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	04/11/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 ensure the assessment entries on the Minimum Data Set (MDS- an assessment and a care screening tool) related to the legal name of Resident 59 was accurately documented and not 120 days overdue. This failure had the potential to negatively affect Resident 59's plan of care and delivery of necessary care and services. Findings: During a review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was admitted to the facility with diagnoses of but not limited to rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and presence of a right artificial hip joint. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 10/15/2024, the MDS indicated Resident 59 had the ability to express ideas and wants. The MDS indicated Resident 59 had the ability to understand other with clear comprehension. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 59 needed supervision or touching assistance with toileting, showering, lower body dressing and putting on and taking off shoes. During a concurrent interview and record review on 4/11/2025 at 10:00 AM with the Minimum Data Set Nurse (MDSN), Resident 59's MDS, dated [DATE]. The MDS indicated Resident 59's middle initial was coded on the section intended for the resident first name. The MDS indicated Resident 59's middle initial was not coded in the section intended for the middle initial. The MDSN stated she is responsible for providing an accurate assessment of the resident. The MDSN stated Resident 59's middle initial should not have been coded on the section for the resident's first name. The MDSN stated the MDS needs to be modified, corrected and transmitted to CMS right away and the 120 days overdue will be corrected. The MDSN stated she needs to make sure the names on the MDS are accurate so the resident can receive quality care and reimbursement to the facility. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Charting and Documentation , date revised 7/2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of one sampled resident (Resident 21) level 1 Preadmission and Resident Review (PASRR- a federal regulation to prevent inappropriate placement of individuals with mental illness, intellectual disability, or developmental disabilities in Medicaid-certified nursing facilities) was documented correctly. This failure had the potential to result in Resident 21 not receiving the necessary care and services. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental illness characterized by disturbances in thought) and dementia (a progressive state of decline in mental abilities). During a review of Resident 21's History and Physical (H&P), dated 1/31/2025, the H&P indicated Resident 21 is not able to make decisions at this time. During a review of Resident 21's Minimum data Set (MDS - a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 21 had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). The MDS indicated resident 21 had other verbal behavioral symptoms directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). The MDS indicated these behaviors occurred for one to three days During review of Resident 21's Change in Condition Evaluation, dated 11/2/2024, the Change in Condition Evaluation indicated Resident 21 continues to use foul language and was removed away from other residents. The Change in Condition Evaluation indicated Resident 21 was in the dining room when she hit another resident in the back of the with an open palm that was sitting in front of her. The Change in Condition Evaluation indicated the incident was unprovoked, no prior altercation noted, and no words exchanged between the residents prior to the incident. The Change in Condition Evaluation indicated Resident 21 used foul language and could not recall why she hit he resident. During a concurrent interview and record review on 4/10/2025 at 1:08 PM with the Case Manger (CM), Resident 21's Preadmission and Resident Review, dated 1/18/2021. The PASRR indicated Resident 21's Level 1 PASRR was negative, cased closed, Level II PASRR not required due to no mental illness, intellectual disability, developmental disability, related conditions and dementia. The CM stated she is responsible for the residents PASRR. The CM stated Resident 21 had a diagnosis of schizophrenia. The CM agreed Resident 21's Level 1 PASRR screening was documented incorrectly. The CM stated if the PASRR 1 is coded incorrectly the resident will not receive resources for mental illness. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/2025 at 12:46 PM with the Director of Nursing (DON), the DON stated if Resident 21 is not properly and accurately screened for the Level 1 PASRR, Resident 21's plan of care will be incorrect. During a review of the facility's policy and procedure (P&P) titled Admission, Transfer, Discharge and Bed-holds, dated 12/2026, the P&P indicated, The facility, in compliance with the Omnibus Budget Reconciliation Act of 1987, requires individuals diagnosed with major mental illness, mental retardation, or developmental disabilities to be screened prior to admission and throughout stay in accordance with PASRR requirements.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on interview and record review the facility failed to ensure a comprehensive care plan and a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death)) was completed for two of 15 sampled residents (Resident 49 and 22). The facility failed to: a. Ensure Resident 22 had a COC and plan of care when Resident 22 passed out with unknown cause and regain consciousness on 01/01/2025. b. Ensure Resident 49 had a COC and care plan in place for Resident 49's left big toe infection. These deficient practices had the potential to negatively affect the delivery of necessary care and services to Resident 22 and 49. Findings: a. a. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (when not enough oxygen passes from your lungs to your blood), muscle weakness (a reduced ability of muscle to generate force, often resulting in difficulty performing daily tasks or feeling fatigued), type 2 diabetes is (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 22's Minimum Data Set (MDS-resident assessment tool) dated 2/28/2025, the MDS indicated Resident 22 had intact cognitive skills (ability to think, understand, learn, and remember) for daily decision-making. The MDS indicated Resident 22's required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting) and with transfers between surfaces. During concurrent observation and interview on 04/08/2025 at 10:39 a.m., with Resident 22, in Resident 22's room, observed Resident 22 sitting up in bed. Residents 22's stated she wants to be out of bed more, but she had a fall and needs more strength on her leg to be able to transfer from bed to a chair. Resident 22 stated she cannot recall the date of her fall. During concurrent interview and record review on 04/10/2025 at 2:15 pm with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 22 health record. LVN 2 stated she recalls that Resident 22 passed out and was assisted on the floor from the shower chair on 1/1/2025. LVN 2 stated that there was no care plan in Resident 22 health record regarding the incident when Resident 22 passing out and was assisted to the floor from the shower chair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 04/11/2025 at 11:49 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she was the charge nurse on 01/01/2025 when Resident 22 passed out while sitting on a shower chair and was assisted to the floor by CNA 2, treatment nurse and RNS. LVN 2 stated the Registered Nurse Supervisor (RNS) did the assessment and thought RNS called the doctor and complete necessary documentation. LVN 2 stated she failed to document the incident on 01/01/2025. LVN 2 stated when Resident 22 complained of leg pain on 01/06/2025 a x-ray was done of Resident 22's leg. LVN 2 stated she thought RNS will do the change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) documentation and initiate a care plan after the incident on 01/01/2025 but was not done by RNS. During a follow up interview on 4/11/25 at 1:03 pm. with the DON, the DON stated RNS should have assess Resident 22 on 01/01/2025 after the incident. The DON stated RNS should have documented a COC, regarding the incident that happened on 01/01/2025. The DON stated it was important to document a COC and implement the care plans to be able to evaluate if Resident 22 was getting worse or stable after the incident on 01/01/2025. 49889 b.During a review of Resident 49's Admission Record dated 4/11/25 the admission record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and depression (a mood disorder that affects how a person feels, thinks and behaves). During a review of Resident 49's Medical Doctor (MD) Note dated 12/15/24, the MD Note indicated Resident 49 was oriented to self, place and time. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/17/2025, the MDS indicated Resident 49 had moderate cognitive impairment, the MDS also indicated Resident 49 needed substantial/maximal assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 49's Progress Note dated 12/25/2024, the Progress Note indicated Resident 49 was seen by a in house physician assistant (PA a licensed healthcare professional who works in collaboration with physicians) and ordered bacitracin ointment 500 unit /gram (gm-unit of measurement) apply to left big toe topically two times a day for skin infection for seven days and a podiatry (a medical specialty focused on the care and treatment of the foot, ankle, and lower leg) consult for toenail care. During a review of Resident 49's Physician Order Summary Report dated 4/11/24, indicated Resident 49 had orders for bacitracin ointment 500 unit/gm apply to left big toe topically two times a day for skin infection for seven days. During a review of Resident 49's Treatment Administration Record (TAR) dated 12/31/24, the TAR indicated Resident 49 had received treatment on her left big toe. The TAR indicated to apply bacitracin ointment topically two times a day for skin infection for seven days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 12:56 p.m. with the Infection Preventionist (IP), the IP stated that Resident 49 was started on bacitracin antibiotic (medication to treat infection) for left big toe infection. The IP stated there was no ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) and comprehensive care plan completed for Resident 49. The IP stated the importance of care plan as it serves as a guide for the nurses when providing care. The IP stated nurses would not be aware of the proper care required and that there could be a decline in Resident 49's condition. The IP stated that Resident 49 should have a COC completed so that the staff could have monitored Resident 49's left toe if it was getting worse or stable. During an interview on 4/11/25 at 10:34 a.m. with the Director of Nursing (DON), the DON stated she was aware that no care plan was initiated for Resident 49's left big toe infection and that there should have been one. The DON stated care plan serves as a guide for licensed staff for Resident 49's care. The DON stated without proper interventions in place there could be a negative outcome for the resident (in general). The DON stated that any time there was a clinical abnormality for Resident 49, a COC should have been done right away so that licensed nurses can start to monitor Resident 49's condition. The DON stated the staff needs to make sure the interventions put in place were effective. During a review of the facility's policies and procedures (P&P) titled Change of condition, revised in 2016, the P&P indicated: If the change in condition does not require an immediate 911 transfer the following steps may be followed: 1.Document assessment findings and communications as soon as practical 2.Notify physician and responsible party of assessment findings. 3.If unable to communicate with the Patient's attending/on-call physician, contact the facility Medical Director. Notify the Patient and/or responsible party of status and subsequent actions/orders. During a review of the facility's P&P titled Care Plan/Episodic dated 8/2014, the P&P indicated It is the policy of this facility to develop an episodic/short term care plan for acute temporary changes and/ or condition. The purpose is to communicate resident's specific problem and approaches to establish guidance to all disciplines on meeting the individual needs of the resident. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation dated 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any change in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record. A. Objective observations B. Medication administration C.Treatment or services preformed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D.Changes in the resident's condition E. Events, incident or accidents involving the resident F. Progress toward or change in the care plan goals and objectives.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 3) referral, appointment and recommendation for ophthalmology (medical specialty focusing on diagnosis and treatment of eye disorders) was arranged to maintain vision. This failure had the potential to result in worsening vision for Resident 3. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of but not limited to diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition when the heart does not pump enough blood) and chronic kidney disease (the kidneys have been damaged and are not properly functioning for at least three months). During a review of Resident 3's History and Physical (H&P), dated 1/23/2025, the H&P indicated Resident 3 was oriented to name, place and time. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 3 was able to express ideas and wants and was able to understand clear comprehension. The MDS indicated Resident 3 required substantial to maximal assistance with oral hygiene, toileting, showering, and dressing. The MDS indicated Resident 3 required substantial to maximal assistance with putting on and taking off footwear, personal hygiene, and rolling from left to right. The MDS indicated Resident 3 required substantial to maximal assistance with sitting, lying down, standing and transferring to a bed or chair. The MDS indicated Resident 3 did not attempt to walk due to medical condition or safety concerns. During a review of Resident 3's Physician Orders, dated 1/9/2024, the Physician orders indicated Resident 3 may be seen by the ophthalmologist (a medical doctor who specializes in the diagnosis and treatment of eye disease and conditions, including medical and surgical procedures). During a review of Resident 3's Care Plan, titled Patterns/Interest, dated 8/30/2024, the Care Plan indicated Resident 3's Activity Preference (considering skills and ability) individual or self-directed activities, watching TV reading her mail .and magazines. The Care Plan interventions indicated to provide any needed supplies and assistance for activities. During a review of Resident 3's Eye Doctor Consultation, dated 2/10/2025, the Eye Doctor Consultation indicated a follow up for cataracts (clouding of the normally clear lens of the eye). The Eye Doctor Consultation indicated Resident 3 had a diagnosis of but not limited to cataract, presbyopia (a common age-related condition that affects the eyes' ability to focus on near objects), and diabetes without retinopathy (any disease or damage to the retina, the light-sensitive tissue at the back of the eye). The Eye Doctor Consultation indicated a referral for occult macular dystrophy (OMD-a rare inherited retinal disease) and cataracts. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Physician Orders, dated 3/31/2025 the Physician Orders indicated Resident 3 needed an ophthalmology consultation for diabetic eyes examination and cataract. During a concurrent observation and interview on 4/8/2025 at 9:57 AM with Resident 3, Resident 3 stated she had been waiting a year for new glasses. Resident 3 stated she has problems with seeing the television and seeing distance. Resident 3 stated she had been using 99 cent glasses to see, but they do not work very well. During an interview on 4/10/2025 at 12:34 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 3 has cataracts. LVN 1 stated the licensed nurses are supposed to input the physician orders for the eye doctor in the resident's chart then notify the case managers and social worker to make an appointment and setup transportation LVN 1 stated if the case manager and social worker are not notified about the residents need for an appointment, referral or consultation the resident will not get the appointment, referral or consultation and the resident's vision will worsen. During a concurrent interview and record review on 4/10/2025 at 12:43 PM with Social Service Director (SSD), Resident 3's Eye Doctor Consultation, dated 2/10/2025. The Eye Doctor Consultation indicated a follow up for cataracts (clouding of the normally clear lens of the eye). The Eye Doctor Consultation indicated Resident 3 had a diagnosis of cataract, presbyopia (a common age-related condition that affects the eyes' ability to focus on near objects), and diabetes without retinopathy (any disease or damage to the retina, the light-sensitive tissue at the back of the eye). The Eye Doctor Consultation indicated a referral for occult macular dystrophy (OMD-a rare inherited retinal disease) and cataracts. SSD stated this was his first time seeing the document from the Eye Doctor Consultation. SSD stated he missed this Eye Doctor Consultation Resident 3's eyes could deteriorate or get worse if the resident's Eye Doctor Consultation referral and recommendations are not followed. During a review on 4/11/2025 at 12:50 PM with the Director of Nursing (DON), the DON stated licensed nurses, SSD and the case manager are responsible for referrals and recommendations. DON stated SSD and the case manager receives the consultations and arrange the appointments for the residents. DON stated this should not take more than a month and the Resident 3's vision can get worse. During a review of the facility's policy and procedure (P&P) titled Ancillary Services, date revised 2016, the P&P indicated Routine and emergency ancillary services such as dental, eye, podiatry, psychiatry, psychology, optometry, ophthalmology and other services are available to meet the resident's health needs in accordance with the resident's assessment and plan of care .Social services or designee will assist residents with appointments, referrals, transportation arrangements, and for reimbursement of services under the state plan, if eligible. Order/s for ancillary services will be relayed to the provider by social services or designee. The ancillary provider will schedule the visit within 1-3 weeks of referral unless the referral is an emergency. During a review of the facility's policy and procedure (P&P) titled Social Service Responsibilities, dated 11/2016, the P&P indicated Ancillary services: ensure the facility has contracts for dental, audiology, vision, podiatry, psychology, and psychiatry and make appropriate routine referrals.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to ensure one of 15 sampled residents (Resident 49) was seen by a podiatrist (a medical specialty focused on the care and treatment of the foot, ankle, and lower leg) for her left big toe infection. This failure placed Resident 49 at risk for complications related to her left big toe infection. Findings: During a review of Resident 49's Admission Record dated 4/11/25 the admission record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and depression (a mood disorder that affects how a person feels, thinks and behaves). During a review of Resident 49's Medical Doctor (MD) Note dated 12/15/24, the MD Note indicated Resident 49 was oriented to self, place and time. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/17/2025, the MDS indicated Resident 49 had moderate cognitive (ability to think, understand, learn, and remember) impairment, the MDS also indicated Resident 49 needed substantial/maximal assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 49's Progress Note dated 12/25/2024, the Progress Note indicated Resident 49 was seen by a in house physician assistant (PA a licensed healthcare professional who works in collaboration with physicians) and ordered bacitracin ointment 500 unit /gram (gm-unit of measurement) apply to left big toe topically two times a day for skin infection for seven days and a podiatry (a medical specialty focused on the care and treatment of the foot, ankle, and lower leg) consult for toenail care. During an interview on 4/11/25 at 1:29 p.m. with Social Services (SS), SS stated he was informed verbally that Resident 49 needed to see a podiatrist in 12/2024. SS stated Resident 49 was scheduled to be seen by the podiatrist back in January but Resident 49 had COVID 19 (respiratory infection). SS stated Resident 49's toe infection could have gotten worse which could lead to amputation (removal of a body part such as a finger, toe, hand, foot, arm or leg) of Resident 49's toe. During an interview on 4/11/2025 at 10:34 a.m. with the Director of Nursing (DON), the DON stated that Resident 49 should have been seen by podiatry as soon as possible when Resident 49's PA recommend a podiatry consult on 12/25/2024. The DON stated that Resident 49's podiatry appointment in January 2025 should have been rescheduled. The DON stated Resident 49's toe infection could have gotten worse and possible amputation of the toe. (continued on next page)

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Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Ancillary Services dated 12/2026, the P&P indicated Routine and emergency ancillary services such as dental, eye, podiatry, psychiatry, optometry, ophthalmology and other services are available to meet the resident's health needs in accordance with the resident's assessment and plan of care. Orders for ancillary services will be relayed to the provider by the social services or designee. The ancillary provider will schedule the visit within 1-3 weeks of referral unless the referral is an emergency.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview and record review, the facility failed to ensure that a resident received continuous oxygen (a medical treatment to help resident breathe better) as ordered by the physician for one of twenty sampled residents (Resident 19) by: a. Failing to ensure Resident 19 received oxygen at eight liters per minute (lpm unit of measurement) via re-breathable mask (a medical oxygen delivery device where the patient inhales a mixture of oxygen and exhaled air, rather than pure oxygen) as ordered by the physician. This deficient practice had the potential to result in Resident 19 receiving inaccurate amount of oxygen and cause complications associated with oxygen therapy. Findings: During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (a long-term condition where there is not enough oxygen in your body), and congestive heart failure (occurs when the heart cannot pump blood efficiently throughout the body). During a review of Resident 19's Minimum Data Set ([MDS], resident assessment tool), dated 3/28/25, the MDS indicated, Resident 19 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) on staff for toileting hygiene, shower/bath self, and personal hygiene. The MDS indicated Resident 19 required oxygen therapy continuously. During an observation on 4/11/25 at 9:09 a.m. in Resident 19's room, Resident 19 was receiving there (3) liters (the volume of oxygen delivered to a patient, measured in liters per minute [LPM]) of oxygen via a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) . During a review of Resident 19's Physician Order Summary dated April 2025, the Physician Order Summary indicated and order to administer oxygen at eight (8) LPM via re-breathable mask to increase oxygen saturation (the percentage of red blood cells carrying oxygen in your blood) to 92 percent (%) and above. During a concurrent observation and interview on 4/11/25 at 9:30 a.m. with License Vocational Nurse (LVN 2), LVN 2 stated that she was responsible for administering oxygen to Resident 19. LVN 2 stated it was important that the residents receive the correct amount of oxygen as ordered. LVN 2 stated incorrect administration of oxygen had the potential for residents to have altered mental status (any deviation from a person's normal state of alertness, attention, and awareness), develop respiratory failure, become unconscious, and die. LVN 2 stated it was important to follow the physician orders to ensure that the residents were receiving the proper care and services. LVN 2 stated Resident 19 was receiving oxygen at 3 LPM via nasal cannula. LVN 2 stated she failed to check Resident 19's physician order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/25 at 12:25 p.m. with the Director of Nursing (DON), reviewed Resident 19's Physician Order Summary, dated April 2025. The DON stated all licensed staff were responsible for administering oxygen to the residents. The DON stated it was important to follow physician orders because it was the care and services that Resident 19 needs and require. The DON stated that residents could experience respiratory distress (any condition that makes breathing difficult), shortness of breath, and could lead to the resident stop breathing if correct oxygen therapy was not administered. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2014, the P&P indicated, Check physician's order for liter flow and method of administration. During a review of the Job Description/Performance Evaluation .Job Title: LVN/LPN [undated], indicated, Properly prepares and administers medications and treatments.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49862 Based on interview and record review, the facility failed to ensure an annual performance evaluation (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) was performed every year for Certified Nursing Assistant (CNA 3). This deficient practice had the potential for the facility not be able to assess the skills necessary for CNA 3 to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings: During a interview and record review on 04/10/2025 at 12:06 pm with the Director of Staff Development (DSD), reviewed CNA 3 employee record. DSD stated there was no records of CNA 3 annual competency training for 2022, 2023 and 2024. DSD stated CNA 3 was hired in 2013 and working 11 p.m. to 7 a.m. shift. During a follow up interview on 04/11/25 at 09:45 am with DSD, the DSD stated it was important to do annual competency and skill evaluation to know if staff were competent to perform their duties to help and care for the residents. The DSD stated he missed CNA 3's annual competency training because CNA 3 works at night (11p.m. to 7 a.m. shift). During an interview on 4/11/25 at 10:44 am with CNA 3, CNA 3 stated he cannot recall when was the last time he did annual skill performance training with DSD. CNA 3 stated the importance of annual performance evaluation and competency was to assess your knowledge and skills. During an interview on 04/11/25 at 1:35 pm with the Director of Nursing (DON), the DON stated DSD should do the annual skills competency performance evaluation for CNAs and all required training as required. During a review of facility's policy and procedure (P&P), titled Employee Training and Competencies, revised 04/2010, the P&P indicated Departmental training and /or competence will be repeated annually and as needed. The Director of Staff Development (or designee) will maintain appropriate records of topics, content, and attendance at any training/competency sessions, as well as copies of any handouts, pre/post-tests, competency demonstration checklists, etc. and documents requirements.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 45981 Based on observations, interviews, and records review, the facility failed to ensure there were competent staff (Cook) was able to carry out position related duties when: 1. [NAME] prepared pumpkin pie, without following the recipe. This deficient practice had the potential to result in decreased puree food quality and had the potential to result in wrong meal preparation. Findings: During a concurrent observation and interview on 4/10/25 at 12:05 p.m. with [NAME] 1, [NAME] 1 was observed pouring milk directly into the food processor and continued blending until the mixture was loose consistency. [NAME] 1 validated that she did not follow the recipe, and that milk should not had been added to the pumpkin pie. [NAME] 1 stated that it is important to follow the recipes for all the residents and especially for the residents that are on puree diets because the consistency could be too thin, and the residents could choke and die. During a concurrent observation and interview on 4/10/25 at 12:15 p.m. with Dietary Manager (DM), DM observed pouring loose mixture into the sink. DM validated the mixture was too loose. DM stated that the cooks are responsible for reading and following the recipes when preparing food, to ensure that the food is prepared correctly. DM stated puree diets need to have the correct consistency to ensure that the mixture is not too loose. DM stated residents that are on puree diets are at greater risk of choking and dying if the consistency of the food is too loose. DM validated that the recipe for the pumpkin pie did not require adding milk to it. During an interview on 4/11/25 12:40 p.m. with Director of Nursing (DON), DON stated that it is important for the cooks to follow the recipes because it affects the quality of the food and could compromise the resident's health if the food is not prepared properly. DON stated if a puree diet is prepared and the consistency is too loose the resident could choke and get aspiration pneumonia (a lung infection that occurs when foreign material, like food, liquid, or stomach contents, is inhaled into the lungs instead of being swallowed). During a review of the Job Description/Performance Evaluation .Job Title: [NAME] [undated], indicated, Prepare food in accordance with planned menus, diet plans, recipes, and portions. During a review of the facility's policy and procedure (P&P) titled, Food and Dining Services, dated 2009, the P&P indicated, The facility prepares and serves all special diets as planned.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45981 Based on observation, interview and record review, the facility failed to ensure staff prepared puree diet (composed of food of a pasty consistency: smooth, with no lumps or pips) was prepared according to the menus and standardized recipes when: 1.Cook added milk to pumpkin pie without following the recipe. This deficient practice had the potential to result in choking for Resident's that has swallowing problem. Findings: During a concurrent observation and interview on 4/10/25 at 12:05 p.m. with [NAME] 1, [NAME] 1 was observed pouring milk directly into the food processor and continued blending until the mixture was loose consistency. [NAME] 1 validated that she did not follow the recipe, and that milk should not had been added to the pumpkin pie. [NAME] 1 stated that it is important to follow the recipes for all the residents and especially for the residents that are on puree diets because the consistency could be too thin, and the residents could choke and die. During a concurrent observation and interview on 4/10/25 at 12:15 p.m. with Dietary Manager (DM), DM observed pouring loose mixture into the sink. DM stated the mixture was too loose. DM stated puree diets need to have the correct consistency to ensure that the mixture is not too loose. DM stated residents that are on puree diets are at greater risk of choking and dying if the consistency of the food is too loose. DM stated the pumpkin pie should have prepared in accordance with the national guidelines manual. During an interview on 4/11/25 12:40 p.m. with Director of Nursing (DON), DON stated that it is important for the cooks to follow the recipes because it affects the quality of the food and could compromise the resident's health if the food is not prepared properly. DON stated if a puree diet is prepared and the consistency is too loose the resident could choke and get aspiration pneumonia (a lung infection that occurs when foreign material, like food, liquid, or stomach contents, is inhaled into the lungs instead of being swallowed). During a review of the Job Description/Performance Evaluation .Job Title: [NAME] [undated], indicated, Prepare food in accordance with planned menus, diet plans, recipes, and portions. During a review of the facility's policy and procedure (P&P) titled, Food and Dining Services, dated 2009, the P&P indicated, The facility prepares and serves all special diets as planned. During a review of the facility's recipe titled, Production Recipe Pumpkin Pie 10 Cut, dated 2024, the Production Recipe indicated, Prepare according to regular recipe, place in food in processor, Process until smooth. Chill and hold at 41F or lower for service.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to ensure the McGeers criteria (a set of guidelines used to define and classify healthcare-associated infections (HAIs) in long-term care facilities) was used for one of 15 sampled residents, when (Resident 49) was prescribed bacitracin (topical antibiotic) ointment for a left big toe infection. This failure had the potential to result in Resident 49 developing antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 49's Admission Record dated 4/11/25 the admission record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and depression (a mood disorder that affects how a person feels, thinks and behaves). During a review of Resident 49's Medical Doctor (MD) Note dated 12/15/24, the MD Note indicated Resident 49 was oriented to self, place and time. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/17/2025, the MDS indicated Resident 49 had moderate cognitive (ability to think, understand, learn, and remember) impairment, the MDS also indicated Resident 49 needed substantial/maximal assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 49's Progress Note dated 12/25/2024, the Progress Note indicated Resident 49 was seen by a in house physician assistant (PA a licensed healthcare professional who works in collaboration with physicians) and ordered bacitracin ointment 500 unit /gram (gm-unit of measurement) apply to left big toe topically two times a day for skin infection for seven days and a podiatry (a medical specialty focused on the care and treatment of the foot, ankle, and lower leg) consult for toenail care. During a review of Resident 49's Physician Order Summary Report dated 4/11/24, indicated Resident 49 had orders for bacitracin ointment 500 unit/gm apply to left big toe topically two times a day for skin infection for seven days. During a review of Resident 49's Treatment Administration Record (TAR) dated 12/31/24, the TAR indicated Resident 49 had received treatment on her left big toe. The Tar indicated to apply bacitracin ointment topically two times a day for skin infection for seven days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 12:56 p.m. with the Infection Preventionist (IP), the IP stated that Resident 49 was started on bacitracin topical antibiotic for Resident 49 left big toe infection. The IP McGeers criteria was not used prior to starting the topical antibiotic. The IP stated the McGeers criteria should have been used to ensure that Resident 49 had a true infection. The IP stated residents can develop antibiotic resistance. During an interview on 4/11/2025 at 10:34 a.m. with the Director of Nurses (DON), the DON stated she was aware Resident 49 was prescribed a topical antibiotic, and that the MC Geers criteria was not used. The DON stated that the MC Geers criteria is used to identify an infection and to ensure residents are not over prescribed with antibiotic . The DON stated there is a potential for residents to become resistant to antibiotic when over prescribed. During a review of the facility's policy and procedure (P&P) titled Antibiotic Stewardship Program dated 6/2023, the P&P indicated the program includes antibiotic use protocols and a system to monitor antibiotic use. a.Antibiotic use protocols, nursing staff shall assess residents who are suspected to have an infection prior to notifying the physician, laboratory testing shall be in accordance with current standards of practice. The facility uses the McGeers criteria to define infections. b.Monitoring antibiotic (ATB) use, antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness.