STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056150	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview, and record review, the facility failed to ensure one of five sample residents (Resident 56) and/or responsible party (RP) was informed in advance, of the risks and benefits of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness, or behavior). This failure resulted into violating the residents' right to make an informed decision regarding the use of psychoactive medications. Findings: During a record review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including unspecified dementia(when symptoms and findings do not meet a the criteria for a specific dementia),depression (persistent feeling of sadness), diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), and anxiety disorder(mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with daily activities). During a record review of Resident 56's Minimum Data Set ([MS]- a standardized assessment and care screening tool) dated 2/22/2024 , the MDs indicated Resident 56 had moderately impaired cognitive skills (problems with person's ability to think, learn, remember, use judgement, and make decisions) and required partial or moderate assistance (helper does less than half the effort) with transfer from bed to chair, bathing, dressing, personal hygiene, and toileting. During a record review of Resident 56's History and Physical (H&P) dated 2/2/2024, the H&P indicated Resident 56 did not have the capacity to understand and make decisions. During a record review of Resident 56's Physician Order Summary Report dated 4/3/2024, the Physician Order Summary Report indicated a physician order of Ativan (medication used to treat anxiety) oral tablet 0.5 milligram (mg- unit of measurement) give one tablet by mouth every 12 hours for anxiety manifested by uncontrollable crying and yelling. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 56's Physician Order Summary Report dated 3/29/2024, the Physician Order Summary Report indicated a physician order of ABHR (compounded preparation containing Ativan (psychotropic medicine), diphenhydramine (relieve symptoms of allergy but can cause sleepiness), haloperidol (brain altering medicines which help reduce psychotic symptoms) and metoclopramide (medicine that relieves nausea) cream transdermal (application of medication through the skin) every four hours as needed for agitation/restlessness one gram (gm- unit of measurement) equals 4 clicks when patient refuses Ativan. During a concurrent interview and record review of Resident 56's medical records with Licensed Vocational Nurse (LVN 2), LVN 2 stated there was no informed consent obtained for the use of Ativan and ABHR cream. LVN 2 stated Ativan was a psychotropic medication, and the facility should obtain a consent before administering the medications because it can affect the mental state of Resident 56. LVN 2 stated ABHR cream contained controlled medicines (drug or chemical whose manufacturer, possession or use regulated by the government) like Ativan and Haldol which would need consent before using it on the resident. During a subsequent interview and record review on 4/12/2024, at 5:50 p.m. with the Director of Nursing (DON), reviewed Resident 56's Informed Consent for Ativan dated 4/11/294 timed at 1:23 p.m., the DON stated there was a discrepancy on the consent because it was signed by the licensed nurse and not the physician. The DON stated the consent was obtained on 4/11/2024 after Ativan was started on 4/3/2024 for Resident 56. The DON stated ABHR cream and Ativan are controlled medicines and required an informed consent even these medications were ordered by the hospice (care, comfort, and quality of life of a resident with a serious illness who is approaching the end of life) physician. The DON stated psychotropics medication can alter the brain and could produce side effects like confusion. During an interview on 4/15/2024, at 11:431 a.m. with Pharmacist Consultant (PC), PC stated ABHR cream and Ativan can affect resident's behavior and would need an informed consent. PC stated informed consent should be in place before administering these medications because without consent these medications could act as a chemical restraint (form of medical restraint in which a drug is used to restrict the freedom of movement of a resident for staff convenience or used as discipline). During a record review of facility's facility and procedure (P&P) titled 'Psychotropic Medication Management dated 2/2017, the P&P indicated informed consent for psychoactive medicines must be verified before use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review, the facility failed to ensure call light was within reach for one of three sampled residents (Resident 60). This failure resulted in Resident 60 feeling lack of self-determination to make decisions, loss of dignity, loss of self-esteem and had the potential to result in Resident 60 not being cable to call staff for help when needed and delay in necessary care and services. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was admitted to the facility on [DATE] with diagnosis including traumatic brain injury (a sudden, external, physical assault damages the brain), cerebral infarction (a loss of blood flow to part of the brain), muscle weakness, history of falling, and acute respiratory distress syndrome (a life-threatening lung injury that allows fluid to leak into the lungs). During a review of Resident 60's History and Physical (H&P), dated 3/22/2024, the H&P indicated, Resident 60 was unable to make his own medical decision. During a review of Resident 60's Minimum Data Set ([MDS]-a standardized assessment and care screening tool) dated 3/27/2024 the MDS indicated Resident 60 required maximal assistance (helper does more than half the effort) from one staff for transfer, shower, toilet hygiene, personal hygiene, dressing, bed mobility, and moderate assistance (helper does less than half the effort) from one staff for eating. During a review of Resident 60's Care Plan, titled At risk for falls and injuries and Resident 60 was found sitting on the floor on 3/25/2024 initiated on 3/29/2024, the care plan intervention indicated, to keep call light within reach. During an observation on 4/9/2024, at 9:32 a.m., in Resident 60's room, Resident 60 was in the bed with his eyes closed. Resident 60's call light on top of his left nightstand behind the radio near the wall. During an interview on 4/9/2024, at 10:06 a.m., with Certified Nurse Assistant (CNA) 1, in Resident 60's room, CNA 1 stated, Resident 60 could not reach the call light and it should be always within reach. CNA 1 stated, if the call light was not within reach, Resident 60 could not get help in a timely manner. CNA 1 stated, if the resident was dependent on staff for care and could not get help, it could lower Resident 60's self-esteem and self-worth. During an interview on 4/10/202, at 3:46 p.m., with Resident 60, in a hallway, Resident 60 stated, there were many times he could not find or reach his call light to call nurse. Resident 60 stated, he felt helpless and sad because he thought staff did not want him to call them because they were busy. Resident 60 stated, he had fall incidents because he could not find his call light to call staff. Resident 60 stated, he tried to get up by himself to go to the bathroom. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2024, at 9:22 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated call light should always place within reach of the resident to accommodate their needs and if there was an emergency. RNS 1 stated, no one wanted to sit on soiled linen or incontinence brief (diaper). RNS 1 stated this would be affecting resident's dignity negatively. During an interview on 4/12/2024, 4:03 p.m., with Director of Nursing (DON), DON stated, the residents' call light should always be within reach to accommodate resident 60's needs in timely manner and respect his dignity and self-worth, especially if the residents depended on their staff for care. During a review of the facility's policy and procedure (P&P) titled, Residents' Rights, revised 6/2015, the P&P indicated: The purpose of this policy is to establish, administer and enforce the rights of our residents . Each resident must be treated with respect . Employees are expected to always protect the rights of each resident . Every resident to be treated with consideration and full recognition of dignity and individuality, including privacy in treatment and care of personal needs. During a review of the facility's policy and procedure (P&P) titled, Dignity-Promoting/Maintaining Dignity, dated 10/2022, the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner, and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines .Respond to requests for assistance in a timely and courteous manner. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 10/2022, the P&P indicated, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light . Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure five of 14 sampled residents (Resident 35, Resident 24, Resident 5, Resident 49, Resident 1 and Resident 3) were informed of the right to develop an advance directive (a legal document prepared by you that expresses what kind of medical care you want, or who was authorized to make decisions for you should you be unable to make or communicate your wishes). This failure resulted in Resident 35, Resident 24, Resident 5, Resident 49, Resident 1, and Resident 3's rights being violated to be fully informed of the option to formulate their advance directives. Findings: a. During a review of Resident 35's Admission Record, the Admission Record, indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including skull fracture (broken bone), right arm fracture, rib fractures, and hypertension (high blood pressure). During a review of Resident 35's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 3/9/2024, the MDS indicated Resident 35 did not have the mental capacity to make decisions. MDS indicated Resident 35 required set up or clean up assistance from staff with eating, oral hygiene, upper body dressing, supervision from staff for walking, toileting, moderate assistance with showering, lower body dressing and putting on and taking off footwear. During a concurrent interview and record review on 4/9/2024 at 12:12 p.m., with the Social Services Director (SSD) 1 reviewed Resident 35's Social Service assessment dated [DATE]. The Social Services Assessment indicated on 3/17/2023 there was no documentation of Resident 35's responsible party was informed or given information regarding how to formulate or develop an advance directive. The SSD 1 stated did not discuss or offer Resident 35 any information on advance directives. b. During a review of Resident 24's Admission Record, the Admission Record, indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and abdominal aortic aneurysm (an enlarged area in the lower part of the body's main artery). During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 1 needed set up or clean-up assistance from staff for eating. MDS indicated Resident 24 needed supervision or touching assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff with toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and rolling from left to right. During a review of Resident 24's History and Physical (H&P), dated 2/13/2024 indicated Resident 24 was an accurate historian and can make medical decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/9/2024 at 3:50 pm, with the SSD 1, Resident 24's Social Service Assessment, dated 3/8/2023 was reviewed. The Social Services Assessment indicated on 3/8/2023 Resident 24 was not offered information on advance directive. SSD 1 stated it was part of the facility's policy to offer an advance directive. c. During a review of Resident 5's Admission Record the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (when the immune system attacks the healthy joint tissues), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), dementia (a general decline in cognitive abilities that impacts a person's ability to perform everyday activities), anxiety (intense excessive and persistent worry and fear about everyday situations), and depression (a persistent feeling of sadness and loss of interest). During a review of Resident 5's H&P, dated 3/18/2024 indicated, Resident 5 was alert and oriented to self, place, and time but unclear if Resident 5 was able to make medical decisions at this time. During a review of Resident 5's MDS. Dated 3/22/2024, the MDS indicated Resident 5 needed set up or clean-up assistance from staff for eating, oral hygiene. The MDS indicated Resident 5 needed substantial and maximal assistance from staff for toileting, showering, lower body dressing, putting on and taking off footwear, personal hygiene. The MDS indicated Resident 5 needed partial and moderate assistance with upper body dressing, rolling from left to right, sitting, lying, standing, and transferring. During a concurrent interview and record review on 4/10/2024 at 3:55 pm, with the SSD 1, Resident 5's Social Service assessment dated [DATE] was reviewed. The Social Services Assessment indicated on 3/18/2024 advance directive information was not offered to Resident 5 or Resident's 5 responsible arty. SSD 1 stated he offered a Durable Power of Attorney (DPOA- a document that establishes who oversaw a person's health or financial decisions) and thought the DPOA was the same as an advance directive. d. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition in which brain function was disturbed either temporarily or permanently due to different diseases or toxins in the body), end stage renal disease (the kidneys can no longer adequately filter waste products from the blood), respiratory failure (a serious condition that makes it difficult to breathe on your own), and heart failure (impairment in the heart's ability to fill with and pump blood). During a review of Resident 49's H&P, dated 1/25/2024 indicated, Resident 49 was alert and oriented to self only. During a review of Resident 49's MDS. Dated 1/26/2024, the MDS indicated Resident 49 needed substantial and maximal assistance from staff for oral hygiene, toileting, upper body dressing, rolling from left to right, lying, sitting, transferring from a chair. The MDS indicated Resident 49 was dependent on staff assistance for showering, lower body dressing putting on and taking off footwear, personal hygiene. The MDS indicated Resident 49 did not attempt to eat or walk due to medical condition and safety concerns. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/10/2024 at 4:20 pm, with the SSD 1, Resident 49's Social Service Assessment, dated 8/10/2023 was reviewed. The Social Service Assessment indicated on 8/10/2023 Resident 49 or Resident 49's Responsible Party was given any information regarding advance directives. SSD 1 stated there was no documentation of an advance directive offered. SSD 1 stated he just asked if the resident has an advance directive or not and documents that the resident does not have an advance directive. e. During a review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), COPD and chronic kidney disease (gradual loss of kidney function that occurs over a period of months to years). During a review of Resident 1's H&P dated 1/25/2024 indicated, Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's MDS. Dated 3/1/2024, the MDS indicated Resident 1 needed staff supervision or touching assistance with eating. The MDS indicated Resident 1 needed substantial and maximal assistance with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, moving from left to right, sitting, lying, standing, transferring to chair. The MDS indicated Resident 1 did not attempt to walk due to medical condition or safety concerns. During a concurrent interview and record review on 4/11/2024 at 9:02 am, with the SSD 1, Resident 1's Social Service Assessment, dated 1/8/2021 was reviewed. The Social Services Assessment indicated on 1/8/2021 Resident 1 did not have an advance directive. SSD 1 stated he discussed Physician Orders for Life-sustaining Treatment ([POLST] a medical form that outlines the wishes of a person with a serious or chronic illness regarding life sustaining measures and end-of-life care) with Resident 1 but did not discuss or offer any information about advance directives. 45269 f. During a record review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction ((damage to the brain from interruption of its blood supply) affecting the right dominant side (muscle weakness or partial paralysis on the right side of the body after a stroke), aphasia (loss of ability to understand or express speech caused by brain damage),muscle weakness and diabetes(a chronic disease characterized by elevated levels of blood glucose [or blood sugar] in a bloodstream) During a record review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had severe impaired cognitive skills (person had trouble remembering, learning new things, or making decisions) and required substantial assistance (helper does more than [NAME] the effort) with bathing, lower body dressing, personal hygiene, toilet hygiene and bed mobility. The MDS indicated Resident 3 had impairment on one side of upper extremity (shoulder, elbow, wrist, and hand). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/10/2024 at 3:15 p.m. with Social Service Director (SSD) 1, SSD1 stated Advance directive was not addressed and was not found on Resident 3's medical records. SSD 1 stated last Interdisciplinary Team (IDT- group of professional and direct care staff that have primary responsibility for the development of a plan for the care of a resident) meeting note dated 5/2/2023 and Social Service assessment dated [DATE], 9/1/2022, and 8/31/2022 did not address or offer information about advance directive to the resident or family representative. SSD stated advance directive was discussed to family or resident upon admission and was addressed during Social Service Assessment. SSD 1 stated advance directive was important to ensure resident's wishes was followed during end of life, so someone was in charge for health care decisions when a resident was unable to make decisions for themselves. During an interview on 4/12/2024, at 5:42 p.m. with the Director of Nursing (DON), the DON stated advance directive will help them determine on how to proceed with the care or fulfill the wish or preference the residents during end-of-life care (health care provided in the time leading up to a person's death). During a record review of facility's policy and procedure (P&P) titled Promoting the Right of Self-determination for Healthcare Decisions and Advance Healthcare Directives dated 11/2016, the P&P indicated Each resident and/ or legal healthcare decision maker will be provided a mechanism for reaching decisions concerning preferred care, including the right to forego or withdraw life sustaining treatment. The P&P indicated Residents will be informed upon admission, periodically of their rights concerning preferred intensity of care and the process for creating and implementing advance healthcare directives. During a review of the facility's policy and procedure (P&P) titled, Promoting the Right of Self-Determination for Healthcare Decisions and advance Directives, dated 11/2026, the P&P indicated, Residents will be informed upon admission and periodically, of their rights concerning self-determination of preferred intensity of care and the process for creating and implementing advanced healthcare directives.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview, and record review, the facility failed to accurately assess and code the Minimum Data Set (MDS, a standardized assessment and care-screening tool) assessment for one of 14 sampled residents (Resident 24) by failing to ensure the MDS was coded correctly. This failure had the potential to result in delayed or missed identification of joint range of motion (ROM, full movement potential of a joint) changes, inaccurate care planning, and inadequate provision of services and treatments for Resident 24. Findings: During a review of Resident 24's Admission Record, the Admission Record, indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted to facility on 3/1/2024 with diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs), abdominal aortic aneurysm (an enlarged area in the lower part of the body's main artery), chronic inflammatory demyelinating polyneuritis (an acquired autoimmune disease of the peripheral nervous system characterized by progressive weakness and impaired sensory function in the legs and arms), left and right ankle contractures (a shortening of muscles, tendons, skin, and nearby soft tissue that causes the joints to shorten and become very stiff, preventing normal movement). During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 needed set up or clean-up assistance from staff for eating. MDS indicated Resident 24 needed supervision or touching assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff with toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and rolling from left to right. MDS indicated transferring was not attempted due to medical condition and concerns. During a review of Resident 24's History and Physical (H&P) dated 2/13/2024, H&P indicated Resident 24 was an accurate historian and was able to make medical decisions. During a concurrent interview and record review on 4/11/2024 at 1:52 p.m. with the Minimum Data Set (MDS) nurse, Resident 24's MDS was reviewed. The MDS indicated on 8/22/2023, 11/22/2023 and 3/5/2024 Resident 24 had no impairment to the lower extremities. MDS nurse stated no impairment means the resident was able to do normal range of motion ([ROM] full movement potential of a joint). During an interview on 4/12/2024 at 10:49 a.m. with MDS nurse, the MDS nurse stated she reviewed the MDS documentation for 8/22/2023, 11/22/2023 and 3/5/2024 and updated the MDS on 4/11/2024 to reflect Resident 24 with a contracture and footdrop and modified the MDS to impairment to the lower extremities to reflect Resident 24's current condition. During a review of the facility's policy and procedure titled MDS Standard of Practice, dated 1/2024, the P&P indicated, It is the practice of this facility to conduct accurate coding and delivery of services provided to capture accurate assessment of each resident's functional capacity and health status as per CMS RAI MDS 3.0 Manual guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure two of 14 sampled residents (Resident 24 and Resident 5) had a Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment done when diagnosed with a mental illness prior to admission. This failure had the potential for Resident 24 and Resident 5 not receiving the necessary services and appropriate psychiatric level of treatment and evaluation in the facility. Findings: During a review of Resident 24's Admission Record, the Admission Record, indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted to facility on 3/1/2024 with diagnoses including schizophrenia (a serious mental disorder in which people interpret reality abnormally) chronic obstructive pulmonary disease ([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs), abdominal aortic aneurysm (an enlarged area in the lower part of the body's main artery), chronic inflammatory demyelinating polyneuritis (an acquired autoimmune disease of the peripheral nervous system characterized by progressive weakness and impaired sensory function in the legs and arms), left and right ankle contractures (a shortening of muscles, tendons, skin, and nearby soft tissue that causes the joints to shorten and become very stiff, preventing normal movement). During a review of Resident 24's Minimum Data Set ([MDS] a comprehensive assessment and care screening tool) dated 1/26/2024, the MDS indicated Resident 24 needed set up or clean-up assistance from staff for eating. MDS indicated Resident 24 needed supervision or touching assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff with toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and rolling from left to right. MDS indicated transferring was not attempted due to medical condition and concerns. During a review of Resident 24's History and Physical (H&P) dated 2/13/2024, H&P indicated Resident 24 was an accurate historian and was able to make medical decisions. During a concurrent interview and record review on 4/12/2024 at 1:20 p.m. with the Assistant Director of Nursing (ADON), Resident 24's PASARR Level 1 Screening (a preliminary assessment to determine whether an individual might have serious mental illness or intellectual disabilities) dated 2/8/2024 was reviewed. The PASARR indicated Resident 24 did not have a diagnosis of schizophrenia. The ADON stated Resident 24's PASARR was done in the hospital and needs to have a PASARR II because Resident 24 has a mental illness. The ADON stated Resident 24 needs PASARR II for any mental support and Resident 24 has schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056150	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (when the immune system attacks the healthy joint tissues), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), dementia (a general decline in cognitive abilities that impacts a person's ability to perform everyday activities), anxiety (intense excessive and persistent worry and fear about everyday situations), and depression (a persistent feeling of sadness and loss of interest). During a review of Resident 5's MDS. Dated 3/22/2024, the MDS indicated Resident 5 needed set up or clean-up assistance from staff for eating, oral hygiene. The MDS indicated Resident 5 needed substantial and maximal assistance from staff for toileting, showering, lower body dressing, putting on and taking off footwear, personal hygiene. The MDS indicated Resident 5 needed partial and moderate assistance with upper body dressing, rolling from left to right, sitting, lying, standing, and transferring. During a review of Resident 5's History and Physical (H&P), dated 3/18/2024, the H&P indicated, Resident 5 was alert and oriented to self, place, and time but unclear if Resident 5 was able to make medical decisions at this time. During a concurrent interview and record review on 4/12/2024 at 1:33 p.m. with the ADON, Resident 5's PASARR Level 1 Screening, dated 3/15/2024 was reviewed. The PASARR I indicated Resident 5 did not have a diagnosis of schizophrenia. The ADON stated Resident 5 has a schizophrenia disorder and should have a screening for PASARR 2 with a diagnosis of schizophrenia. The ADON stated Resident 24 and Resident 5 both have a mental disorder of schizophrenia, and the diagnosis of schizophrenia was documented incorrectly on the PASARR screening from the hospital, and no one caught the mistake. During a review of the facility's policy and procedure (P&P) titled California Department of Health Care Services Preadmission Screening and Resident Review (PASARR) Level 1 Assessment Guide, dated 1/12/2023, the P&P indicated, The Level I Screening should always reflect the individual's current condition.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure two of 14 sampled residents (Resident 24 and 3): 1.Received Restorative Nursing Aide (RNA- helps tide rehabilitative care for residents) services as recommended by the physical therapist (a healthcare professional who specializes in helping patients improve their physical function). This failure had the potential to result in Resident 24 developing contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and decreased mobility. 2. Provide a communication tools or system to Resident 3 who had aphasia (loss of ability to understand or express speech due by brain damage) to be able to communicate requests and needs. This failure had the potential for Resident 3 to feel isolated, afraid, and upset as she cannot communicate her needs to facility staff. Findings: During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs), abdominal aortic aneurysm (an enlarged area in the lower part of the body's main artery), chronic inflammatory demyelinating polyneuritis (an acquired autoimmune disease of the peripheral nervous system characterized by progressive weakness and impaired sensory function in the legs and arms), left and right ankle contractures. During a review of Resident 24's Minimum Data Set (MDS- a comprehensive assessment and a care screening tool) dated 1/26/2024 the MDS indicated Resident 24 needed set up or clean-up assistance from staff for eating. The MDS indicated Resident 24 needed supervision or touching assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff with toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and rolling from left to right. During a review of Resident 24's History and Physical (H&P), dated 2/13/2024 indicated, Resident 24 was an accurate historian and can make medical decisions. During an interview on 4/9/2024 at 10:23 am with Resident 24, Resident 24 stated he could walk a few feet with two-person assistance a month ago. Resident 24 stated his foot just gets worse, stated he has been in and out the hospital but that has nothing to do with his feet. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/12/24 at 11:00 a.m. with Restorative Nursing Aide (RNA 1), Resident 24's Documentation Survey Report, dated February 2022- December 2023 were reviewed. The Documentation Survey Report indicated on: 2/11/2022-2/13/2022 not applicable (NA) 2/14/2022 No documentation (blank) 2/15/2022 NA 2/17/2022 NA 2/19/2022-2/21/2022 NA 2/22/2022 No documentation 2/23/2022-2/24/2022 NA 2/27/2022 No documentation 3/1/2022-3/4/2022 NA 3/6/2022 No documentation 3/7/2022 NA 3/11/2022-3/13/2022 NA 3/15/2022 No documentation 3/17/2022 No documentation 3/31/2022 NA 4/1/2022-4/2/2022 NA 4/3/2022-4/4/2022 No documentation 4/5/2022-4/7/2022 NA 4/8/2022 No documentation 4/11/2022 No documentation 4/13/2022 NA 4/15/2022 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/17/2022 No documentation 4/18/2022 NA 4/20/2022 NA 5/2/2022 NA 5/7/2022 blank 5/10/2022-5/11/2022 NA 5/16/2022 NA 5/17/2022-5/18/2022 No documentation 5/20/2022-5/21/2022 NA 5/22/2022-5/23/2022 No documentation 5/31/2022 6/1/2022-6/2/2022 NA 6/13/2022 NA 6/15/2022-6/20/2022 NA 6/22/2022-6/23/2022 NA 6/24/2022 No documentation 6/25/2022-6/27/2022 NA 6/30/2022 NA 7/1/2022-7/3/2022 NA 7/8/2022-7/10/2022 NA 7/17/2022-7/21/2022 NA 7/24/2022 NA 7/25/2022 No documentation 7/28/2022-7/29/2022 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/30/2022-7/31/2022 No documentation 8/1/2022 NA 8/5/2022 NA 8/6/2022-8/8/2022 No documentation 8/9/2022 NA 8/13/2022-8/18/2022 No documentation 8/20/2022 No documentation 8/21/2022 NA 8/23/2022 NA 8/24/2022-8-30-2022 No documentation 8/31/2022 NA 9/1/2022 No documentation 9/3/2022 No documentation 9/6/2022-9/9/2022 No documentation 9/11/2022 No documentation 9/13/2022 NA 9/15/2022-9/16/2022 NA 9/17/2022 NA 9/18/2022 NA 9/20/2022-9/21/2022 No documentation 9/25/2022-9/26/2022 No documentation 9/29/2022 No documentation 10/7/2022 No documentation 10/11/2022-10/12/2022 No documentation (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/14/2022-10/16/2022 NA 10/19/2022 NA 10/21/2022 NA 10/24/2022 NA 10/31/2024 No documentation 12/1/2022-12-2/2022 NA 12/3/2022 blank 12/5/2022-12/10/2022 No documentation 12/12/2022 No documentation 12/13/2022 RR 12/14/2022 NA 12/15/2022 RR (Resident refused) 12/16/2022-12/17/2022 12/19/2022 NA 12/20/2022-12/21/2022 No documentation 12/22/2022 RR 12/23/2022-12/24/2022 No documentation 12/26/2022 NA 12/27/2022 RR 12/28/2022 No documentation 12/29/2022 RR 12/30/2022-12/31/2022 NA 1/3/2023-1/6/2023 RR 1/7/2023 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/9/2023-1/13/2023 RR 1/14/2023 NA 1/16/2023-1/20/2023 RR 1/23/2023-1/24/2023 RR 1/25/2023-1/27/2023 No documentation 1/30/2023 NA 1/31/2023 No documentation 2/1/2023-2/3/2023 No documentation 2/6/2023 No documentation 2/8/2023 -2/10/2023 No documentation 2/13/2023-2/24/2023 No documentation 2/15/2023 NA 2/16/2023-2/17/2023 No documentation 2/20/2023-2/22/2023 No documentation 2/23/2023 NA 2/24/2023 No documentation 2/28/2023 No documentation 3/1/2023-3/2/2023 RR 3/3/2023 No documentation 3/6/2023-3/7/2023 No documentation 3/9/2023-3/10/2023 3/14/2023 NA 3/15/2023-3/16/2023 3/17/2023 RR (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/2023 RR 3/21/2023-3/22/2023 No documentation 3/23/2023 RR 3/27/2023-3/29/2023 No documentation 3/30/2023 RR 3/31/2023 No documentation 5/1/2023-5/3/2023 No documentation 5/4/2023 NA 5/5/2023 No documentation 5/8/2023-5/17/2023 5/18/2023 RR 5/19/2023 No documentation 5/22/2023 RR 5/23/2023 No documentation 5/24/2023-5/25/2023 No documentation 5/26/2023 No documentation blank 5/29/2023 No documentation blank 5/31/2023 No documentation blank 6/1/2023-6/6/2023 No documentation 6/7/2023-6/8/2023 RR 6/9/2023 No documentation 8/13/2023-6/15/2023 RR 6/19/2023-6/20/2023 RR 6/21/2023 No documentation (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/22/2023 RR 6/23/2023 No documentation 6/26/2023 No documentation 6/27/2023-6/30/2023 RR 7/3/2023 No documentation 7/4/2023-7/5/2023 RR 7/6/2023 No documentation 7/7/2023 RR 7/10/2023 No documentation 7/11/2023-7/14/2023 RR 7/17/2023 RR 7/18/2023-7/19/2023 NA 7/20/2023-7/21/2023 RR 7/24/2023-7/26/2023 NA 7/27/2023-7/28/2023 RR 7/31/2023 NA 8/1/2023 NA 8/2/3023 RR 8/3/2023-8/4/2023 NA 8/7/2034-8/8/2023 NA 8/9/2023 RR 8/10/2023 NA 8/11/2023 RR 8/14/2023 RR (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/15/2023-8/21/2023 NA 8/22/2023 RR 8/23/2023 NA 8/24/2023-8/25/2023 RR 8/28/2023-8/29/2023 NA 8/30/2023 RR 8/31/2023 NA 9/1/2023 RR 9/4/2023-9/8/2023 NA 9/12/2023-9/24/2023 RR 9/28/2023-9/29/2023 NA The Documentation Survey Report indicated ambulation with forward wheel walker and bilateral ankle foot orthosis ([AFO] ankle brace used to provide support, align the ankle and foot) and second person to follow with a wheelchair up to five times a week as tolerated. The Documentation Survey Report indicated, on: 2/11/20222-2/15/2022 NA 2/17/2022 RR 2/19/2022-2/21/2022 NA 2/22/2022 No documentation 2/23/2022-2/25/2022 NA 2/27/22-/2-28/2022 3/1/2022-3/3/2022 NA 3/6/2022 RR 3/11/2022-3/13/2022 NA 3/15/2022 NA 3/17/2022 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/18/2022 No documentation 3/20/2022 NA 3/23/2022 NA 3/27/2022 NA 3/29/2022-3/31/2022 NA 4/1/2022-4/7/2022 NA 4/10/2022-4/13/2022 NA 4/15/2022 NA 4/16/2022 RR 4/17/2022-4/18/2022 NA 4/20/2022 NA 4/23/2022 NA 4/25/2022-4/26/2022 NA 4/28/2022 RR 4/30/2022 NA 5/1/2022 RR 5/2/2022 NA 5/3/2022 RR 5/4/2022 NA 5/5/2022-5/6/2022 RR 5/7/2022 NA 5/9/2022-5/11/2022 NA 5/13/2022-5/14/2022 RR 5/15/2022-5/17/2022 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/19/2022 RR 5/20/2022-5/22/2022 NA 5/23/2022 No documentation 5/25/2022-5/28/2022 RR 5/29/2022-5/31/2022 NA 6/1/2022-6/3/2022 NA 6/4/2022 RR 6/5/2022-6/6/2022 NA 6/7/2022 RR 6/8/2022-6/9/2022 NA 6/11/2022 NA 6/12/2022 RR 6/14/2022 RR 6/15/2022-6/20/2022 6/22/20226/27/2022 NA 6/28/2022-6/29/2022 RR 6/30/2022 NA 7/1/2022-7/3/2022 NA 7/4/2022 RR 7/5/2022-7/15/2022 NA 7/16/2022 RR 7/18/2022-7/21/2022 NA 7/22/2022-7/23/2022 RR 7/24/2022-7/26/2022 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/27/2022 RR 7/28/2022-7/31/2022 NA 8/1/2022-8/10/2022 NA 8/12/2022-8/13/2022 NA 8/14/2022-8/15/2022 No documentation 8/16/2022-8/17/2022 NA 8/19/2022 RR 8/20/2022-8/25/2022 NA 8/27/2022 NA 8/28/2022 No documentation 8/19/2022-8/31/2022 NA 9/1/2022-9/11/2022 NA 9/13/2022-9/15/2022 NA 9/17/2022-9/24/2022 NA 9/25/2022-9/26/2022 No documentation 9/27/2022-9/30/2022 NA 10/3/2022-10/4/2022 NA 10/6/2022-9/12/2022 NA 10/13/2022 RR 10/14/2022-10/31/2022 NA 12/1/2022-12/2/2022 NA 12/3/2022 No Documentation 12/5/2022-12/10/2022 NA 12/12/2022-12/17/2022 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/19/2022 NA 12/20/2022 No documentation 12/21/2022 NA 12/22/2022 NA 12/23/2022 NA 12/24/2022 No documentation 12/26/202212/28/2022 NA 12/29/2022 RR 12/30/2022-12/31/2022 NA 1/2/2023 NA 1/3/2023 RR 1/4/2023-1/11/2023 NA 1/12/2023 RR 1/13/2023-1/31/2023 NA 2/1/2023-2/2/2023 NA 2/3/2023 No documentation 2/6/2023 NA 2/7/2023 RR 2/8/2023-2/10/2023 NA 2/13/2023 No documentation 2/14/2023-2/15/2023 NA 2/16/2023 No documentation 2/17/2023 NA 2/20/2023 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/23/2023-2/27/2023 NA 2/28/2023 No documentation 3/1/2023-3/2/2023 RR 3/4/2023 NA 3/6/2023-3/7/2023 No documentation 3/8/2023 RR 3/9/2023-3/10/2023 NA 3/14/2023-3/17/2023 NA 3/20/2023 RR 3/21/2023 NA 3/22/2023 No documentation 3/23/2023 NA 3/27/2023-3/28/2023 No documentation 3/29/2023 NA 3/30/2023 RR 3/31/2023 No documentation 4/3/2023-4/4/2023 NA 4/5/2023 RR 4/7/2023 NA 4/10/2023 NA 4/12/2023-4/13/2023 RR 4/18/2023-4/21/2023 RR 4/24/2023-4/26/2023 No documentation 4/27/2023-4/28/2023 RR (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/1/2023 RR 5/2/2023-5/3/2023 5/4/2023 NA 5/5/2023 No Documentation 5/8/2023-5/12/2023 No documentation 5/15/2023-5/16/2023 RR 5/17/2023 No documentation 5/18/2023-5/22/2023 RR 5/22/2023 RR 5/23/2023 No documentation 5/24/2023-5/27/2024 RR 5/29/2023 No documentation 5/31/2023 RR 6/1/2023-6/2/2023 RR 6/5/2023-6/6/2023 No documentation 6/9/2023 NA 6/13/2023-6/14/2023 RR 6/15/2023 NA 6/16/2023 No documentation 6/19/2023-6/20/2023 RR 6/21/2023 NA 6/22/2023 RR 6/23/2023 No documentation 6/26/2023 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/27/2023 RR 6/29/2023-6/30/2023 RR 7/3/2023 No documentation 7/4/2023-7/5/2023 RR 7/6/2023 No documentation 7/7/2023 RR 7/11/2023-7/17/2023 RR 7/18/2023-7/20/2023 NA 7/21/2023 RR 7/24/2023-7/26/2024 NA 7/27/2023-7/28/2023 RR 7/31/2023 NA 8/1/2023 NA 8/2/2023 RR 8/3/2023-8/8/2023 NA 8/9/2023 RR 8/10/2023 NA 8/14/2023 RR 8/15/2023-8/21/2023 NA 8/22/2023 RR 8/23/2023 NA 8/24/2023-8/25/2023 RR 8/28/2023-8/29/2023 NA 8/30/2023 RR (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/31/2023 NA 9/1/2023 RR 9/4/2023-9/8/2023 NA 9/12/2023-9/15/2023 RR 9/18/2023-9/21/2023 NA 9/22/2023 RR 9/25/2023 NA 10/2/2023-10/4/2023 NA 10/5/2023 RR 10/6/2023-10/10/2023 NA 10/11/2023-10/12/2023 RR 10/13/2023-10/20/2023 NA 10/23/2023 RR 10/24/2023-10/26/2023 NA 10/27/2023 RR 10/30/2023 NA 10/31/2023 No documentation 11/1/2023-11/8/2023 NA 11/9/2023-11/10/2023 RR 11/13/2023 NA 11/14/2023 No documentation 11/15/2023-11/20/2023 11/21/2023 No documentation 11/22/2023-11/24/2023 NA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/28/2023 RR 11/29/2023-11/30/2023 NA 12/1/2023 NA 12/5/2023-12/6/2023 RR 12/8/2023-12/14/2023 NA 12/15/2023-12/18/2023 RR 12/19/2023 NA 12/20/2023 No documentation 12/21/2023 NA 12/25/2023-12/26/2023 NA 12/27/2023 No documentation 12/28/2023-12/29/2023 NA Ambulation with front wheel walker, bilateral AFO's and second person to follow with a wheelchair up to 5 times a week as tolerated was documented NA, no documentation or RR. RNA 1 stated NA, or no documentation means RNA services were not done for Resident 24. RNA 1 stated RR means the Resident 24 refused RNA services. RNA 1 stated if a resident was refusing or cannot tolerate RNA services RNA should inform the charge nurse. RNA 1 stated residents' that were not receiving RNA services could injure themselves, worsen their physical condition and have a decline in mobility or range of motion. RNA 1 stated the facility has no flagging in the system in place to notify licensed staff when residents refused RNA services or not done. RNA 1 stated the RNA should check the Documentation Survey Report documentation to make sure RNA services were done and report to licensed staff for missed, refusal and not done RNA services. RNA 1 stated CNAs were given the task to do RNA services when they not supposed to do it, and when CNAs document NA the RNA services could get missed. During an interview on 4/12/2024 at 11:52 a.m. with Certified Nurse Assistant (CNA 3) CNA 3 stated she was instructed on first month of this year never to document NA. CNA 3 stated there should be a reason why a task was not done and should be documented. CNA 3 stated if a task was documented NA, the CNA should communicate to the RNA about why the task was marked NA. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/12/2024 at 2:49 p.m. with Registered Nurse Supervisor (RNS 4), Resident 24's Physical Therapy (PT) Discharge Summary, dated 2/11/2022 was reviewed. The Physical Therapy (PT) Discharge Summary indicated a recommendation for an ambulation with a forward wheel walker and bilateral AFO with a second person to standby with a wheelchair up to six times a week as tolerated. RNS 4 stated the recommendation does not match what was transcribed on the Documentation Survey Report. RNS 4 stated the recommendation was supposed to be six times a week and nursing staff did not follow the recommendation of the physical therapist. RNS 4 stated there was a communication breakdown with physical therapy and RNA. RNS 4 stated there was no documentation indicating Resident 24 physician was notified when Resident 24 refused RNA services and there was no documentation the physician recommended or prescribed interventions for Resident 24. RNS 4 stated Resident 24 could have a decline in function, a problem with mobility, and a ROM problem, when the recommendations were not followed for the RNA program. During a review of the facility's policy and procedure titled Restorative Nursing Program dated December/2021, the P&P indicated, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. 45269 2. During a record review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (muscle weakness or partial paralysis on the right side of the body after a stroke), aphasia, muscle weakness and diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly). During a record review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was severely impaired cognitive skills (person had trouble remembering, learning new things, or making decisions) and required substantial assistance (helper does more than [NAME] the effort) with bathing, lower body dressing, personal hygiene, toileting hygiene and bed mobility. The MDS indicated the resident had an impairment on one side of upper extremity (shoulder, elbow, wrist, and hand). During an observation on 4/9/2024, at 12:59 p.m. in Resident 3's room, Resident 3 was unable to talk when asked with questions and started crying. There was no communication tool to use for Resident 3 to communicate needs to facility staff at the bedside. During an interview on 4/11/2024, at 3:00 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated Resident 3 could only say no and thank you. CNA 2 stated there was no communication board (a board with images used by residents to be able to express needs and communicate with facility staff) used to communicate to Resident 3. CNA 2 stated she looked at resident's facial expression to determine what the resident was expressing to her. During an interview on 4/12/2024, at 12:01 p.m. with Registered Nurse Supervisor (RNS 3), RNS 3 stated the facility would not be able to meet resident's needs if the resident who had aphasia was unable to communicate properly to the staff. RNS 3 stated resident (in general) would be frustrated and upset if his or her needs were not provided in a timely manner. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/2024, at 5:46 p.m. with the Director of Nursing (DON), the DON stated the resident would not be able to get the care she needs, or the facility would not be able to meet her needs if the resident was unable to express or communicate to the staff. During a record review of facility's P&P titled Accommodation of Needs Positive Practice dated 11/20217, the P&P indicated The facility will honor the right of the resident to reside and receive services with reasonable accommodation of individual needs and preferences. The P&P indicated the facility's staff is instructed to meet resident's personal, mental, and physical needs which included socialization, home-like environment and maintaining independent functioning.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 46537 Based on observation, interview, and record review, the facility failed to ensure three out of 38 sampled residents (Resident 16, 34, and 3) with limited range of motion (ROM - the extent of movement of a joint) and/or limited mobility, received restorative nursing (a program available in nursing homes that helps residents maintain any progress they have made during therapy treatments, enabling them to function at a high capacity) care per Physical Therapist (PT-(a healthcare professional who specializes in helping patients improve their physical function) and Occupational Therapist (OT-a healthcare professional who specializes in helping patient improve ability to perform daily tasks) recommendation and follow through the progress of the residents who received restorative nursing care by : 1. Failing to apply left-hand splint (a rigid or flexible device that maintains in position a displaced or movable part) as recommended by therapist, to assess and evaluate the progress of Restorative Nursing Assistant (RNA) service for Resident 16. 2. Failing to assess and evaluate the progress of RNA services for Resident 34 and Resident 3 and provide RNA services as recommended by therapist. These failures had the potential to result in Resident 16,34, and 3 high risks for further ROM decline and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: 1. During a review of Resident 16's Admission Record, the Admission Record indicated, Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosed including intervertebral disc stenosis of cervical region (one or more bony openings within the spine begin to narrow and reduce space for the nerves around neck area), spinal stenosis of lumbar region (one or more bony openings within the spine beginning to narrow and reduce space for the nerves around the back), radiculopathy of cervical region (a pinched nerve in the spine around your neck region), and functional quadriplegia (the lack of ability to use one's limbs or to ambulate due to extreme debility, not due to spinal cord injury). During a review of Resident 16's History and Physical (H&P), dated 2/16/2024, the H&P indicated Resident 16 was able to make his own medical decision. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 16's Minimum Data Set ([MDS]-a standardized assessment and care screening tool) dated 5/11/2021, the MDS indicated Resident 16 required maximal assistance (helper does more than half the effort) from one staff for transfer, dressing, moderate assistance (helper does less than half the effort) from one staff for shower, toilet hygiene, personal hygiene, bed mobility and supervision or touching assistance (helper provides verbal cues/touching/steadying/contact guard assistance) from one staff for eating. The MDS section GG (functional abilities and goals) indicated, Resident 16 had no impairment (an absence of or significant difference in a person's body structure or function or mental functioning) on upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). During a review of Resident 16's MDS, dated [DATE], the MDS section G (functional status) indicated, Resident 16 had impairment on both upper extremity and no impairment on lower extremity. During a review of Resident 16's MDS, dated [DATE], the MDS G indicated, Resident 16 had impairment on both upper extremity and no impairment on lower extremity. During a review of Resident 16's MDS, dated [DATE], the MDS G indicated, Resident 16 had impairment on one side of upper extremity and impairment on one side of lower extremity. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 required maximal assistance (helper does more than half the effort) from one staff for transfer, moderate assistance (helper does less than half the effort) from one staff for shower, toilet hygiene, personal hygiene, dressing, bed mobility, and set up assistance (helper sets up) from one staff for eating. The MDS section GG indicated, Resident 16 had impairment on both upper extremity and no impairment on lower extremity. During a review of Resident 16's Care Plan titled Decline in ROM/strength to bilateral upper extremities, initiated on 5/27/2021 the care plan interventions indicated assistance with splint, passive range of motion (PROM- the residents does not perform any movement themselves instead, the therapist moves the limb or body part around the stiff joint, gently stretching muscles and reminding them how to move correctly) exercises to left hand daily, then apply left hand comfy splint for four to six hours daily as tolerated and report any decline to therapy and nursing. During a review of Resident 16's Care Plan (CP) titled Resident 16 chose to not use left splint and requested for handroll (used to prevent the fingers of the hand from being in a tight fist which could cause contracture) initiated on 4/10/2024, the care plan interventions indicated to accept resident's right to refuse and show respect for resident's decision. During a review of Resident 16's PT progress and Discharge Summary notes dated 5/26/2021, the PT progress and discharge summary notes indicated, Reason for discharge: restorative nursing care, discharge plan and instruction: remain in this facility under RNA program. During a review of Resident 16's OT therapist progress & Discharge Summary notes dated 5/26/2021, indicated, Reason for discharge: restorative nursing care, Discharge plan and instruction: RNA for bilateral upper and lower extremities active range of motion (AROM- The residents do most of the movement, but they get a little help to complete the movements correctly by therapist) exercise, donning of left hand comfy splint and sit to stand training using a front wheel walker. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 16's Order Summary Report, dated 4/12/2024, indicated no order for RNA service or left-hand comfy splint. During a concurrent observation and interview on 4/9/2024, at 10:33 a.m., with Resident 16 in Resident 16's room, Resident 16 was on sitting position in bed. Resident 16's left hand and fingers were stiff and rigid. Resident 16 was holding a handroll which was made of rolled small towel and fixed with rubber bands on his left hand. Resident 16 stated, he would like to receive more therapy for his left hand because he did not lose left hand function. Resident 16 stated, he was receiving RNA services but not daily. Resident 16 stated, he was receiving RNA services for two to three times a week and his left hand was getting worse. Resident 16 stated, there was no equipment or splint provided to him. There was no splint at Resident 16's bedside. During an interview on 4/11/2024, at 11:50 a.m., with RNA 3, RNA 3 stated, Resident 16 has been receiving RNA services up to five times a week. RNA 3 stated, she did not provide services when Resident 16 refused. RNA 3 stated, when Resident 16 was having a bad day and she respected his decision not to do exercises. RNA 3 stated, she did not document refusal, but she notified licensed nursing staff to document refusal. RNA 3 stated, Resident 16 refused to wear left hand splint and it should be in his drawer. RNA 3 stated, if RNA service was not provided properly as ordered or recommended, the resident's physical condition could decline further. During a concurrent observation and interview on 4/11/2024, at 11:53 a.m., with Resident 16 and RNA 3 at the patio, Resident 16 was sitting on a wheelchair holding the handroll on his left hand. RNA 3 asked Resident 16 about his refusal to wear splint on his left hand. Resident 16 stated, he had never received a left-hand splint and no reason to refuse it. RNA 3 checked all drawers, closet, and bedside table, but she could not find Resident 16's left hand splint. During a concurrent interview and record review on 4/11/2024, at 12:07 p.m., with RNA 1, Resident 16's Documentation Survey Report dated 3/1/2024 to 4/11/2024 was reviewed. The Documentation Survey Report indicated, there was no documentation for bilateral upper and lower AROM exercise and don (put on) of left-hand comfy splint. RNA 1 stated he did not know why RNA service task did not show in the report. RNA 1 stated he could not provide any evidence that the services was provided to Resident 16. During a concurrent interview and record review on 4/11/2024, at 2:40 p.m., with the Director of Rehabilitation (DOR), Resident 16's Restorative Therapy Referral dated 5/27/2021 was reviewed. The Restorative Therapy Referral indicated, Resident 16 was at risk for decline in bilateral upper and lower ROM and strength. The Restorative Therapy Referral indicated a goal to maintain and increase bilateral upper and lower ROM and strength, The Restorative Therapy Referral indicated, to provide RNA service seven times a week as tolerated with bilateral upper and lower AROM and don of left-hand comfy splint four to six hours with no sign and symptom of redness or marking, sit to stand training using a four wheeled walker. The DOR stated, this was her recommendation for Resident 16 and RNAs should have provided the services and documented. The DOR stated once the resident was discharged from the therapy it was the nursing responsibility to follow through the progress of residents RNA services. The DOR stated, she notified the recommendation to nursing staff and trained the RNA according to her recommendation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 4/12/2024, at 9:22 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 16's Nurses Progress Notes dated from 3/1/2024 to 4/12/2024, were reviewed. The Nurses Progress Notes indicated, there was no documentation regarding Resident 16 refusing RNA services. RNS 1 stated, Resident 16 did not refuse the RNA services per record. RNS 1 stated, nursing staff did not do joint mobility assessment ([JMA] a brief assessment of a resident's ROM in both arms and both legs), and ROM assessment. RNS 1 stated, there should be a way to track the residents' progress and evaluate the outcome of RNA services for effectiveness. RNS 1 stated, if the resident refused RNA services, RNA should inform licensed staff. RNS 1 stated licensed staff should assess Resident 16 of the reason behind the refusal and tried to find the cause to accommodate the resident. 2.During a review of Resident 34's Admission Record, the Admission Record indicated, Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (a life-threatening condition that happens when part of your brain doesn't have enough blood flow) affecting right dominant side, dependence on renal dialysis (remove extra fluid and waste products from your blood when the kidneys are not able to), and generalized muscle weakness. During a review of Resident 34's History and Physical (H&P), dated 8/30/2023, the H&P indicated, Resident 34 was able to make his own medical decision. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 required dependent assistance (helper does all the effort) from two or [NAME] staff for shower, toilet hygiene, dressing, maximal assistance (helper does more than half the effort) from one staff for bed mobility, transfer, and set up assistance (helper sets up) for eating. The MDS indicated, Resident 34 had impairment on one side for upper and lower extremity. During a review of Resident 34's Care Plan titled Resident 34 required the use of an external device (right hand splint) initiated on 4/10/2024, with intervention including use device as prescribed by physician. During a review of Resident 34's Care Plan titled Resident 34 was at risk for decline in bilateral upper extremity ROM related to impaired mobility initiated on 3/6/2023, with interventions including don right-hand splint five times a week, two hours on and 2 hours off during day. During a review of Resident 34's PT therapist progress & Discharge Summary notes dated 9/13/2023, indicated, Reason for discharge: refer to restorative nursing care, Discharge plan and instruction: right lower PROM exercise and left lower Active Assisted Range of Motion (AAROM- the resident uses the muscles around a weak joint to complete stretching exercises with the help of a physical therapist or equipment) exercise five times a week as tolerated. During a review of Resident 34's OT therapist progress & Discharge Summary notes dated 9/14/2023, indicated, Reason for discharge: refer to restorative nursing care, Discharge plan and instruction: the resident discharged to RNA for splinting. During a review of Resident 34's Physician Order Summary Report dated 4/12/2024, indicated, there was no order for RNA service or right-hand splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 4/9/2024, at 10:49 a.m., with Resident 34 in Resident 34's room, Resident 34 was in bed and right-hand splint was noted. Resident 34 stated, she had received two RNA service sessions in three weeks, and she would like to receive the RNA services more frequently. Resident 34 stated, RNA performed exercise for her right side only. During a concurrent interview and record review on 4/11/2024, at 12:18 p.m., with RNA 1, Resident 34's Documentation Survey Report dated from 3/1/2024 to 4/11/2024 was reviewed. The Documentation Survey Report indicated, there was no documentation for right lower PROM exercise and left lower Active Assisted Range of Motion exercise five times a week and right-hand splint. RNA 1 stated, he did not know why RNA services task did not show in the report. RNA 1 stated, he could not provide any evidence that the services was provided to Resident 34. During a concurrent interview and record review on 4/11/2024, at 2:50 p.m., with DOR, Resident 34's Restorative Therapy Referral, dated 3/3/2023 was reviewed. The Restorative Therapy Referral indicated, Resident 34 had hemiplegia (weakness or paralysis on one side of the body) following cerebral infarction affecting right dominant side. The Restorative Therapy Referral indicated, Goal: Maintain and increase bilateral upper and lower ROM and strength. The Restorative Therapy Referral indicated RNA service as tolerated. The Restorative Therapy Referral indicated, left upper and lower extremity AAROM and right upper and lower extremity PROM. The Restorative Therapy Referral indicated, don of right-hand splint two hours on and two hours off during day. The Restorative Therapy Referral indicated, prior to don right hand splint, perform ROM, assess skin for breakdown. The DOR stated this was her recommendation for Resident 34. During a concurrent interview and record review on 4/12/2024, at 10:53 a.m., with the Director of Staff Development (DSD), the facility's RNA Program Binder, dated from 1/2023 to 4/2024 was reviewed. The RNA Program Binder indicated, last completed meeting and minute was 11/29/2023. The RNA Program Binder indicated, there weas no documentation for January, March, and April of 2024. The RNA Program Binder indicated, there was partially completed meeting and minutes on 2/27/24, but Resident 16 and 34 were not on the list of the residents who received RNA services. DSD stated, the meeting was regularly done until November 2023, but the meeting was not done since 11/2023. DSD stated, there was RNA meeting on 2/2024, but not all residents were discussed. DSD stated, the facility did not have any way to track and assess the progress of the residents who receives RNA program. During an observation on 4/12/2024, at 10:53 a.m., in Resident 34's room, RNA 2 was at the Resident 34's bedside. RNA 2 was observed taking off Resident 34's right hand splint. RNA 2 lifted right Resident 34 arm up and down. RNA 2 moved right fingers and hand up, down, and side to side. RNA 2 did not perform any ROM on Resident 34's left upper extremity. During an interview on 4/12/2024, at 10:53 a.m., with the Director of Nursing (DON), the DON stated, RNA services should be provided as recommended by therapist. DON stated, the facility should have placed a system to track the progress and assess the residents for any improvement or decline. DON stated, if RNA services were not provided as recommended by PT and /or OT, resident might have a decline in mobility and would be at risk for contracture. DON stated, if the residents who received RNA services were not assessed and evaluated on their progress, they might not achieve their highest level of ROM and optimal physical functions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Programs, dated 12/2021, the P&P indicated, Provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include but is not limited to . Encouraging residents to remain active and assisting with any exercises according to the plan of care. Promoting independence in ADLs. performing tasks for residents only as needed to ensure completion of tasks. Assisting residents in adjustment to their disabilities and use of any assistive devices. Assisting residents with range of motion exercises, performing passive range of motion for residents who lack active range of motion ability . Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include Passive or active range of motion. Splint or brace assistance. Bed mobility training and skill practice. Training and skill practice in transfers or walking .The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented. During a review of the facility's P&P titled, RNA Job Description, revised 11/13/2017, the P&P indicated, Key/Essential Duties: Administrative Functions: Plans. develops, organizes, implements. evaluates, and directs restorative care services. as well as its programs and activities, in accordance with current rules. regulations and guidelines that govern the long-term care facility . Assists in developing. implementing, and maintaining an ongoing quality assurance program for restorative care services. Maintains a current file of residents treated. Maintains treatment grids, care plans, and progress notes as required. 3. During a record review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (muscle weakness or partial paralysis on the right side of the body after a stroke), aphasia, muscle weakness and diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly). During a record review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was severely impaired cognitive skills (person had trouble remembering, learning new things, or making decisions) and required substantial assistance (helper does more than [NAME] the effort) with bathing, lower body dressing, personal hygiene, toileting hygiene and bed mobility. The MDS indicated the resident had an impairment on one side of upper extremity (shoulder, elbow, wrist, and hand). During a record review of Resident 3's OT Therapist Progress and Discharge Summary dated 9/22/2021 indicated OT was started on 8/31/2021 and the care ended 9/22/2021. The OT Therapist Progress and Discharge Summary dated 9/23/2021 indicated the resident was discharged to Long Term Care and Restorative Nursing Assistance for bilateral (both) upper extremities (arms, forearm, wrist, and hand AAROM and PROM of bilateral lower extremities (part of the body that includes hip, thigh, knee, leg, ankle, and foot). During an observation on 4/9/2024, 12:59 a.m. in Resident 3's room, Resident 3 was sitting in a wheelchair, unable to speak, right hand had a handroll and contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a record review of Resident 3's medical health record indicated no documentation on Resident 3's progress or decline after being discharged from physical therapy or occupational therapy. No documentation of joint mobility assessment since admission and only two documents about RNA Services dated 9/23/2021 and 3/24/2024 were found. Resident 3's medical health record indicated RNA services were not addressed in the Interdisciplinary (IDT- group of professional and direct care staff that have primary responsibility for the development of a plan for the care of a resident) meeting. During a review of Resident 3's Restorative Therapy Referral dated 9/23/2021, the Restorative Therapy Referral indicated RNA up to six times a week as tolerated with bilateral upper extremities AAROM exercise and bilateral extremities PROM exercises. During a record review of Restorative Therapy referral dated 3/24/2024, the Restorative Therapy Referral indicated RNA Services five times a week as tolerated with bilateral/ lower extremity passive range of motion exercises and don of right-hand splint or handroll. During a concurrent interview and record review on 4/11/2024, at 11:44 a.m., with RNA 1 Resident 3's medical health records were reviewed. RNA 1 stated there was no RNA order for Resident 3 nor documentation of RNA services being provided to Resident 3. During a concurrent observation and interview on 4/15/2024, at 9:14 a.m. with RNA 3, RNA 3 was observed performing PROM exercises on the right upper extremity (right arm) of Resident 3, the resident was unable to extend the right arm. RNA 3 stated sometimes Resident 3 could not perform the exercises because of pain and stated resident had received something for pain before the exercises were performed. RNA 3 observed trying to apply the splint on the contracted right hand of resident but was unable. During a record review of Resident 3's Medication Administration Record (MAR) dated 4/15/2024, the MAR indicated no pain medication was administered and Resident 3 had no pain. During a review of Resident 3's Care Plan, the Care Plan indicated Resident 3 was requiring use of an external device / orthotic right-hand splint (device that supports, aligns, positions, immobilizes to correct a deformity and improve function) initiated 4/10/2024. The Care Plan's interventions included was to use the device as prescribed by the doctor and consult with therapy department as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45269 Based on observation, interview and record review, the facility failed to ensure two cartridges (container) of morphine (controlled medicine used to relieve pain) tablets were stored in the cubex machine (automated medication dispensing system) after delivery by pharmacy to the facility. This failure had a potential to result in the inability to identify drug diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) and theft. Findings: During a Medication Storage room observation on 4/11/2024, at 9:00 a.m. with Registered Nurse Supervisor (RNS) 2, observed two red containers with plastic locks not labeled were inside the medication storage room. RNS 2 opened the two red containers, and each red container had a cartridge that contained four morphine extended release (ER- medicine was slowly release into the body over a period) 15 milligrams (mgs- unit of measurement) tablets. During an interview on 4/11/2024, at 9:10 a.m. with RNS 2, RNS 2 stated morphine tablets not properly stored could lead to drug diversion. RNS 2 stated it was the responsibility of the RN to ensure the morphine was stored in the cubex and confirmed that the red containers were not labeled with the name of medicine, and plastic locks could be easily removed. During a record review of facility's Delivery Reconciliation Form, the Delivery Reconciliation Form indicated on 1/7/2024 four tablets of morphine ER 15 mgs were received by the facility. During a record review of facility's Delivery Reconciliation Form, the Delivery Reconciliation Form indicated a fill date and time of 3/1/2024 at 10:46 a.m. four tablets of Morphine ER 15 mgs. was received. During an interview on 4/12/2024, at 12:01 p.m. with RNS 3, RNS 3 stated morphine should be stored in the cubex machine upon receiving from pharmacy and the licensed nurse should call the pharmacy that it was restocked in the cubex to prevent discrepancy. RNS 3 stated morphine should be stored securely to prevent theft and drug diversion. During an interview on 4/11/2024, at 9:47 a.m. with the Director of Nursing (DON), the DON stated licensed nurses should store morphine in the cubex machine upon receiving them for tracking and proper accountability. The DON stated morphine was a narcotic (drug that produces numbness, or sleepiness, often taken for pleasure or pain and could lead to addiction) drug and had to be accounted for to prevent drug diversion. During a record review of facility's policy and procedure(P&P) titled Medication Ordering and Receiving from Pharmacy dated 5/2022, the P&P indicated procedures for receiving controlled substances included: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.A nurse signs for the controlled medicines on the pharmacy delivery ticket and inspects the medications. b.A nurse reconciles controlled substance orders and refill request against what has been received from pharmacy. c.A nurse notifies if controlled substance orders or doses are missing or incorrect. d.The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit. e. Controlled substance inventory sheets are completed. During a record review of facility's P&P titled Controlled Substance Storage dated 5/2022, the P&P indicated controlled medications are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws. Controlled medicines are subject to abuse or drug diversion and are stored in a permanently affixed double lock compartment separate from all other medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure the consultant pharmacist's recommendation in the Medication Regime Review (MRR- a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication), were communicated to the physician for two of 14 sampled residents (Resident 2, 56, 24, and Resident 1) for unnecessary medications review. This failure resulted in Resident 2, 56, 24, and Resident 1 receiving an unnecessary medication that can lead to adverse side effects and the potential to result in harm. Findings: 1. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses anxiety disorder (mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with daily activities), unspecified osteoarthritis (degenerative joint disease), and osteoporosis (condition in which bones become weak and brittle). During a review of Resident 2's Minimum Data Set([MDS] a standardized assessment and care screening tool) dated 3/22/2024, the MDS indicated Resident 2 had severely impaired cognitive skills (person had trouble remembering, learning new things, using judgement, and making decisions) and was dependent on staff with toileting hygiene, bathing, and personal hygiene. During a review of Resident 2's MRR indicated Resident 2 was currently on Ativan (drug that works in the brain to relieve symptoms of anxiety, trouble sleeping, severe agitation and seizure) two milligrams (mgs-unit of measurement) by mouth every 12 hours. The pharmacist recommended the current dose exceeded the daily dose threshold (minimum amount of dose required to produce a specific effect or response) for anxiolytics (medicine used to treat anxiety) and to change the dose of Ativan to 0.5 mg by mouth every 6 hours if it is clinically relevant (ability of therapy to improve the resident's condition). During a record review of Resident 2's Physician Order Summary dated 3/21/2024, the Order Summary indicated a physician order of Ativan oral tablet two mgs. give 1 tablet by mouth every 12 hours for anxiety disorder manifested by yelling for no reason. During a review of Resident 2's Physician Order Summary dated 3/21/2024 indicated a physician order to monitor behavior of anxiety manifested by yelling for no reason every shift. During a review of Resident 2's Medication Administration Record (MAR) for the month of April, the MAR indicated from April 1 to April 12, 2024, Resident 2 had only one episode of yelling for no reason on the evening shift (3:00 p.m. to 11:00 p.m.) of 4/6/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions), depression (persistent feeling of sadness), diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), and anxiety disorder. During a review of Resident 56's MDS dated [DATE], the MDS indicated the Resident 56 had moderately impaired cognitive skills and required partial or moderate assistance (helper does less than half the effort) with transfer from bed to chair, bathing, dressing, personal hygiene, and toileting. During a record review of Resident 56's H&P dated 2/2/2024, indicated Resident 56 did not have the capacity to understand and make decisions. During a record review of Resident 56's Physician Order Summary Report dated 1/27/2024 indicated a physician order of Metformin (drug to treat high blood sugar) oral tablet 500 mgs. give one tablet by mouth two times a day for diabetes. During a record review of Resident 56's MRR, the MRR indicated the pharmacist recommended to take Metformin with food. During a subsequent interview on 4/12/2024, at 10:11 a.m. with the Director of Nursing (DON), DON stated she checked the facility's MRR. The DON stated pharmacist recommendations for February and March 2024 were not found. DON stated pharmacist had to send her the MRR for February and March 2024. DON stated she did not know if the MRR for the months of February and March 2024 were followed up because the forms were blank. During an interview on 4/12/2024, at 12:01 p.m. with Registered Nurse Supervisor (RNS 2), RNS 2 stated the facility would fax the MRR form to the physician's office, or the licensed nurse would call the physician about the pharmacist recommendations regarding residents' medications. RNS 2 stated they document on the nurse's progress notes after a follow up with the physician and fill up the MRR form that it was reviewed and followed up with the physician. RNS 2 stated possible side effects of medications could occur and affect residents' health if MRR recommendations were not addressed by the facility. During a concurrent interview and record review on 4/12/2024 at 4:21 p.m. with the DON, the DON stated pharmacist reviewed the medication regimens of residents but unsure if pharmacist recommendations were followed up by licensed nurses. DON stated thru record review of medical record of Resident 56 and Resident 2, indicated Resident 56's Metformin order was not followed up and Resident 2's recommendation for Ativan was not addressed. During a telephone interview on 4/15/2924, at 11:31 a.m. with Pharmacist Consultant (PC), PC stated he did not get feedback from the facility if the recommendations were followed up or completed. PC stated he talked to the DON and reviewed the residents' medical record again to verify if the recommendations were done. PC stated MRR ensure monitoring of resident's medication which could minimize harm by providing the optimal dose and preventing possible adverse effect. PC stated if MRR recommendations were not acted upon possible risk of adverse effect could happen to residents which can be preventable. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45269 3.During a review of Resident 24's Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted to facility on 3/1/2024 with diagnoses including gastro-esophageal reflux disease (a condition in which stomach acid moves up into the esophagus causing heartburn), gastroenteritis (infectious diarrhea), and colitis (swelling or inflammation of the large intestine). During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 needed set up or clean-up assistance from staff for eating. MDS indicated Resident 24 needed supervision or touching assistance with oral hygiene. The MDS indicated Resident 24 was dependent on staff with toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and rolling from left to right. During a review of Resident 24's Physician Order Summary Report, dated 2/8/2024 indicated, Resident 24 had an order for metoclopramide (medication for nausea and vomiting) five milligrams one tablet by mouth every six hours for antiemetic (prevent vomiting). During a review of Resident 24's H&P dated 2/13/2024, H&P indicated, Resident 24 was an accurate historian and was able to make medical. decisions. During a concurrent interview and record review on 4/12/2024 at 4:24 p.m., with the Director of Nursing (DON), Resident 24's Medication Regiment Review dated 2/24/2024 was reviewed. The MRR indicated, there was no documentation that the physician was informed of the pharmacist recommendations to assess the ongoing need for metoclopramide due to an increased risk of tardive dyskinesia (causes repetitive, involuntary movements, such as grimacing and eye blinking) with long term use. The DON stated a blank MRR form means the MRR was not communicated to the doctor. The DON stated there was no documentation that the physician was informed to follow up on the pharmacist recommendation for metoclopramide. 4. During a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including of but not limited to heart failure(impairment in the heart's ability to fill with and pump blood), diabetes (high blood sugar levels), chronic obstructive pulmonary disease([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and chronic kidney disease(gradual loss of kidney function that occurs over a period of months to years). During a review of Resident 1's Physician Order Summary Report, dated 10/20/2024 indicated Resident 1 had an order for tamsulosin (medication that helps to relax the muscles in the bladder.) 0.4 mg one capsule by mouth in the morning for urinary retention. During a review of Resident 1's H&P dated 1/25/2024, H&P indicated, Resident 1 had the capacity to understand and make medical decisions. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 needed staff supervision or touching assistance with eating. The MDS indicated Resident 1 needed substantial and maximal assistance with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, moving from left to right, sitting, lying, standing, transferring to chair. During a concurrent interview and record review on 4/12/2024 at 6:13 p.m. with the Director of Nursing (DON), Resident 1's MRR dated 1/25/2024 was reviewed. The MRR indicated, there was no documentation that the physician was informed of the pharmacist recommendations to clarify the indication of tamsulosin because tamsulosin is used for stone expulsion in females. During an interview on 4/12/2024 at 6:13 p.m. with the DON, the DON stated the physician has not been informed of the pharmacist recommendation for tamsulosin 0.4 mg. During a review of the facility's policy and procedure (P&P) titled, Pharmacy Services for Nursing Facilities, dated 8/2019, the P&P indicated, The consultant pharmacist will identify medications that may be considered unnecessary (An unnecessary drug is any drug used in excessive doses, including duplicate therapy; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above). as defined above or below. The attending physician will be notified for clarification or alteration of the medication order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review the facility failed to: 1.Ensure seven (7) over-the-counter medication were not expired in (1) out of two (2) sampled medication storage rooms. This failure had the potential for harm to residents due to the potential loss of strength of the medications, and the potential for the residents to receive ineffective medication dosages. 2.One of five sample residents' (Resident 22) medicines were not left on the bedside table by a Licensed Vocational Nurse (LVN) 1. This deficient practice had the potential for delay or omission (patient did not receive the medicines that had been ordered) of Resident 22's medications affecting the health of the resident. Findings: 1.During a concurrent observation and interview on [DATE] at 8:51 a.m. with Registered Nurse (RNS 2) in Medication Storage Room, the following medications were stored in an open cabinet: a. Five bottles of multivitamin expired on ,d+[DATE]. b. One bottle of Vitamin B 12 expired on ,d+[DATE]. c. Six bottles of Vitamin B 12 expired [DATE]. d. Seven boxes of unopened nasal decongestant expired ,d+[DATE]. e. Eight bottles of Aspirin 81 milligrams (mgs- unit of measurement) expired ,d+[DATE]. f. One bottle of Vitamin D expired ,d+[DATE]. g. One bottle of multivitamin expired ,d+[DATE]. RNS 2 stated these medication bottles should be taken out from the medication room and should be discarded. RNS 2 stated these medicines should not be left in the cabinet uncovered because nurse could mistakenly use the expired medicines to administer to the residents. RNS 2 stated expired medicines had lost their efficacy and could affect residents' care if administered. During an interview on [DATE], at 9:47 a.m. with the interim Director of Nursing (DON), the DON stated expired medicines were not effective and potency were decreased which could affect residents' health. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During a record review of Resident 22's Admission Record, the Admission record indicated Resident 22 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including paraplegia(inability to move the lower parts of the body voluntarily), dementia (loss of cognitive functioning such as thinking, remembering and reasoning which can affect and interfere with daily life and activities), and heart failure(weakened heart condition that causes fluid buildup in the feet, arms, lungs and other organs due to the heart inability to pump blood as well as it should) During a record review of Resident 22's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated [DATE], the MDS indicated Resident 22 had moderately impaired cognitive skills (person had trouble remembering, learning new things and make decisions) and required supervision or touching assistance with eating. The MDS indicated Resident 22 was dependent on staff with bathing, transferring from bed to chair, lower body dressing and showering. During an observation on [DATE], at 10:54 a.m. in Resident 22's room, observed a medicine cup filled with medications on top of Resident 22's bedside table. Resident 22 stated the medicine cup was her morning medications given by LVN 1. Resident 22 stated she was being changed and cleaned by the staff that was why she had to take the medicines at a later time. During an interview on [DATE] at 11:07 a.m. with LVN 1, LVN 1 stated she signed the medications as given or administered in Resident 22's Medication Administration Record (MAR- legal record of drugs administered to a resident where the licensed nurse signs off on the record at the time the medicine was administered) when she left the medicines in Resident 22's bedside table. LVN 1 stated she did not wait for Resident 22 to take her medicines and should have waited for Resident 22 to take all her medicines and then sign off on the MAR to ensure Resident 22 took all the medications given. LVN 1 stated Resident 22 might have forgotten to take her medicines and the policy of the facility was to ensure medicines were taken by the resident in the presence of a licensed nurse. During an interview on [DATE] at 4:19 p.m. with LVN 2, LVN 2 stated medicines should not be left at the bedside of a resident unattended. LVN 2 stated the licensed nurse should be present when the residents take their medicines to ensure the medicines were taken by the resident. LVN 2 stated leaving medicines at the bedside table unattended by licensed nurses could lead to possible omission of medicines which could impact their health. During an interview on [DATE], at 10:49 a.m. with the DON, the DON stated licensed nurse should ensure the medications were taken by the resident. the licensed nurses should not leave the medicines unattended The DON stated there was a possibility the resident might not take them on time or might not take it which could affect their health. During a record review of facility's policy and procedure (P&P) titled Medication Storage in The Facility dated , d+[DATE], the P&P indicated outdated, contaminated, or deteriorated medications and those in containers that are without secure closures are immediately removed from stock, disposed of according to procedures for medication, and reordered from pharmacy if a current order exists. During a record review of facility's P&P titled Medication Administration- General Guidelines updated , d+[DATE], the P&P indicated medications are administered at the time they are prepared and the person who prepares the dose for administration is the person who will administer the medicine. The P&P indicated the resident is always observed after administration to ensure the dose was completely ingested.

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	056150	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen when: 1.Banana puree with a label of use by date of [DATE], egg puree with a label of use by date of [DATE], lettuce with a label of use by date of [DATE], and eggs with a label of use by date of [DATE] remains in the kitchen. This failure had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and parasites) in 55 out of 55 residents who received food from the facility. Findings: During an observation on [DATE] at 8:24 am in the kitchen, there was banana puree with a use by date on [DATE], egg puree with a use by date on [DATE], lettuce with a use by date on [DATE], and eggs with a use by date of [DATE]. During an interview on [DATE] at 8:24 am with Dietary Aide (DA 1) DA1 stated the cooks were responsible for labeling and dating food and all kitchen staff was responsible for removing expired items from the kitchen freezer and refrigerator. DA 1 stated, if expired food was not removed and serve to residents, residents could get sick with foodborne illness. During a review of the facility's policy and procedure (P&P) titled, Food Safety in Receiving and Storage, dated ,d+[DATE], the P&P indicated Food is received and stored by methods to minimize contamination and bacterial growth. Expiration dates and use by dates will be checked to assure dates are within acceptable parameters.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to assess mental capacity (ability to make decisions) and provide information to two of three sampled residents (Resident 60 and Resident 45) and their responsible parties before signing arbitration agreement (a way of resolving a dispute without filing a lawsuit and going to court). This failure had the potential to result in Resident 60 and Resident 45 not fully understand their right to limit opportunity to initiate judicial proceedings that challenge unfavorable decisions. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated, Resident 60 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury (a sudden, external, physical assault damages the brain), cerebral infarction (a loss of blood flow to part of the brain), muscle weakness, history of falling, and acute respiratory distress syndrome (a life-threatening lung injury that allows fluid to leak into the lungs). During a review of Resident 60's History and Physical (H&P), dated 3/22/2024, indicated, Resident 60 was unable to make his own medical decision. During a review of Resident 60's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 3/27/2024, the MDS indicated Resident 60 required maximal assistance (helper does more than half the effort) from one staff for transfer, shower, toileting hygiene, personal hygiene, dressing, bed mobility, and moderate assistance (helper does less than half the effort) from one staff for eating. During a review of Resident 60's Arbitration Agreement, dated 3/27/2024, indicated, Resident 60 signed the arbitration agreement on 3/27/2024. The Arbitration Agreement indicated, no signature of Resident 60's authorized agent. The Arbitration Agreement indicated, no signature of witness. During a phone interview on 4/10/2024, 8:41 a.m., with Resident 60's Family Member (FM)1, FM 1 stated, she did not know about arbitration agreement that was signed by Resident 60. FM 1 stated, she believed Resident 60 could not understand the content of the arbitration agreement and should not have signed it. During a review of Resident 45's Admission Record, indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), metabolic encephalopathy (brain dysfunctions due to problems with your metabolism, or your body's chemical processes that turn food into energy and filter out harmful toxins), and epilepsy (a sudden, uncontrolled burst of electrical activity in the brain). During a review of Resident 45's H&P, dated 1/18/2023, indicated, Resident 45 did not have mental capacity to make decision. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 required dependent assistance (helper does all the effort) from two or more staff for eating, shower, personal hygiene, dressing, toilet hygiene, bed mobility, and transfer. During a review of Resident 45's Arbitration Agreement dated 1/19/2023, indicated, Resident 45 signed the arbitration agreement on 1/19/2023. The Arbitration Agreement indicated no signature of Resident 45's authorized agent. The Arbitration Agreement indicated, there was no signature of witness. During an interview on 4/10/2024, at 9:07 a.m., with Admission Coordinator (AC), AC stated, she believed the arbitration agreement was part of admission requirement, but she was not sure about that. AC stated she and her assistant were still in training. During an interview on 4/10/2024, at11:41 a.m., with Admission Coordinator Assistant (ACC), ACC stated, residents' who did not have mental capacity to make decision should not have signed arbitration agreement. ACC stated, it should not be a part of admission requirement because it was optional. ACC stated, it was important to make sure that resident understood about arbitration agreement because this would limit resident's choice and it was resident's right to know what it was, and they could rescind within 30 days. During an interview on 4/12/2024, at 4:03 p.m., with the Director of Nursing (DON), the DON stated, the arbitration agreement could be beneficial to the facility and might limit the resident's right to pursue court proceeding to seek justice. The DON stated, AC should have made sure the residents have mental capacity (ability to make decision) to signed it, otherwise AC should have contacted the responsible party or authorized agent. During an interview on 4/12/2024, at 5:49 p.m., with Administrator (ADM), ADM stated, the facility should have determined the resident's mental capacity from resident H&P and made sure the resident or responsible party fully understood arbitration agreement. ADM stated full disclosure of arbitration agreement was important because this might limit the residents' opportunities to pursue legal process or action against the facility by signing the arbitration agreement. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, dated 5/2023, the P&P indicated, This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission, or as a requirement to continue receiving care at facility . Policy Explanation and Compliance Guidelines: 1. When explaining the arbitration agreement, the facility shall: a. Explicitly inform resident or designated representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue receiving care. b. Explain to the resident or designated representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure resident or designated representative acknowledges that he/she understands agreement. d. Complete, sign, and retain (with agreement) a declaration of explanation in electronic health record. 2. The agreement must . c. Explicitly grant rights to rescind agreement within 30 calendar days of signing it. d. Explicitly state there is no requirement to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to observe infection control practices and procedures in the facility by failing to: 1. Ensure dietary staff did not store its personal food items in the kitchen refrigerator. This failure had the potential to result in cross contamination (transfer of harmful bacteria from one place to another) of the resident's food and to cause the spread of food borne illnesses (illness caused by food contaminated with bacteria, viruses, and parasites) to residents. 2.Wear personal protective equipment([PPE] specialized clothing or equipment worn by an employee for protection against infectious materials) properly when providing care for Resident 215. This failure had the potential to spread infection among residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 4/9/2024 at 8:24 a.m. with Dietary Aide (DA 1) in the kitchen, in the refrigerator there was a silver metal cup filled with a thick brown substance covered with plastic, undated and unlabeled. DA 1 stated that was her personal cup. DA 1 stated facility staff are should not keep personal food item in the refrigerator to reduce cross contamination of resident food. During an interview on 4/12/2024 at 3:25 pm with Registered Dietician (RD 1) stated she was told the DA 1 had her personal cup in the kitchen refrigerator. RD 1 stated staff were not supposed to keep their personal food items in the refrigerator due to infection control. During a review of the facility's policy and procedure (P&P) titled, Kitchen Sanitation and Cleaning Schedules, dated 2/2009, the P&P indicated to, Maintain a clean sanitary and safe kitchen. 45269 2. During a record review of Resident 215's Admission Record, indicated Resident 215 was admitted to the facility on [DATE] with diagnoses including end stage renal failure (kidneys stop functioning on a permanent basis), diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), and dependence on renal dialysis (procedure used to remove waste products and excess fluids from the blood). During a record review of Resident 215's History and Physical (H&P) dated 4/11/2024, the H&P indicated Resident 215 was alert, oriented to time, place, and person (normal level of consciousness and had the capacity to make decisions regarding medical treatment). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/9/2024, at 11:00 a.m. observed Licensed Vocational Nurse (LVN 1) entered Resident 215's room don (put on) an isolation gown untied on the front and back that was covering only half of the body and touching the floor. LVN 1 performed a fingerstick (pricking a finger to collect blood) to check Resident 215's blood sugar. During an interview on 4/9/2023 at 11:07 a.m. with LVN 1, LVN 1 stated Resident 215 was on Enhanced Standard Precaution (an approach of targeted gown and glove use during high contact resident care activities to prevent transmission of multi drug resistant organism on high-risk residents) because of resident's dialysis access (where the dialysis machine will connect to the resident's bloodstream). During a record review of Resident 215' s Physician Order Summary Report indicated Resident 215 had a left upper arm arteriovenous fistula shunt (AV Shunt-connection that is made between artery and a vein for dialysis access done in operating room). During an interview on 4/12/2024, at 4:21 p.m. with the Director of Nursing (DON), the DON stated improper wearing of isolation gown had the potential for LVN 1 's uniform to get contaminated and spread the infection among residents and staff members. During an interview on 4/15/2024 at 8:54 a.m. with Infection Preventionist Nurse (IPN), IPN stated for residents on Enhanced Standard Precaution, the staff should wear gown and gloves. IPN stated LVN 1's gown should be tied at the back and front to completely cover the body. IPN stated not wearing the gown the correct way could increase the opportunity to spread infection. During a record review of facility's policy and procedure(P&P) titled Donning PPE dated 2012, the P&P indicated donning the gown should fully cover torso from neck to knees, arms to end of wrist and wrap around the back.