she needs to void, notify the physician. Check the urine for unusual appearance such as color, blood, etc. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidently removed. Report any complaints the resident may have of burning, tenderness, or pain in the urethral area. Observe for other signs and symptoms of UTI or urinary retention. Report findings to the physician or supervisor immediately.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 39550 Based on observation, interview and record review, the facility failed to ensure that residents received continuous oxygen as ordered by the physician for two of three sampled residents. (Resident 70 and Resident 287). The deficient practice had a potential to cause Resident 70 and Resident 287 to have shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood). Findings: a. During a review of Resident 70's Admission Record, the Admission Record indicated the facility admitted the resident on 2/23/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), encounter for palliative care (person and family-centered treatment, care and support for people living with a life-limiting illness), and dependence on supplemental oxygen. During a review of Resident 70's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/5/2025, the MDS indicated Resident 70 had severely impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS also indicated Resident 70 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 70's Order Summary Report, the Order Summary Report indicated an order for: - Oxygen (O2) at 2 liters/minute via nasal canula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously for COPD and oxygen desaturation. May titrate to 5 liters as needed. Every shift. Order date: 2/27/2025. Start date: 2/27/2025 During an observation on 3/7/2025 at 7:30 p.m., in Resident 70's room, observed Resident 70 in bed. Observed an O2 concentrator at bedside. The O2 concentrator was on, Resident 70's nasal canula was connected to the O2 concentrator, however, Resident 70 was not wearing the nasal canula. During a concurrent observation and interview on 3/7/2025 at 7:45 p.m., with Registered Nurse 2 (RN 2) in Resident 70's room, observed Resident 70's nasal cannula connected to an oxygen concentrator that was on, however, Resident 70 was not wearing the nasal cannula. RN 2 stated that its okay that Resident 70 is not wearing her nasal canula because Resident 70's oxygen order is as needed and not continuous. Observed RN 2 place Resident 70's nasal canula on Resident 70. During an observation on 3/8/2025 at 10:40 a.m., in Resident 70's room, observed Resident 70 on the bed. Observed Resident 70's nasal cannula connected to an oxygen concentrator that was on, however, Resident 70 was not wearing the nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/8/2025 at 10:43 a.m., with Licensed Vocational Nurse 2 (LVN 2) in Resident 70's room, observed Resident 70's nasal cannula connected to an oxygen concentrator that was on, however, Resident 70 was not wearing the nasal cannula. LVN 2 stated that Resident 70 should have her nasal canula on but Resident 70 always removes it. LVN 2 stated that LVN 2 will get an order from Resident 70's physician to change the order because Resident 70 always removes it. During an interview with the Director of Nursing (DON) on 3/9/2025 at 5:06 p.m., the DON stated that continuous oxygen via nasal cannula should have been provided to Resident 70 to ensure Resident 70 was provided supplemental oxygen to avoid complications such as labored breathing and/or shortness of breath. During a review of the facility's policy and procedure titled, Oxygen Administration, review date 1/3/2025, the policy and procedure indicated oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. 47883 b. During a review of Resident 287's Admission Record, the Admission Record indicated that the facility initially aditted Resident 287 on 4/27/2024 and readmitted the resident on 3/3/2025 with diagnoses including pneumonitis (lungs tissue inflammation, swelling, and irritation), urinary tract infection (an infection in any part of the urinary system), and type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). During a review of Resident 287's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/12/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 287 was dependent on the assistance of two or more helpers for activities of daily living (ADL-activities related to personal care). During a review of Resident 287's History and Physical (H&P), dated 3/4/2025, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 287' Care plan (a form where licensed nurses can summarize a person's health conditions, specific care needs, and current treatments), dated, 7/9/2024, the care plan indicated that Resident 287 had an altered respiratory status related to respiratory failure with hypoxia (the condition where the lungs are failing to adequately oxygenate the blood). The care plan interventions indicated an intervention to provide continuous oxygen as ordered. During a review of Resident 287's Physician Order, dated 10/11/2024, the Physician Orders indicated the following orders: 1. Administration of oxygen at 2L/min (measurement of oxygen flow) via nasal canula (a device that gives additional oxygen through the nose) continuously. 2. Change oxygen humidifier every week on Monday and PRN, when consumed with name and date label. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/7/2025, at 8:40 PM, Resident 287 was observed in bed, with oxygen being administered via nasal canula without a humidifier. During a concurrent observation and interview on 3/7/2025 at 8:42 PM in Resident 287's room with LVN 1, observed the oxygen concentrator connected to the resident via nasal canula at three (3) liters/minute (L/min-measurement of oxygen flow) without a humidifier. LVN 1 checked the Physician order and stated that oxygen should be continuously administered to Resident 287 via nasal canula at 2 L/min and with a humidifier. During an interview on 3/7/2025 at 8:50 PM with Director of Nursing (DON), the DON stated that oxygen should be administered to Resident 287 according to the physician order to prevent a possibility of hyperoxygenation and respiratory complications for the resident. During a review the facility policy and procedure named Physician Services, last reviewed on 1/3/2025, the policy and procedure indicated: Drugs, biologicals, laboratory services, radiology and other diagnostic services shall be administered or performed only upon the written order of a person duly licensed and authorized to prescribe such drugs and services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on observation, interview, and record review, the facility failed to: 1. Ensure licensed nurses did not leave medications at residents' bedside unattended by a licensed nursed for one of three sampled resident (Resident 57) This deficient practice increases the risks of harm to the resident from omitting the dose, double dosing, and mixing the medications that could cause adverse (unfavorable) or even fatal effects on the resident 2. Ensure a resident was given the first dose of antibiotic timely for one of three sampled residents (Resident 60) This deficient practice resulted in the delay of medication administration of an antibiotic which has a potential to cause bacteria to reproduce. Findings: a. During a review of Resident 57's Admission Record, the Admission Record indicated the facility readmitted the resident on 2/15/2025 with diagnoses including chronic hematogenous osteomyelitis (a bone infection that occurs when bacteria spread through the bloodstream to the bone) right ankle and foot, type 2 diabetes mellites (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer, non-pressure chronic ulcer on right heel and midfoot with necrosis of bone (a condition where bone tissue dies due to a loss of blood supply). During a review of Resident 57's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/19/2025, the MDS indicated Resident 5's has intact cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 57 required setup or clean up assistance with eating, supervision or touching assistance from staff with oral hygiene, and required partial/moderate assistance with toileting hygiene. During an observation on 3/7/2025 at 8:31 p.m. in Resident 57's room, observed Resident 57 in his wheelchair, observed two pills in an unlabeled medication cup (1 white round pill/1 clear oblong pill) on top of Resident 57's bedside table. The two pills in the unlabeled medication cup was unattended by a licensed nurse. During a concurrent observation and interview on 3/7/2025 at 8:32 p.m., in Resident 57's room. Resident 57 stated that the two pills in the unlabeled medication on on his bedside table belongs to Resident 57. Resident 57 stated that his nurse left his medications for him to take at a later time. Resident 57 stated that his nurse leaves it at his bedside all the time and it's no big deal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/2025 at 8:35 p.m. with Registered Nurse 2 (RN 2), RN 2 stated that she is assigned to Resident 57 today (3/7/2025). RN 2 stated that she left Resident 57's two pills in a medication cup on Resident 57's bedside table. RN 2 stated that she left the medications at bedside because the 5:00 p. m. medications are only vitamins. RN 1 continued to state that Resident 57 is trustworthy. RN 1 stated that she always leaves his medications unattended at Resident 57's bedside table because RN 2 has no control to when Resident 57 takes his medication. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 3/9/2025 at 11:34 a.m., RN 1 reviewed Resident 57's medication records and stated that there is no documented evidence of a Medication Self Administration Assessment prior to 3/7/2025. RN 1 stated that a Medication Self Administration Assessment should be done prior to allowing a resident to self administer his/her medication to assess if the resident is able to self administer their own medications safely. RN 1 continued to state that residents' medications should not be left at bedside unattended because licensed nurses have to ensure that residents take their medications safely and to avoid residents from choking. During a review of the facility's policy and procedure titled Medication Adminitration- General Guidelines, review date 1/3/2025, indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medication. The resident is always observed after medication administration to ensure that the dose was completely ingested. b. During a review of Resident 60's Admission Record, the Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 60's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition. During a review of Resident 60's physician's orders dated 3/8/2025 at 3:22 a.m., the physician's order indicated an order for Cipro (Ciprofloxacin- antibiotic is used to treat bacterial infections in many different parts of the body) oral table. Give 500 mg by mouth every 12 hours for UTI for 10 days. Confirmed by: Registered Nurse 2 (RN 2). During a review of Resident 60's care plan for resident is on antibiotic therapy related to culture result, the care plan indicated an intervention to administer medication as ordered. During a concurrent interview and record review with the MDS Nurse (MDSN) on 3/8/2025 at 5:11 p.m., reviewed Resident 60's medical records. The MDSN stated Resident 60's physician's order and stated that RN 2 received an antibiotic order, Cipro 500 mg, on 3/8/2025 at 3:22 a.m. The MDSN reviewed Resident 60's MAR (Medication Administration Record) and stated that Resident 60 was administered his first dose of his new antibiotic order on 3/8/2025 at 9:00 a.m. The MDSN continued to state that Resident 60 is supposed to receive his first dose of his new antibiotic order within four hours of the antibiotic order being received. The MDSN further stated that RN 2 should have administered after receiving the new antibiotic order because Cipro is available in the facility's pharmacy e-kit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/9/2025 at 5:09 p.m. with the Director of Nursing (DON), the DON stated that Resident 60 was not administered his antibiotic timely. RN 2 should have administered Resident 60's antibiotic within 4 hours of receiving the new antibiotic order. The DON stated that there is no excuse because the antibiotic is available in he facility's e-kit. During a review of the facility policy and procedure titled Provider Pharmacy Requirements, review date 1/3/2025, indicated medications should be promptly available such as anti-infectives, .are available within 4 hours. During a review of the facility's policy and procedure titled Medication Administration- General Guidelines, review date 1/3/2025, indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39550 Based on observation, interview and record review, the facility failed to follow the pharmacy's medication recommendation label of discarding two opened eye drop bottles after 28 days of opening from one in five medications carts (Medication Cart 1 3-11 shift) This deficient practice had the potential to compromise the therapeutic effectiveness of the medication and increase the risk of contamination, which could result in a negative impact to the health, and well-being of the residents. Findings: During a concurrent observation and interview on 3/7/2025 at 6:05 p.m. with Registered Nurse 2 (RN 2), observed Medication Cart 1 3-11 shift. Observed two opened eye drops: One opened eye drop container of Alpheagan (prescription eye drop that helps lower pressure in the eye and treats glaucoma [A group of eye conditions that can cause blindness]), labeled date open 1/20/2025 discard after 28 days and one opened eye drop container of Latanoprost (medication that treats glaucoma), labeled date opened 1/24/2025 discard after 28 days. RN 2 stated that both eye drops should have been discarded after 28 days of opening because bacteria can grow in open bottles. RN 2 stated that Alpheagan should have been discarded on 2/18/2025 and Latanoprost should have been discarded on 2/22/2025. to ensure resident safety. During an interview on 3/9/2025 at 11:04 a.m. with the Pharmacist Consultant (PC), the PC stated that the discard label on the eye drops is a pharmacy recommendation, and it is not a regulation. During an interview on 3/9/2025 at 11:10 a.m., with the Director of Nursing (DON), the DON stated that because the pharmacy label indicated to discard the eye drops after 28 days, licensed nurses should have discarded the eye drops. Licensed nurses are to read the label prior to medications administration. During a review of the facility's policy titled Procedures For All Medications, review date 1/3/2025, indicated to administer medications in a safe and effective manner. Read medication label before administering.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38469 Based on observation, interview, and record review, the facility failed to ensure leftover food brought from outside by residents' family and visitors were labeled with a resident identifier and use-by-date in one of one resident refrigerator (Refrigerator 1). This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) for the residents. Findings: During a concurrent observation and interview on 3/7/2025 at 6:33 p.m., with Registered Nurse 3 (RN 3), observed the residents' refrigerator in the nurse's station. Observed in the refrigerator, two plastic bags of undetermined leftover food with one bag with a room number with no name and date and the other plastic bag containing undetermined food items with no resident's name and no date. RN 3 stated that this refrigerator is used to store resident's food and had to be labeled with an identifier and date. RN 3 stated that any leftover food that is more than three days old had to be discarded. RN 3 stated that leftover food that is more than three days old can possibly get contaminated with salmonella (bacteria that causes diarrhea, fever, and stomach pains) and result in food poisoning if ingested by the residents. During a review of the facility's policy and procedure titled, Food Brought by Family/Visitors, last reviewed on 1/3/2025, the policy indicated that perishable (foods likely to spoil, decay, or become unsafe to consume if not kept refrigerated) foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date .the nursing staff is responsible for discarding perishable foods on or before the use by date.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 39550 Based on interview, and record review, the facility failed to ensure the facility had arranged provisions of hospice services by failing to: 1. Ensure the contracted hospice agency provided training programs to facility staff as per contractual agreement. 2. Ensure there is a designated staff to coordinate care and services provided by hospice and the facility. 3. Ensure documented evidence was provided to validate hospice staff was physically in the facility to provide hospice related services to one of three sampled residents (Resident 70) These deficient practices has the potential to negatively affect the resident's physical comfort, psychosocial well-being, and has the potential to delay or have a lack of necessary care and services. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated the facility admitted the resident on 2/23/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), encounter for palliative care (person and family-centered treatment, care and support for people living with a life-limiting illness), and dependence on supplemental oxygen. During a review of Resident 70's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/5/2025, the MDS indicated Resident 70 had severely impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS also indicated Resident 70 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 70's Order Summary Report, the report indicated an order dated 5/7/2024 to admit the resident to hospice. a. During an interview Registered Nurse 1 (RN 1) on 3/9/2025 at 8:39 a.m., RN 1 stated that the facility has only have one resident on hospice, Resident 70. RN 1 stated she has not received an in-service training from the hospice agency caring for Resident 70. During an interview with Certified Nursing Assistant 4 (CNA 4) on 3/9/2025 at 9:05 a.m., CNA 4 stated CNA 4 was assigned to resident 70 today, 3/9/2025. CNA 4 stated that CNA 4 has worked in the facility as a CNA for about 1 year. CNA 4 further stated that she has not received in-service training from Resident 70's hospice agency. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Nurse (MDSN) on 3/9/2025 at 9:14 a.m., the MDSN stated he has been employed at the facility since 6/2024 and has not had an in-service training conducted by the hospice agency. During a concurrent interview and record review with the Administrator (ADM) on 3/9/2025 at 4:22 p.m., the ADM reviewed the facility's hospice contract dated 5/10/2010 and stated that hospice has not fulfilled their contract. The ADM stated that she was not aware that training should have been provided by the hospice agency. The ADM further stated that moving forward she will be coordinating with the facility Director of Staff Development to schedule in-service training from the hospice agency. During an interview with the Director of Nursing (DON) on 3/9/2025 at 5:07 p.m., the DON stated that she was not aware of the hospice orientation and training portion of the hospice contract. During a review of the facility's hospice contract dated 5/17/2010, indicated under Hospice Orientation and Training: The Hospice will provide educational resources to The Facility for purposes of orientation, teaching and/or continuing education on an as needed basis, but at least, on a quarterly basis, at the facilities request. b. During an interview with the MDSN on 3/9/2025 at 9:12 a.m., the MDSN stated that the he was not sure of who the facility's hospice coordinator was. The MDSN stated that he thinks it is the Social Services Director. During an interview RN 1 on 3/9/2025 at 9:54 a.m., RN 1 stated that the hospice coordinator is the ADM. During an interview with the Social Services Director (SSD) on 3/9/2025 at 10:38 a.m., when asked who the facility's hospice coordinator was, the SSD stated that the hospice coordinator is the DON and the resident's physician. The SSD stated that she is not the facility's hospice coordinator. The SSD stated that if the facility needed something from hospice the charge nurses would call the hospice directly. During an interview with the ADM on 3/9/2025 at 4:21 p.m., the ADM stated that the facility does not have a designated hospice coordinator. The ADM stated she is not the hospice coordinator. During an interview with the DON on 3/9/2025 at 5:11 p.m., the DON stated that the facility does not have a hospice coordinator, and that the facility should have one. The DON stated that it is important to have a hospice coordinator in the facility so that the facility will be able to provide quality care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Hospice Program, reviewed on 1/3/2025, indicated the facility has designated . to coordinate care provided to the resident by our facility staff and the hospice staff. (Note: this individual is a member of the IDT with clinical and assessment skills who is operating within the state scope of practice act) He or she is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions to ensure quality of care for the residents and family; c. ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the residents as needed to coordinate the hospice care with the medical care provided by other physicians; e. Ensuring that facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents. c. During a current interview and record review with on 3/9/2025 at 9:27 a.m. with the MDSN, the MDSN reviewed Resident 70's hospice binder. The MDSN stated that there was no documented evidence that hospice staff was in the facility. There is no sign in sheet for hospice staff. The MDSN stated that when hospice staff is in the facility hospice staff should be signing on a sign-in sheet in Resident 70's hospice binder. During a concurrent interview and record review on 3/9/2025 at 3:57 p.m., with the Director of Staff Development (DSD), the DSD stated that the DSD sees hospice staff in the facility. The DSD reviewed Resident 70's hospice binder and stated that there is no sign-in sheet for hospice staff. The DSD stated that there is no documented evidence that hospice staff is in the facility. During an interview with the DON on 3/9/2025 at 5:12 p.m., the DON stated that the facility does not have sign-in sheets specifically for hospice staff. The DON stated that moving forward the facility will have a sign-in sheet dedicated to hospice staff. When hospice staff arrive to the facility hospice staff is to sign in on the hospice sign in sheet. The DON continued to state that by signing in in the hospice sign-in sheet, that ensures that hospice staff was physically in the facility to provide hospice care to the resident. During a review of the facility's policy and procedure titled Charting and documentation, reviewed on 1/3/2025, indicated all services provided to the resident shall be documented in the resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38469 Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident's nasal cannula (a medical device that delivers supplemental oxygen therapy to people with low oxygen levels) oxygen tubing was not touching the floor for one of one sampled resident (Resident 137). 2. Ensure a resident's nasal cannula was labeled with the date when it was last changed for one of three sampled residents (Resident 287). These deficient practices had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. Findings: 1. During a review of Resident 137's Admission Record, the Admission Record indicated the facility admitted the resident on 2/28/2025 with diagnoses including morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems) and heart failure (a chronic condition that occurs when the heart can't pump enough blood and oxygen to the body). During a review of Resident 137's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 2/28/2025, the H&P indicated that the resident had the capacity to understand and make decisions During a review of Resident 137's physician orders dated 2/28/2025, the physician order indicated an order to administer oxygen at two (2) liters per minute (LPM- unit of measurement for oxygen) via nasal cannula continuously every shift. During a concurrent observation and interview on 3/7/2025 at 7:53 p.m., with the Director of Nursing (DON), observed Resident 137's nasal cannula oxygen tubing on the floor. The DON stated that the tubing is already contaminated and can introduce infection to the resident and had to be replaced immediately. During a review of the facility's policy and procedure titled, Policies and Practices-Infection Control, last reviewed on 1/3/2025, the policy indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances. 47883 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 287's Admission Record, the Admission Record indicated that the facility initially admitted Resident 287 on 4/27/2024 and readmitted the resident on 3/3/2025 with diagnoses including pneumonitis (lung tissue inflammation, swelling, and irritation), urinary tract infection (an infection in any part of the urinary system), and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 287's Minimum Data Set (MDS - a resident assessment tool) dated 10/12/2024, the MDS indicated that the resident had severely impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 287 was dependent on assistance of two or more helpers for activities of daily living (ADL- activities related to personal care). During a review of Resident 287's H&P dated 3/4/2025, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 287's care plan (a document that summarizes a resident's needs, goals, and care/treatment) dated 7/9/2024, the care plan indicated that Resident 287 had an altered (changed or modified) respiratory status related to respiratory failure with hypoxia (the condition where the lungs are failing to adequately oxygenate the blood). The care plan indicated an intervention to provide continues oxygen as ordered. During a review of Resident 287's physician orders dated 10/11/2024, the physician orders indicated the following: - Administration of oxygen at two (2) liters (L- measurement of oxygen flow) via nasal cannula continuously. - Change oxygen nasal cannula every week on Monday and as needed (PRN) with name and date label. During an observation on 3/7/2025 at 8:40 p.m., observed Resident 287 in bed with oxygen being administered to the resident via nasal cannula. During a concurrent observation and interview on 3/7/2025 at 8:42 p.m., in Resident 287's room with LVN 1, observed Resident 287's nasal cannula oxygen tubing not labeled with the date when it was last changed. LVN 1 checked the physician order and stated that the nasal cannula oxygen tubing had to be changed every Monday and labeled with the date when it was last changed. During an interview on 3/7/2025 at 8:50 p.m., with the DON, the DON stated that oxygen tubing had to be labeled with the date when it was last changed to prevent a possibility of respiratory infection in Resident 287. During an interview on 3/9/2025 at 2:50 p.m., with the Infection Preventionist (IP), the IP stated that oxygen tubing should be changed in the facility every Monday and as needed and labeled with the date when it was last changed to prevent respiratory infection. (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 the facility's policy and procedure titled, Infection Control, last reviewed on 1/3/2025, the policy indicated, This facility's infection control policies and practices are intended to facilitate maintaining safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.