STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056166	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview and record review the facility failed to ensure three out of three sampled residents (Residents 67,75 and 347) self- determination was not violated when a monitoring system (contactless cardiorespiratory monitor with cloud service) with microphone and speaker was turned on without giving consent. This failure violated the rights of Residents 67,75 and 347. Findings: During a review of Resident 67 Admission Record dated 4/25/25, the admission record indicated Resident 67 was admitted on [DATE] and readmitted [DATE] with diagnosis including anxiety (feelings of worry, nervousness or fear), depression (persistent feelings of sadness, hopelessness, loss of interest) diabetes mellitus type two (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 67's History and Physical (H&P) dated 12/18/24, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 67's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2025 indicated Resident 28's cognitive function was intact. The MDS also indicated that Resident 28 needs set-up or clean up assistance (helper sets up and cleans up) with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 67's Informed Consent dated 7/7/24, the informed consent indicated that Resident 67's sister had signed consent for the technology system. The Informed consent also indicated the client's responsibility for all services provided by the group for my care. The consent indicated the understanding and agreement that the insurance may be billed for the service and may be responsible for deductibles. During an interview on 4/25/25 at 11:23 a.m. with Resident 67, Resident 67 stated a round dish device with green lights above her bed on the wall was a night light. Resident 67 stated she did not sign any informed consent that she was aware of. Resident 67 stated she did not know it was monitoring her heart rate (HR) or respirations (RR) and did not know there was a speaker in the device. Resident 67 stated not aware the staff can hear all the conversations. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 75's Admission Record dated 4/25/25, the admission record indicated Resident 75 was admitted on [DATE] and readmitted [DATE] with diagnosis including heart failure, chronic kidney disease, hypertension (high blood pressure). During a review of Resident 75's psychological consultation dated 3/24/2025, the psychological consultation indicated Resident 75 was alert and judgement intact. During a review of Resident 75's MDS dated [DATE] indicated Resident 75's had moderate cognitive impairment. The MDS also indicated that Resident 75 was dependent (helper does all the work) with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an interview on 4/25/25 at 11:23 a.m. with Resident 75, Resident 75 stated that she did not know what that device with green lights over the head of her bed. Resident 75 stated that no one ever told her what it is for and not aware it has a speaker. During a review of Resident 342's Admission Record dated 4/18/25, the admission record indicated Resident 342 was admitted on [DATE] with diagnosis including osteomyelitis (infection in the bone) left ankle and foot, DM and hypertension. During a review of Resident 342's H&P dated 4/23/35, the H&P indicated Resident 342 had the capacity to understand and make decisions. During an interview on 4/25/25 at 11:30 am with Resident 342, Resident 342 stated that she thought the round dish with greenlights above the head of her bed on the wall was a night light and was never explained to her what it is. During an interview on 4/22/25 at 2:03 pm with the Director of Staff Development (DSD), the DSD stated the device monitoring system is to help lower the rate of rehospitalization s for our residents. The DSD stated that she had not in-serviced any of the staff about the monitoring system. The DSD stated the Administrator (ADM) and Director of Nurses (DON) are responsible for educating the staff about the monitoring system and that the admissions department is responsible for getting consent from the residents. During an interview on 4/25/25 at 3:39 p.m. with the admissions coordinator (AC) The AC stated that monitoring system that uses wireless technology to measure the residents' heart rate, blood pressure, temperature, and respirations in real time it is used to help detect any changes in the resident's vital signs. The system then downloads the information to the Point and Click care (PCC- cloud based software that stores electronic health record used in long term care settings) where the nurse reviews the data. The AC stated when the green lights are on that means the system is activated and monitoring your vital signs when the red lights are on that means the system is not activated. The AC stated customer service for the monitoring system either calls him or emails him when the resident needs to sign a consent. After the admissions department gets the consent signed, they upload the consent into the PCC and allow the monitoring system to have access to the resident's medical record. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/25/25 at 3:39 p.m. with the AC of the monitoring system informed consents for Resident 67,75 and 342. The AC stated that Resident 67 had a consent, Resident 75 denied consent and Resident 342 was admitted a week ago and that Resident 342 had not signed any admission papers yet. The AC stated that the informed consent did not talk about a speaker on the monitor. During a concurrent interview on 4/25/25 at 3:39 pm with the AC, and record review of the instructions for the monitoring system indicated when a successful connection with the specified Wi-Fi network is established, all LED's will switch to green. The instructions also indicated there was a speaker on the back of the monitor. The AC stated he was not aware there was a speaker on the monitor or about the magnetically susceptible devices and he might have been told about the phone. The AC stated that it is the residents' right to know and it could be an invasion of privacy. During a concurrent observation and interview on 4/25/25 at 4:15 pm with AC in Resident 67 and 342's room, the AC stated Resident 67 and 342's monitoring system were activated because the green lights were on outside monitoring system has an access to Resident 67 and 342's medical record. During an interview on 4/25/25 at 4:39 pm with Licensed vocational Nurse (LVN), LVN 5 stated the LVN 5 stated the residents should be told about the speaker it is an invasion of privacy. LVN 5 stated residents have the right to know about it. During an interview on 4/25/25 at 4:52 pm with Certified Nursing Assistant 5 (CNA), CNA 5 stated he does not know anything about the monitor with the green lights in the residents' rooms on the wall above the beds. CNA5 stated he did not know there was a speaker on the monitor, and he thinks residents should be told about the speaker. CNA5 stated he feels it would be an invasion of privacy and residents should be told what it is. During a concurrent interview and record review on 4/25/25 at 6:03 pm with the Director of Nurses (DON). The DON stated that in the morning the Registered Nurse (RN) turns on the monitoring system on the unit and that the Licensed vocational Nurses (LVN's) do not use them. The DON stated she does not use it for her Quality Assurance and Performance improvement (QAPI- data driven approach to improving the quality of life in nursing homes) because the data is not in real time. The DON stated she did not know there was a speaker on the monitor and that residents should be informed. [NAME] stated it could be an invasion of privacy. During an interview on 4/25/25 at 6:43 pm with the Administrator (ADM), the ADM stated the monitoring system is used as a retrospective tool to help prevent rehospitalization s and that the data is not used in the facility's QAPI plan. The ADM stated residents need to make educated decisions for themselves that's why we have informed consents. The ADM stated that the facility does not pay for the communication feature in the program and that the residents should be told about the speakers on the monitor and that they are not turned on. The ADM stated it is an invasion of privacy when not being informed about monitoring. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled the Circadian system dated 2/2024 the P&P indicated it is the policy of the center to utilize an additional tool, to help minimize rehospitalization of residents. The system provides retrospective monitoring and not real time data. The system is a predictive tool for potential change in condition for residents and does not replace due nursing process. Residents and /or their interested party will be educated about the process of Circadia virtual monitoring and consent will be obtained. If a resident refuses to consent, the device will not be activated.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure two of two sampled residents (Resident 60 and Resident 75) were aware of their rights. This failure had the potential l to violate the resident rights and had the potential to not allow the opportunity for residents to exercise their right. Findings: During a review of Resident 60's Admission Record (Face Sheet) , the Face Sheet indicated, Resident 60 was admitted to the facility on [DATE] with diagnoses of but not limited to respiratory failure occurs when the lungs can not properly exchange gases, causing abnormal levels of carbon dioxide and/or oxygen in the arteries), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and atrial fibrillation (a rapid heart rate). During a review of Resident 60's History and Physical (H&P), dated 2/20/2025, the H&P indicated Resident 60 had the capacity to understand and make decisions. During a review of Resident 60's Minimum Data Set (MDS) , dated 3/8/2025, the MDS indicated, Resident 60 was dependent on staff for toileting, showering, lower body dressing and putting on and taking off footwear. The MDS indicated Reside 60 required substantial to maximal assistance from nursing staff for upper body dressing, personal hygiene, sitting, standing and transferring. During a review of Resident 75's Admission Record (Face Sheet) , the Face Sheet indicated, Resident 75 was originally admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia, hemiparesis, cardiac arrest, acute respiratory failure and heart failure. During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool) , dated 4/2/2025, the MDS indicated, Resident 75 had the ability to express ideas and wants. The MDS indicated Resident 75 had the ability to understand others with clear comprehension (the action or capability of understanding something). During an interview on 4/23/2025 at 10:00 am with the Resident Council (an organized group of residents in the nursing home, that works to address resident concerns, improve living conditions, and promote engagement) , Resident 60 stated in Spanish she was not aware of her rights. Resident 60 stated the facility took one of her shower days off and now she only takes a shower two days a week and wanted three days a week and the staff did not allow her to shower three days a week. Resident 65 stated she was not aware of her rights and did not know what her rights were During an interview on 4/24/2025 at 10:58 a.m., with Certified Nursing Assistant (CNA) 9, CNA 9 stated shower days are twice a week on Mondays and Thursdays and Wednesdays and Saturdays. CNA 9 stated the facility does not shower residents on Sunday unless it is a special request for alert residents. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2025 at 4:52 p.m., with Certified Nursing Assistant (CNA) 10, CNA 10 stated residents have set shower days that are set up by the licensed staff. CNA 10 stated residents are not allowed to shower on Sundays. During an interview on 4/25/2025 at 5:33 p.m., with Social Worker (SW), the SW stated the Administrator just asked her to go around to residents and explain resident rights. The SW stated she had not explained the resident rights to Resident 60. The SW stated she will give a copy of the resident rights to Resident 60 in Spanish. The SW stated the residents should have been given a copy of the residents right now upon admission. During an interview on 4/25/2025 at 7:47 p.m., with the Director of Nursing (DON), the DON stated the SW is responsible for explaining the resident rights to the residents. The DON stated the SW is supposed to give a copy of the resident rights on admission and at the quarterly meetings. The DON stated this is the residents' home in order for them to function the residents need to know their rights. During a review of the facility's policy and procedure (P&P) titled, Job description: Social Services Clerk, dated revised 8/3/2016, the P&P indicated, .Inform the resident/family of the resident's personal and property rights. Assist resident with information concerning resident rights, living wills. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, date revised 2/2021, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . be informed about his or her rights and responsibilities .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility failed to follow and implement its policy and procedure (P&P) regarding the use of restraints (any manual method physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement) for one of five sampled residents (Resident 29) by failing to: 1.Ensure physician order had the specific reason for the use of restraint that will benefit the resident's medical symptom. 2.Monitor and assess Resident 29's tolerance while Peek-A-Boo mittens (specialized, padded mittens used to prevent residents from pulling or interfering with medical devices) when removed. These failures had the potential to put Resident 29 at risk for unnecessary prolonged use of restraint that could lead to decline in mobility and injury. Findings: 1.During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included tracheostomy (medical procedure where a hole is created in the neck to allow access to the windpipe for breathing), Tourette's disorder (condition that involves repetitive movements or unwanted sounds that cannot be easily controlled), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and acute respiratory failure (lungs cannot adequately provide oxygen and makes it difficult to breathe on your own). During a review of Resident 29's Minimum Data Set (MDS- resident assessment tool) dated 4/11/2025, the MDS indicated Resident 29 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making (decisions are poor and required supervision or cues). The MDS indicated Resident 29 was dependent on staff with bed mobility, transfer to and from a bed to a chair, toileting hygiene, bathing, dressing, and oral hygiene. The MDS indicated Resident 29 did not have any form of restraints in place. During a review of Resident 29's Physician Order Summary Report dated 1/8/2024, the Physician Order Summary Report indicated an order for assistive device: Release Peek-A-Boo Mittens every two hours for 15 minutes and check for skin breakdown. The Physician Order Summary indicated to notify the physician as indicated. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 29's Medication Administration Record (MAR) for the month of April 2025, the MAR indicated an order dated 1/9/2024 for an assistive device: release peek-a-boo mittens every two hours for 15 minutes and check for skin breakdown and documented every 2 hours. The MAR indicated the releasing of mittens and checking for skin breakdown were documented and scheduled at 12:00 a.m., 2:00 a. m., 4:00 a.m., 6:00 a.m., 8:00 a.m.,10:00 a.m., 12:00 a.m., 200 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m. and 10:00 p.m. During an observation 4/24/2025, at 8:10 a.m. Resident 29 had no peek-a-boo mittens on both hands. Observed no staff member was present in the room of Resident 29. During an observation on 4/24/2025, at 10:00 a.m. in Resident 29's room, Resident 29 had no mittens on both hands. Observed no staff present inside the resident's room. During an interview on 4/24/2025, at 1:13 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated when she came in this morning Resident 29 had no peek a boo mitten on both hands because the night shift staff removed them. CNA 2 stated she put in a clean pair of hand mittens at 10:30 a.m. and she made sure the hand mittens were not too tight to prevent impairment of circulation. CNA 2 stated Resident 29 had a habit of pulling his tracheostomy and gastrostomy tube. CNA 2 stated the peek-a-boo mittens were considered restraints because they restrict resident's movement. During an interview on 4/24/2025, at 12:35 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated every two hours the staff release the hand mittens by removing the mittens. LVN 1 stated the CNA placed both mittens back on Resident 29 at 11:45 a.m. LVN 1 stated the bilateral (both) hand mittens were not a form of restraints because the mittens are keeping him safe by preventing the resident to grab the tracheostomy. During an observation on 4/25/2025, at 9:00 a.m. in Resident 29's room, Resident 29 had the hand mittens in placed on both hands. During an observation on 4/25/2025, at 11:41 a.m. and at 12:03 p.m. in Resident 29's room, Resident 29 had no hand mitten on the left hand. Observed no staff member to watch and observe Resident 29 while hand mitten was off on the left hand. During a concurrent interview and record review on 4/25/2025, at 2:42 p.m. with LVN 2 reviewed Resident 29's electronic record. LVN 2 stated a physician order of Assistive Device: release Peek-A-Boo mittens every two hours for 15 minutes and check for skin breakdown dated 1/8/2024. LVN 2 stated Resident 29's bilateral hand mittens were removed one at a time every 4 to 6 hours. LVN 2 confirmed through record review, the hand mittens were removed for 15 minutes and agreed he should be in the room when the mittens were released for resident's safety. LVN 2 stated he should have been there while the left mitten was not on the resident because the resident could pull his tracheostomy and gastrostomy tube. LVN 2 stated properly assessing and monitoring of restraints was important to determine if the resident still needs the restraint because prolonged use could impair circulation and high risk for skin breakdown. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2025, at 6:30 p.m. with the Director of Nursing (DON), the DON stated hand mittens were considered a restraint. The DON stated the facility performed trial reduction of restraints and the licensed nurses were responsible in removing the restraints during assessment. The DON stated the licensed nurses should stay and assess the resident's reaction or behavior while off the restraint. The DON stated it was important for the licensed nurses to stay in the room and observe resident's reaction and behavior while restraints are off to ensure resident's safety. The DON stated the resident could be at risk for accidental decannulation (removal of tracheostomy tube) that could lead to respiratory arrest (medical emergency that occurs when a person stops breathing or breathes inadequately), and death. During a review of facility's policy and procedure (P&P), titled Use of Restraints, revised 04/2017, the P&P indicated Restraints shall be only used upon the written order of a physician and the order will include the specific reason for the restraint and how the restraint will be used to benefit the resident's medical symptom. The P&P indicated the physician order should include the type of restraint, period of time for the use of the restraint and reorder of restraint by the physician should be issued only after a review of the resident's condition by his physician. The P&P indicated a resident placed in a restraint will be observed at least every thirty minutes and on-going reevaluation for the needs of restraints should be conducted. The P&P indicated restraints should not be used for staff convenience or prevention of falls.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility accurately assesses and documented on the Minimum Data Set (MDS- a resident assessment tool) reflective of the residents' status at the time of assessment on two of five sampled residents (Resident 29 and Resident 78) by failing to: 1.Ensure Resident 29 used bilateral (both) hand mittens was accurately assessed in the MDS as a restraint (any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement). 2.Ensure Restorative Nursing Assistant Services (RNA services performed to restore and maintain physical function of a resident as directed by their established care plan) performed for Resident 78 was documented and assessed in the MDS. These failures had the potential of not identifying Resident 29 and Resident 78's relevant care needs and developing a plan of care that will meet Resident 29 and 78's needs. Findings: 1.During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included tracheostomy (medical procedure where a hole is created in the neck to allow access to the windpipe for breathing), Tourette's disorder (condition that involves repetitive movements or unwanted sounds that cannot be easily controlled), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and acute respiratory failure (lungs cannot adequately provide oxygen and makes it difficult to breathe on your own). During a review of Resident 29's Minimum Data Set (MDS- resident assessment tool) dated 4/11/2025, the MDS indicated Resident 29 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making (decisions are poor and required supervision or cues). The MDS indicated Resident 29 was dependent on staff with bed mobility, transfer to and from a bed to a chair, toileting hygiene, bathing, dressing, and oral hygiene. The MDS indicated Resident 29 did not have any form of restraints in place. During a review of Resident 29's Physician Order Summary Report dated 1/8/2024, the Physician Order Summary Report indicated an order for assistive device: Release Peek-A-Boo Mittens every two hours for 15 minutes and check for skin breakdown. The Physician Order Summary indicated to notify the physician as indicated. During an observation on 4/22/2025, at 11:18 a.m. in Resident 29's room, observed Resident 29 was laying on a low bed, landing pads (a floor pad designed to help prevent injury should a person fall) on both sides of his bed and hand mittens were in place on both hands. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025, at 1:13 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated when she came in this morning Resident 29 had no peek a boo mitten on both hands because the night shift staff removed them. CNA 2 stated she put in a clean pair of hand mittens at 10:30 a.m. and she made sure the hand mittens were not too tight to prevent impairment of circulation. CNA 2 stated Resident 29 had a habit of pulling his tracheostomy and gastrostomy tube. CNA 2 stated the peek-a-boo mittens were considered restraints because they restrict resident's movement. During a concurrent interview and record review 4/11/2025 on 4/24/2025, at 9:10 a.m. with Minimum Data Set Assistant (MDSA), reviewed Resident 29's MDS dated [DATE]. MDSA confirmed the Peek-A-Boo Mittens were not assessed in the MDS as a restraint. MDSA stated Resident 29 's hand mittens were not considered restraint because the mittens help Resident 29 from removing life saving devices like tracheostomy and gastrostomy tube. MDSA stated as per Resident Assessment Instrument's (RAI-comprehensive assessment and care planning process of residents in the nursing home) definition of a restraint, the Peek-A-Boo mittens are restraints. MDSA stated not assessing accurately Resident 29's Peek-A-Boo mittens in the MDS will affect the data and assessment submitted to Center of Medicare and Medicaid (CMS) and could impact the quality of care and can cause delay of services for Resident 29. 2.During a review of Resident 78's Admission Record, the Admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] to the facility with diagnoses that included pneumonia (an infection/inflammation in the lungs), candidiasis (fungal infection caused by an imbalance of healthy bacteria and yeast in the body), dependence on respirator (a person requires a mechanical breathing machine to support their breathing because they can no longer breathe independently), dependence on renal dialysis (relying on dialysis treatments to sustain life when one's kidneys have failed to properly filter waste and excess fluid from the blood), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and tracheostomy(medical procedure where a hole is created in the neck to allow access to the windpipe for breathing). During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 had moderately impaired cognitive skills and was dependent (helper does all the effort) on staff with rolling from lying on back to left or right side on the bed, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. The MDS indicated Resident 78 was not in a Restorative Nursing Program (RNP- aims to help residents in long-term care maintain or regain their abilities of daily living by promoting independence and preventing functional decline). During a review of Resident 78's Physician Order Summary Report dated 3/25/2025, the Physician Order Summary Report indicated an order for RNA to perform active assisted range of motion(AAROM-type of exercises where a resident uses their muscles to move a body part but the resident receive assistance from an external force like a therapist, a device or even gravity) to bilateral lower extremities and bilateral upper extremities while sitting at the edge of the bed everyday three times a week as tolerated one time a day every Monday, Wednesday and Friday. During a concurrent interview and record review on 4/25/2025, at 12:25 p.m. with MDSA, reviewed Resident 78's MDS dated [DATE]. MDSA stated RNA program was not coded correctly in Resident 78 MDS. (continued on next page)

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Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2025, at 6:30 p.m. with the Director of Nursing (DON), the DON stated hand mittens was a form of restraint and should be coded and assessed as a restraint in the MDS for Resident 29. The DON stated RNA Services performed on Resident 78 should be included in the MDS assessment. The DON stated MDS was an assessment tool used to get a clear picture of the residents' condition and needs. During a review of facility's policy and procedure (P&P) titled, Comprehensive Assessment, revised 3/2022, the P&P indicated Comprehensive assessments are conducted to assist in developing person -centered care plan. During a review of facility's Job Description of MDS Coordinator, the Job Description of MDS Coordinator indicated The MDS Coordinator will ensure that all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions and are aware of the penalties, including civil money penalties, for false certification. The Job description of MDS Coordinator included developing preliminary and comprehensive assessments of the nursing needs of each resident, utilizing the forms required by current rules and regulations.

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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** 49889 Based on interview and record review, the facility failed to ensure 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) was accurately documented for one of four reviewed residents (Residents 28). This deficient practice had the potential to result in an inappropriate placement and delay of needed services for Resident 28. Findings: During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including anxiety(feelings of worry, nervousness or fear), depression (persistent feelings of sadness, hopelessness, loss of interest) and post-traumatic stress disorder (PTSD- a health condition that develops after a person experiences or witnesses a traumatic event). During a review of Resident 28's History and Physical (H&P) dated 12/18/2024, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool) dated 2/22/2025, the MDS Resident 28's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 28 needs partial/moderate assistance (helper does less than half the work) with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 28 was taking an anti-depressant (medication that can alter thoughts, emotions and behaviors) and an antipsychotic (a type of medication prescribed to treat mental health problem) medications and had an active diagnosis of anxiety, depression and PTSD. During a review of Resident 28's PASARR Level 1 dated 2/16/2024 indicated Resident 28's PASARR Level 1 was negative and a PASARR Level 11 was not required. During a review of Resident 28's Physician Order Summary report dated 4/24/2025, the Physician Order Summary report indicated Resident 28 was taking paroxetine (anti-depressant) 10 milligram (mg-unit of measurement) give in the morning for depression manifested by self-isolation started on 3/20/2025. The Physician Order Summary report also indicated Resident 28 was taking risperidone (antipsychotic medication) 1 mg in the morning for PTSD manifested by social isolation started on 9/28/2024. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/24/2025 at 7:58 .a.m. with the Minimum Data Set Assistant (MDSA), The MDSA stated Resident 28 have a diagnoses of PTSD, depression and anxiety and was started on paroxetine and risperidone after the PASARR Level 1 screening was done on 2/16/2024. MDSA stated there should have been another PASARR Level 1 done when Resident 28 was started on paroxetine and risperidone. The MDSA stated Resident 28 could have missed out on specialized services. The MDSA stated if we do not provide the right treatments Resident 28 could have a functional and cognitive decline. During an interview on 4/24/2025 at 7:58 a.m. with the Director of Nursing (DON), the DON stated a new PASARR Level 1 should have been completed. Resident 28 does have a diagnoses of depression , anxiety, and PTSD and was taking psychotropic medications. The DON stated Resident 28 may have been able to get some extra services and have a better quality of life. During a review of the facility's policy and procedure (P&P) titled Admission Criteria dated 3/2019, the P&P indicated All new admissions and re-admissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident review (PASARR) process. The nurse notifies the social worker when the resident is identified as having a possible (or evident) MD, ID or RD. The social worker was responsible for making referrals to the appropriate state-designated authority.

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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 that a preadmission screening assessment ([PASRR] a federal requirement that evaluates individuals seeking admission to Medicaid-certified nursing facilities to ensure they are not inappropriately placed for long-term care) level II was done for two of 19 residents (Resident 31 and Resident 4) who was diagnosed with a mental illness schizophrenia (a chronic mental disorder characterized by disruptions in thought processes, perceptions, emotions, and social interactions). This deficient practice had the potential for Resident 31 and Resident 4 not receiving the necessary and appropriate psychiatric level of treatment and evaluation in the facility. Findings: During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE], with diagnoses including schizophrenia, epilepsy (brief episodes of abnormal electrical activity in the brain). During a review of Resident 31's History and Physical (H&P), dated 3/19/2025, the H&P indicated, Resident 31 had the capacity to understand and make decisions. During a review of Resident 31's Minimum Data Set ([MDS], resident assessment tool), dated 3/18/25, the MDS indicated, Resident 31 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with tub/shower transfer .Is taking antipsychotic medication (a type of drug used to treat symptoms of psychosis). During a review of Resident 31's Preadmission Screening and Resident Review (PASRR) Level I Screening Document dated 3/16/2025, under Section III-Serious Mental Illness is marked No. During a review of Resident 31's Medication Administration Record (MAR) dated 3/2025, the MAR indicated Seroquel 25mg 1 tablet by mouth 2 times a day for schizophrenia. During a concurrent interview and record review on 4/24/2025 at 7:58 a.m. with Minimum Data Set Assistant (MDS A), Resident 31's MDS, Section I-Active Diagnosis .dated 3/22/2025. The MDS indicated, Psychiatric/Mood Disorder is checked for schizophrenia. MDS A validated Resident 31's MDS was marked for schizophrenia. MDS A stated PASRR level I is a tool used to assess residents with mental disorders such as schizophrenia. in order for the residents to receive the necessary care and services that they require. MDS A stated the facility has to review the PASRR referral during admission and readmission. MDS A stated the facility is responsible for ensuring that the residents have the appropriate diagnosis because residents may require medications and treatment that they may not receive, and the residents could have behaviors that could have a negative outcome for the residents and staff. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder, (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs)). During a review of Resident 4's H&P dated 3/31/2025, indicated, Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was dependent on nursing staff for oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS indicated Resident 4 did not attempt to stand, walk or transfer to the bed or chair due to medical condition and safety concerns. The MDS indicated Resident 4 had an active diagnosis of schizophrenia. During a review of Resident 4's Preadmission Screening and Resident Review (PASRR) Level I Am screening), dated 3/28/2025, the Preadmission Screening and Resident Review (PASRR) Level I Screening) indicated, Resident 4 did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusion, and/or mood disturbances. During a concurrent interview and record review on 4/24/2025 at 9:26 AM with Social Worker (SW), Resident 4's Preadmission Screening and Resident Review (PASRR) Level I Screening), dated 3/28/2025 SW stated a level II PASARR is needed when there is a behavior, or diagnosis of schizophrenia, and the resident is receiving psychiatric medications. SW stated Resident 4 had a diagnosis of schizoaffective disorder and bipolar and is considered a mental disease. SW stated upon admission to the facility she checks PASARR level I to see if the resident needs a PASARR level II The SW stated Resident 4's Level I PASARR was documented wrong at the hospital. The SW stated Resident will not receive the proper treatment and care for a mental disease. During an interview on 4/24/2025 at 8:24 a.m. with Director of Nursing (DON), DON stated the PASRR is an important tool used for residents that are diagnosed with a serious mental illness. DON stated the PASRR allows for residents to receive the extra services that may be needed and could improve their quality of life. During a record review the facility's policy and procedure (P&P) dated 2019, the P&P indicated .All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. 45981 49889

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure an attempt was made to find the identity for one of one sampled resident (Resident 192) since being admitted to the facility on [DATE]. This failure had a potential to result in Resident 192 being known as [NAME] Doe not receiving adequate care and services to prevent a decline in physical, mental, and psychosocial well-being. Findings: During a review of Resident 192's Admission Record (Face Sheet) , the Face sheet indicated, Resident 192 was admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia(total paralysis of the arm, leg, and trunk on the same side of the body), acute respiratory failure (a serious condition where the lungs struggle to adequately transfer oxygen into the blood or remove carbon dioxide, leading to a potentially life-threatening deficiency in oxygen or a buildup of carbon dioxide), encephalopathy (a group of conditions that cause brain dysfunction) and sepsis ((a life-threatening blood infection). During a review of Resident History and Physical (H&P), dated 4/8/2025, the H&P indicated Resident 192 did not have the capacity to understand and make decisions. During an interview on 4/22/2025 at 10:00 AM with a Social Worker (SW), she stated she was awaiting a call back from the hospital for the past two weeks. SW stated she did not know she needed to call law enforcement to identify Resident 192. The SW stated for all she knows Resident 192 has been a missing person since January 2025 and his family needed to find him. SW stated she will contact law enforcement. During an observation on 4/22/2025 at 12:34 PM Resident 192's room the Administrator and a law enforcement officer were at Resident 192's bedside and the law enforcement officer took picture and fingerprints of Resident 192. During an interview on 4/25/2025 at 5:33 PM with the SW, the SW stated there are no new updates to identify Resident 192. The SW stated she is waiting to hear from a nationwide data base for identification of the fingerprints. During an interview on 4/25/2025 at 7:05 PM with the Director of Nursing (DON), the DON stated when Resident 192 arrived at the facility an effort should have been made to call to find out who Resident 192 is. The DON stated the police are the main source. The DON stated Resident 192's family or loved ones could be looking for him. (continued on next page)

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F 0675 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, Job description: Social Services Clerk, dated revised 8/3/2016, the P&P indicated, . Obtain information concerning the resident's personal and family problems, past illnesses, etc . Interview residents/families as necessary. Assist in providing solutions for social and practical environmental problems including seeking financial assistance, discharge planning (including collaboration with community agencies), and referrals to other community agencies when specialized assistance is required .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview and record review the facility failed to ensure one of the one sampled, Resident 4 was treated for candidiasis (a fungal infection typically on the skin or mucous membranes caused by candida). This failure resulted in Resident 4 having an untreated oral fungal infection since 3/29/2025. Findings: During a review of Resident 4 s Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to candidiasis, acute respiratory failure (a serious condition where the lungs struggle to adequately transfer oxygen into the blood or remove carbon dioxide, leading to a potentially life-threatening deficiency in oxygen or a buildup of carbon dioxide) and cardia arrest (when the heart stops beating suddenly). During a review of Resident 4's History and Physical (H&P), dated 3/31/2025, the H&P indicated, Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) , dated 4/4/2024, the MDS indicated Resident 4 was dependent on nursing staff for oral hygiene, toileting, showering, dressing, and personal hygiene. The MDS indicated resident 4 did not attempt to [NAME], walk or transfer to the bed or chair due to medical condition and safety concerns. The MDS indicated, Resident 4 had an active diagnosis of candidiasis. During an observation on 4/22/2025 at 12:25 PM in Resident 4's room, Resident 4 was in bed lying on the right side with a tracheostomy (a surgical procedure where a hole (stoma) is created in the windpipe (trachea) to allow breathing through a tube inserted into the stoma, bypassing the nose and the mouth) connected to ventilator. Resident 4's mouth was dry, and the tongue was white. During an interview on 4/25/2025 at 12:07 PM with Registered Nurse Supervisor (RNS 2), RNS 2 stated all the nursing staff are responsible for oral care. RNS 2 stated Resident 4 has an active diagnosis of candidiasis. RNS 2 stated Resident 4 does not have an order in the resident's chart to treat candidiasis. RNS 2 stated candidiasis is like a yeast infection. RNS 2 stated candidiasis can spread to the lungs. RNS 2 stated Resident 4 could catch pneumonia (an infection that inflames the air sacs in one or both lungs) and the breathing is affected. RNS 2 stated it is important to do mouth care to prevent infection. During an interview on 4/25/2025 at 12:52 PM with Respiratory Therapist Supervisor (RTS), RTS stated the respiratory therapist are responsible for oral suction. The RTS stated he reports to charge nurse any change of condition like signs of thrush. The RTS stated candidiasis is oral thrush and is a yeast. RTS stated he noticed the resident tongue was white but did not report it to anyone. The RTS stated he does not know what could happen to the resident if oral thrush goes untreated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2025 at 7:42 PM with the Director of Nursing (DON), the DON stated Resident 4 was admitted on [DATE] with candidiasis. The DON stated the licensed staff should have called the doctor for medication to treat the candidiasis. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily living (ADL), Supporting, date revised 3/2018, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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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** 45981 Based on interview and record review, the facility failed to ensure the resident, who had a history of pneumonia and pleural effusion and verbalized shortness of breath (SOB)/difficulty breathing at rest on 3/23/2025 at 2:13 a.m., blood pressure of 98/57 millimeters of mercury [mmHg] is unit of measurement) on 3/25/2025 at 9:48 a.m. and yellow sputum (mucus cough up from the respiratory tract) , cough, congestion (buildup of mucus in the airways, leading to difficulty breathing), lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness) and SOB on 3/25/2025 at 11:00 p.m. was assessed and monitored for one of four sampled residents (Resident 294). The facility failed to 1. Ensure Licensed Vocational Nurse (LVN unknown) informed Resident 294's medical doctor (MD) when Resident 294's had shortness of breath (SOB)/difficulty breathing at rest on 3/23/2025 at 2:13 a.m. 2. Ensure LVN (unknown) informed Resident 294's MD of Resident 294's systolic blood pressure (SBP- the force of blood pushing against artery wall when the heart contracts and pumps blood) of 98/57 mm/Hg per Resident 294's physician order for sepsis (a life-threatening blood infection) prevention. These deficient practices had the potential for delayed interventions and put Resident 294's at risk for respiratory failure. Findings: During a review of Resident 294's Admission Record, the Admission Record indicated Resident 294 was admitted to the facility on [DATE], with diagnoses including pneumonia (an infection that inflames the air sacs in one or both lungs), pleural effusion (fluid in the lungs), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and systemic lupus erythematosus ([SLE] often called lupus, chronic autoimmune disease where the body's immune system attacks healthy tissues and organs). During a review of Resident 294's Physician Order Summary Report, dated 3/11/2025, the Physician Order Summary Report indicated to notify medical doctor (MD) if the patient has any of the following symptoms: systolic blood pressure (SBP- the force of blood pushing against artery wall when the heart contracts and pumps blood) of less than (<) 110 millimeters of mercury (mmHg-unit of pressure) .every shift for sepsis prevention. During a review of Resident 294's Alert Charting dated 3/23/2025 at 2:13 a.m., the Alert Charting indicated, Resident 294 had shortness of breath (SOB)/difficulty breathing at rest. Resident 294 on supplemental oxygen of two (2) liters per minute via nasal cannula (device that gives additional oxygen through your nose) and medication nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled). During a review of Resident 294's Physician Order Summary Report, dated 3/25/2025, the Physician Order Summary Report indicated, to monitor vital signs every four hours and signs and symptoms of Covid-19 (highly contagious respiratory infection) such as but not limited to shortness of breath .if any, notify MD appropriately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 294's Situation, Background, Assessment, Recommendation (SBAR) & Initial 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)/Alert Charting & Skilled Documentation dated 3/25/2025 at 11:00 p.m., the SBAR/COC, indicated, Resident 294 with yellow sputum (mucus cough up from the respiratory tract) , cough, congestion (buildup of mucus in the airways, leading to difficulty breathing), lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness) and SOB. The SBAR/COC indicated Resident 294 was tested positive on rapid Covid antigen test (used to quickly detect the presence of the virus that causes COVID-19). The SBAR/COC indicated MD was notified and ordered chest x-ray (imaging of the chest), Zithromax (antibiotic used to treat respiratory infection) 500 milligram (mg-unit of measurement), and Paxlovid (medication used to treat mild to moderate COVID 19 infection). During a review of Resident 294's Minimum Data Set ([MDS], resident assessment tool), dated 3/26/25, the MDS indicated, Resident 294 requires modified independence (some difficulty in new situations only) in cognitive (ability to think, understand, learn, and remember) skills for daily decision-making. Resident 294 was dependent (helper does all the effort. resident does none of the effort to complete the activity) with toileting hygiene, shower/bath self. The MDS indicated Resident 294 required continuous oxygen therapy. During a review of Nurses Progress Notes dated 3/26/2025 timed at 10:34 p.m., the Nurses Progress Notes indicated Resident 294 was transferred to general acute care hospital (GACH) on 3/26/2025 at 4:30 p.m. During a review of Resident 294's general acute care hospital (GACH) History and Physical (H&P) dated 3/26/2025 indicated Resident 294's diagnoses of acute hypercapnic respiratory failure (a condition where the lungs fail to adequately remove carbon dioxide from the blood, leading to a buildup in the blood), bilateral pleural effusion and gastro jejunostomy tube(GJ tube- is a specialized feeding tube that is placed through the skin, into the stomach and then into the jejunum (which is the upper part of the small intestine) malfunction. During an interview on 4/23/2025 at 9:25 a.m. with Certified Nurse Assistant (CNA 4), CNA 4 stated Resident 294 had a productive cough and would sneeze frequently since Resident 294's admission on 3/11/2025. CNA 4 stated Resident 294 would spit up a large amount of yellow mucous (a thick, slippery fluid produced by mucous membranes in the body) frequently. CNA 4 stated she had informed LVN 1 (unknown time) about Resident 254's cough but does not know what interventions were done after LVN 1 was notified. CNA 4 stated a change of condition must be reported immediately to the license staff and CNA 4 must complete a Stop and Watch (is an early warning tool used by staff to identify and communicate potential changes in a resident's condition) documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2025 at 9:00 a.m. with License Vocational Nurse (LVN 1), reviewed Resident 294's Blood Pressure Summary, dated 3/25/2025. The Blood Pressure Summary, indicated, on 3/25/2025 at 9:48 a.m. Resident 294's blood pressure was 98/57 mmHg. LVN 1 validated the doctor should have been notified immediately because it was a deviation from Resident 294's baseline blood pressure reading. LVN 1 stated Resident 294 was weak and had a productive cough. LVN 1 stated Resident 294 should have been assessed and monitored after her blood pressure reading was 98/57 mmHg to ensure Resident 294 did not have further decline. LVN 1 stated a change of condition could be but not limited to shortness of breath, low blood pressure, weakness, productive cough and change in the residents mental status. LVN 1 stated residents that tested positive with Covid-19 should have their vital signs taken every four hours and documented on the computer. During an interview on 4/25/2025 at 10:15 a.m. with Registered Nurse (RN 1), RN 1 stated Resident 294 required breathing treatments (inhaled mist delivers the medication directly into the lungs, helping to improve breathing and relieve symptoms like wheezing and shortness of breath) due to the resident having shortness of breath. RN 1 stated Resident 294 would have shortness of breath at least once during RN 1 shift and would reduce the shortness of breath temporarily. RN 1 stated Resident 294 had a productive cough with moderate yellow mucous and sneezed frequently. RN 1 stated a change in vital signs, lethargy (a state of extreme tiredness, sluggishness, and a lack of energy or motivation), coughing, and shortness of breath were considered a change of condition and should be reported to the doctor immediately. RN 1 stated residents should be assessed and monitored when a change of condition occurs to identify potential health risks that may occur. During an interview on 4/25/2025 at 5:38 p.m. with Director of Nursing (DON), the DON stated a low blood pressure of 98/57 mmHg could lead to dizziness, fainting, and falls which could be dangerous for the residents, especially if their mobility was impaired. The DON stated assessing and monitoring residents helps to detect underlying conditions which could be causing low blood pressure and allows for timely interventions. The DON stated Covid-19 positive residents vital signs should be done every four hours, staff are to complete a change of condition and documented. During a review of Resident 294's Medication Administration Record (MAR), dated 3/25/2025, the MAR indicated to monitor every four hours vital signs and signs and symptoms of Covid-19 such as but not limited to cough . increased weakness/fatigue .sneezing/cold-like symptoms if any, and notify MD appropriately. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, dated 2021, the P&P indicated: 1.The nurse will notify the resident's attending physician or physician on call when there has been the following but not limited to .significant change in the resident's physical/emotional/mental condition. 2.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition status. During a review of the facility's policy and procedure (P&P) titled Coronavirus Disease (COVID-19)-Identification and Management of III Residents, dated 9/2022, the P&P indicated, Residents are monitored daily for signs of respiratory infection and/or symptoms of COVID-19, including .cough .shortness of breath . fatigue. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Job Description: Licensed Vocational Nurse, [undated], the Job Description indicated, Duties and Responsibilities Administrative Functions .Monitors vital signs, administers medications, and observes any changes in condition. During a review of Los Angeles County Department of Public Health Covid-19 Skilled Nursing Facility (SNF) Guidelines dated 12/2023, the Covid-19 SNF Guidelines indicated, All residents should be assessed for symptoms and have their vital signs checked .especially for residents with confirmed COVID-19, for example every 4 hours.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview and record review the facility failed to provide the necessary care and services to prevent development or worsening of pressure injury (injury to skin and underlying tissue resulting from prolonged pressure on the skin) for two of four sampled residents (Resident 53 and Resident 83). The facility failed to 1. Ensure Resident 53's skin assessment was done during shower days on Wednesdays and Saturdays and other remaining days when Resident 53 received a bed bath. 2.Ensure facility followed Resident 53's care plan titled Risk for Skin Breakdown dated 9/2023 with interventions included to turn and reposition resident at least every two hours, reassess skin daily by Certified Nursing Assistant (CNA) and weekly by licensed nurses or treatment nurse. 3. Monitor and assess Resident 83's right leg for skin breakdown. These deficient practices had the potential for Resident 53 and 83's pressure injury to progress and developed new pressure injury. Findings: 1.During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was admitted to the facility on [DATE], with diagnoses including anoxic brain damage (occurs when the brain does not receive enough oxygen, leading to brain damage), and contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff, which prevents normal movement of a joint or other body part) of muscle, multiple sites. During a review of Resident 53's History and Physical (H&P), dated 3/3/2025, the H&P indicated, Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53's Minimum Data Set ([MDS], resident assessment tool), dated 3/18/2025, the MDS indicated, Resident 53 was dependent (helper does all the effort, and resident does none of the effort to complete the activity) with toileting hygiene, shower/bath self, and personal hygiene. The MDS indicated Resident 53 was always incontinent of bowel (no episodes of continent bowel movements. The MDS indicated Resident 53 was at risk of developing pressure ulcers/injuries .resident had one unstageable pressure ulcers/injuries, on skin and ulcer/injury treatments and turning and repositioning program. During a review of Resident 53's Braden Scale (tool used to assess a resident's risk of developing pressure injury) dated 3/2025, the Braden Scale indicated, Resident 53 had a score of eight (score of below 9-very high risk of developing pressure injury). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's care plan titled Risk for Skin breakdown dated 7/11/2023, the care plan goal indicated Resident 53's skin will remain intact with no development of new pressure injury for three months. The care plan interventions indicated included to conduct a systematic skin inspection, observe skin integrity during morning and afternoon care, bathe and shower as scheduled, keep Resident 53 clean and dry, evaluate skin weekly, paying particular attention to the bony prominences (areas where bones are close to the skin's surface) and notify the physician and resident representative of all changes in skin condition. During a review of Resident 53's shower schedule, titled Skilled Nursing Facility (SNF) Station Shower Schedule (undated) indicated, Resident 53's shower days were Wednesday and Saturday. During review of Resident 53's shower signs off sheet for Wednesday and Saturday, the shower sign off sheet indicated the following days Resident 53 did not receive bathe/shower: 1.On 2/5/2025- Wednesday 2.On 3/5/2025- Wednesday 3.On 3/8/2025- Saturday 4.On 3/12/2025- Wednesday During an interview 4/23/2025 at 2:52 p.m. with Certified Nurse Assistant (CNA 5), CNA 5 stated it was important that the residents are bathed because it helps to remove dirt, sweat and germs that could cause infection. CNA 5 stated she documents on the skin inspection sheets and shower sign off sheet. CNA 5 stated Resident 53 was totally dependent on care and has a pressure injury to his sacrococcyx, left foot and should be turned/repositioned every two hours and as needed. CNA 5 stated that it was important to turn/reposition residents because they could develop pressure injury. CNA 5 stated that it was her responsibility to turn and reposition residents (in general) and document in Resident 53's electronic health record. During an observation 4/23/2025 at 3:37 p.m. Resident 53 eyes open, lying on his back, non-verbal, responsive to tactile stimulation (nerve signals beneath the skin's surface that inform the body of texture, temperature and other touch-sensation). During an interview on 4/24/2025 at 9:51 a.m. with Certified Nurse Assistant (CNA 6), CNA 6 stated Resident 53 was non-verbal and require total assistance from the staff. CNA 6 stated that he was responsible for turning/repositioning the residents every two hours and as needed in order to prevent Resident 53's pressure injury from getting worse and developing another one. CNA 6 stated he documents turning and repositioning in electronic health record. CNA 6 stated that he was responsible for completing a skin inspection on the residents during shower days and documents on the skin inspection sheet. CNA 6 stated residents are showered twice weekly and as needed. CNA 6 stated the importance of showering residents was to remove the dirt, the skin is inspected at that time and if there are any skin issues they can be found. CNA 6 stated it is the residents right to be showered and to be able to receive proper hygiene. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/24/2025 at 10:29 a.m. with Treatment Nurse (TN 1), TN 1 stated Resident 53's had pressure injury on his left lateral heel and left lateral ankle head (connects with the bone at the back of the foot). TN 1 stated the pressure injuries were discovered on Wednesday 4/2/2025 while rounding with the wound care doctor. TN 1 stated the pressure injuries had dark discoloration and needed to be debrided (removal of damaged tissue) by the wound care doctor. TN 1 stated the CNAs should do skin inspection during shower o bathing the residents. TN 1 stated the purpose of the skin inspection was to look for any changes to the resident's skin. TN 1 stated CNAs should report abnormal findings immediately to the license nurse and treatment nurse. TN 1 stated the CNA's document on the skin inspection sheets and TN 1 signs afterwards. TN 1 stated Resident 53's skin was assessed daily by her. TN 1 stated showering was important for the residents because it removes sweat, dirt, and bacteria which could contribute to residents developing pressure injury. TN 1 stated turning and repositioning residents was also important because it relieves pressure, aids in their circulation and helps to prevent pressure injuries. TN 1 stated CNA's should document when the residents were turned/repositioned every two hours. Reviewed Resident 53's Turning & Repositioning Schedule for the following dates and times were documented as follows: On 3/26/2025 10:41a.m, 1:32 p.m., and 4:12 p.m., 6:54 p.m., and 10:37 p.m. On 3/27/2025 11:10 a.m., 4:33 p.m., 6:00 p.m., and 9:59 p.m. On 3/28/2025 1:52 p.m., 5:11 p.m., and 9:47 p.m. On 3/31/2025 5:00 a.m., and 10:20 a.m. On 4/1/2025 6:55 a.m., 2:07 p.m., 4:13 p.m., 6:17 p.m., and 10:30 p.m. On 4/2/2025 5:00 a.m., 10:23 a.m., 4:35 p.m., 6:34 p.m., and 10:12 p.m. On 4/3/2025 6:34 p.m., and 10:20 p.m. TN 1 validated and confirmed Resident 53 had not been turned/repositioned every two hours and that could have contributed to the resident developing the pressure injuries. During an interview on 4/24/2025 at 10:45 a.m. with the Director of Nursing (DON), the DON stated Resident 53 was dependent on care and was nonverbal. The DON stated all staff were responsible for turning and repositioning the residents. The DON stated residents that were dependent on care must be turned/repositioned every two hours and as needed. The DON stated repositioning the residents helps to maintain their circulation, redistributes pressure and prevents the development of pressure injuries. The DON stated it was the CNA's responsibility to shower the residents and at that time they are able to inspect their skin. The DON stated cleaning the residents was crucial for preventing the spread of infections and ensuring patient safety. During an observation on 4/24/25 at 11:00 a.m. Resident 53 lying in bed on his back with his eyes open. During an observation on 4/24/25 at 1:30 p.m. Resident 53 lying in bed on his back with his eyes open. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/24/25 at 4:39 p.m. Resident 53 lying in bed on his back, Resident 53 was groaning, sweating, and had facial grimacing. 45269 2. During a review of Resident 83's Admission Record, the Admission Record indicated Resident 83 was initially admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including gastrostomy(GT- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem), tracheostomy(medical procedure where a hole is created in the neck to allow access to the windpipe for breathing) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dependence on ventilator (a medical device to help support or replace breathing). During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83 had severely impaired cognitive skills and was dependent (helper does all the effort) on staff with bed mobility, bathing, toileting hygiene, dressing, oral hygiene, and personal hygiene. The MDS indicated Resident 83 was always incontinent with stool (having no voluntary control over defecation), had no pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and was at risk to develop pressure injury. During a review of Resident 83's Braden Scale (an assessment tool used to determine patient's risk for developing a pressure injury) dated 4/22/2025, the Braden Scale indicated Resident 83 was a high risk to develop pressure injury. During a review of Resident 83's Physician Order Summary Report dated 4/24/2025, the Physician Order Summary Report indicated an order for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to apply bilateral knee splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) every day for two and half hours five times a week or as tolerated. During a review of Resident 83's Care Plan titled Resident had an open area on right shin Stage II (characterized by partial-thickness skin loss), pressure injury (prolonged pressure on the skin that results in injury to the skin and underlying tissue, usually occur over bony prominence because of long-term pressure), initiated 3/11/2025 , the Care Plan indicated Resident 83 was readmitted to the facility on [DATE] and the right shin Stage II was unstageable pressure injury (a type of pressure injury where the depth and extent of the tissue damage cannot be determined). The Care Plan indicated interventions included evaluating skin daily, and treatment as ordered. During a concurrent observation and interview on 4/24/2025, at 10:47 a.m. with RNA 1 and RNA 2 in Resident 83's room, RNA1 and RNA 2 were performing passive range of motion (an outside force such as a therapist or a machine moves a joint through its full range of motion while the person being moved does not use their own muscles to do the movement) on Resident 83's both upper arms and both legs. RNA 1 and RNA 2 applied the splints on Resident 83's both contracted knees. RNA 1 stated she did not remember any redness on the right leg and the treatment nurse should be notified if there were any skin changes on the resident's legs during application of the splints. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025, at 1:23 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated Resident 83 had redness on his right leg but could not remember when it started and not sure if it came from another facility or hospital. During an interview on 4/24/2025, at 12:03 p.m. with Certified Nursing Assistant (CNA1), CNA1 stated they report to treatment nurses and charge nurses if there was a skin breakdown or any abnormal skin changes. CNA1 stated the CNAs document on the Stop and Watch Form (early warning tool used by CNAs to document any change in the resident's condition) to be given to the charge nurse. During an interview on 4/24/2025, at 2:53 p.m. with CNA 7, CNA7 stated she could not remember Resident 83 had a skin breakdown on his right leg and had the resident multiple times. CNA 7 stated the CNAs were not documented on Stop and Watch Form for any change in skin condition. During a concurrent interview and record review of Resident 83's electronic chart on 4/24/2025, at 1:52 p.m. with Treatment Nurse (TN 2) , TN 2 stated the right anterior (towards the front) leg wound was discovered during their skin rounds with the physician on 3/11/2025. TN 2 stated the staff did not notify her about the Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on right leg. TN 2 stated certified nursing assistants, restorative nursing assistants abnormal skin observations were relayed to the Treatment Nurses, Charge nurses and Registered Nurses. TN 2 stated that it was a pressure injury on the right leg because it was located on the bony prominence of the right leg and probably from the bilateral knee splints (a device used to support and improve range of motion). TN 2 stated the Stage II pressure injury on the right shin was preventable if it was assessed and reported early when the area was just redness and had not reached to Stage II pressure Injury. During a concurrent interview and record review on 4/25/2025, at 11:25 a.m. with Registered Nurse (RN 2), reviewed Resident 83's electronic record. RN 2 stated an order dated 10/15/2024 indicated bilateral knee splint application for six hours five times a week as tolerated. On 3/6/2025 Resident 83's physician order was changed to bilateral knee splint for three to six hours five times a week. On 4/24/2025, the physician order was changed to bilateral knee splint for two and half hours five times a week as tolerated. RN 2 stated the Stage II injury on the right leg was from positioning or turning and the application of splint on the knees. RN 2 stated everyone was responsible in ensuring the resident's knee splints were applied properly. RN 2 stated applying the knee splints correctly could prevent skin breakdown caused by the pressure on the skin by the splints. RN 2 stated the knee splints skin area should be monitored frequently. During an interview on 4/25/2025, at 3:59 p.m. with Director of Rehabilitation Services (DOR), the DOR stated Resident 83's had a physician order for a bilateral knee splint. The DOR stated the staff should check the skin underneath the splints at least every 2 hours and assess resident's tolerance to the knee splints. The DOR stated the RNA should check the range of motion and skin condition before applying the knee splints. During an interview on 4/25/2025, at 6:30 p.m. with the Director of Nursing (DON), the DON stated CNAs should be observing and reporting any skin breakdown to the licensed nurses and should use the stop and watch form to document any skin breakdown. The DON stated the licensed nurses should assess resident's skin report any abnormal findings to the physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised 4/2020, the P&P indicated The facility will evaluate, report and document potential changes in the skin and review the interventions for effectiveness on an outgoing basis. The P &P indicated for device related pressure injuries, the facility will monitor regularly for comfort and signs of pressure related injury and will review , select medical devices that will minimize tissue damage, including size, shape , its application and ability to secure the device. The P&P indicated, Reposition all residents with or at risk of pressure injuries on a individualized schedule, as determined by the interdisciplinary care team.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to implement the necessary services and care on one of four sampled residents (Resident 78) by failing to: 1.Ensure the Restorative Nursing Services (nursing interventions that promote the residents' ability to adapt and adjust to living independently and safely) Order was being implemented and followed by restorative nursing assistant (RNA- healthcare professional who focuses on helping patients regain and maintain their physical and functional abilities after an illness or injury). 2. Ensure RNA informed licensed nurse of Resident 78 unable to perform active assisted range of motion(AAROM-type of exercises where a resident uses their muscles to move a body part but the resident receive assistance from an external force like a therapist, a device or even gravity) to bilateral lower extremities and bilateral upper extremities while sitting at the edge of the bed everyday three times a week as tolerated one time a day every Monday, Wednesday and Friday as ordered by Resident 78's physician. These failures had the potential for Resident 78 to have a decline in overall physcial functioning and range of motion that can lead to contracture (loss of motion of a joint associated with stiffness and joint deformity) development. Findings: During a review of Resident 78's Admission Record, the Admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] to the facility with diagnoses that included pneumonia (an infection/inflammation in the lungs), candidiasis (fungal infection caused by an imbalance of healthy bacteria and yeast in the body), dependence on respirator (a person requires a mechanical breathing machine to support their breathing because they can no longer breathe independently), dependence on renal dialysis (relying on dialysis treatments to sustain life when one's kidneys have failed to properly filter waste and excess fluid from the blood), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and tracheostomy(medical procedure where a hole is created in the neck to allow access to the windpipe for breathing). During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 had moderately impaired cognitive skills and was dependent (helper does all the effort) on staff with rolling from lying on back to left or right side on the bed, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. The MDS indicated Resident 78 was not in a Restorative Nursing Program (RNP- aims to help residents in long-term care maintain or regain their abilities of daily living by promoting independence and preventing functional decline). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 78's Physician Order Summary Report dated 3/25/2025, the Physician Order Summary Report indicated an order for RNA to perform active assisted range of motion(AAROM-type of exercises where a resident uses their muscles to move a body part but the resident receive assistance from an external force like a therapist, a device or even gravity) to bilateral lower extremities and bilateral upper extremities while sitting at the edge of the bed everyday three times a week as tolerated one time a day every Monday, Wednesday and Friday. During a review of Resident 78's Activities of Daily Living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves)) Task dated 3/26/2025 to 4/18/2025, the ADL Task indicated Resident 78 was provided with passive range of motion ([PROM] the range of motion that is achieved when an outside force such as a therapist causes movement of a joint and is usually the maximum range of motion that a joint can move) for 15 minutes. During a concurrent interview and record review on 4/24/2025, at 10:13 a.m. with Restorative Nursing Assistant (RNA1), reviewed Resident 78 ADL Task Screen. RNA 1 confirmed the documentation on the ADL Task Screen indicated PROM was being documented. RNA 1 stated Resident 78 was weaker, that was the reason why Resident 78 will receive Physical Therapy (a healthcare profession that uses exercises, stretches, and other techniques to improve mobility, reduce pain, and restore function) as of 4/24/2025. RNA 1 admitted she made a mistake and should have been careful in documenting and should follow the RNA Orders. During a concurrent interview and record review on 4/25/2925, at 3:59 p.m. with Director of Rehabilitation (DOR), reviewed Resident 78's electronic health record. The DOR stated Resident 78 was discharged from Physical Therapy Program on 1/31/2025 because Resident 78 had not improved. The DOR stated Resident 78 was under RNA Services on 1/31/2025 and the order was for RNA to perform bilateral lower extremities and bilateral upper extremities active assisted range of motion (AAROM) exercises three times a week as tolerated. The DOR stated on 3/25/2025, an order of RNA Services to perform AAROM bilateral lower extremities and bilateral upper extremities while the resident was sitting on the edge of the bed. The DOR stated they were working on the resident's trunk muscles, but the resident was not able to maintain the sitting position. The DOR stated the RNAs should notify the charge nurse or RN Supervisor if the resident was not getting AAROM exercises as ordered and was only tolerating the passive exercises. The DOR stated the RNAs did not mention about the resident was only receiving passive ROM during meetings and the licensed nurses were responsible in checking if the RNAs had provided the services. The DOR stated Resident 78 could be at risk of not maintaining the level of mobility when the resident was discharged from PT Services on 1/31/2025. During a review of the facility's Job Description of Restorative Nurse Assistant (RNA), the Job Description of RNA indicated RNAS are directly supervised by nursing management and the RNAS should communicate to appropriate staff any significant changes in condition or motivational level of resident. The Job description of RNAs indicated the RNAs should chart appropriately and report to Nursing, PT, OT any residents' problems , referrals, or reassessment needs.

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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 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** 45269 Based on observation, interview, and record review, the facility failed to ensure oral care and oral suctioning were provided to one of four sampled residents (Resident 57) when Resident 57 had dried secretions on the mouth. This failure had the potential to put Resident 57 at risk for airway obstruction (a blockage in the airway that prevents air from moving in and out of the lungs), and respiratory infection. Findings: During a review of Resident 57's Admission Record, the Admission Record indicated Resident 57 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included tracheostomy (medical procedure where a hole is created in the neck to allow access to the windpipe for breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dependence on respirator(patient is unable to breathe independently requiring continuous use of mechanical device to support their breathing), respiratory failure(when lungs cannot properly get enough oxygen into the blood and unable to remove carbon dioxide in the body) and quadriplegia(paralysis on both arms and both legs). During a review of Resident 57's Minimum Data Set (MDS- a resident assessment tool) dated 3/22/2025, the MDS indicated Resident 57 had severely impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 57 was dependent (helper does all the effort) on staff with rolling from lying on back to left and right side on the bed, oral hygiene, bathing, personal hygiene, dressing, and toileting hygiene. During a review of Resident 57's History and Physical (H&P) undated, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57's Physician Order Summary Report dated 2/26/2025, the Physician Order Summary Report indicated an order to suction Resident 57 as needed every two hours. During a review of Resident 57's Physician Order Summary Report dated 5/10/2024, the Physician Order Summary Report indicated give 15 milliliter (ml- unit of measurement) of Chlorhexidine Gluconate Solution (germicidal mouthwash that reduces bacteria in the mouth) by mouth every shift as mouthwash and if unable to gargle, use toothettes (soft foam tipped swabs designed for gentle cleaning and oral care) and apply on the gumline to prevent gingivitis(inflammation of gums). During an observation on 4/22/2025 at 2:10 p.m. in Resident 57's room, Resident 57 had a tracheostomy connected to a ventilator (breathing machine) and was not able to speak. Observed dried secretions covering resident's whole mouth. (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 observation and interview on 4/22/2025 at 2:23 p.m., with Respiratory Therapist (RT)1 in Resident 57's room, RT 1 stated they performed oral care every shift and as needed on residents who are on a ventilator. RT 1 stated Resident 57 needed to be suctioned as soon as possible because of the dried secretions on Resident 57's mouth. RT 1 stated Resident 57's mouth had to be cleared of secretions to prevent infection and maintain her dignity. During an interview on 4/22/2025, at 2:29 p.m., with Licensed Vocational Nurse (LVN 6), LVN 6 stated oral care was important to reduce incidence of ventilator associated with pneumonia ([NAME]- lung infection that develops in a patient who has been on a breathing machine) on residents who were on ventilator (breathing machine). During an interview on 4/25/2025, at 12:38 p.m. with Respiratory Therapy Supervisor (RTS), RTS stated oral care, and oral suctioning was the responsibility of the licensed nurses and respiratory therapists. RTS stated Resident 57 could be at risk for skin breakdown around her mouth and risk to develop [NAME] if oral care and oral suctioning was not performed. During an interview on 4/25/2025, at 10:35 a.m. with Registered Nurse (RN1), RN 1 stated Resident 57 had a lot of oral secretions and oral care, and suctioning should be performed in a timely manner to prevent the resident from getting infection. During a review of facility's policy and procedures (P&P) titled, Ventilator Associated Pneumonia, revised 2018, the P&P indicated Oral care will be provided daily to all patients to maintain oral hygiene and prevent potential complications such as oral infections. During a review of facility's P&P titled, Mouth Care, revised 2/2018, the P& P indicated Mouth care will keep the resident's lips and oral tissues moist by cleansing and freshening the mouth. The P&P indicated mouth care can prevent oral infections.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to ensure the Nurse Assistant Training Program was renewed under the California department of Public Health (CDPH) licensing and certification program (L&C) denied application on [DATE]. This failure had the potential to put the residents' safety at risk when not ensuring the facility had an approved Nurse Assistant Training Program. Findings: During a concurrent interview on [DATE] at 9:30 a.m. with the Director of Staff Development (DSD), and record review of the facility's Nurse Assistant Training Program Notice dated [DATE]. The nurse assistant training program notice indicated communication notices were sent on [DATE] and [DATE] outlining the documents or revisions required to complete the application. A Resume with verifiable qualification, one year of verifiable experience in teaching adults or completion of a course of teaching adults was needed. The DSD stated that she was aware that the facility's Nurse Assistant Training Program had expired on [DATE] and that she had just sent in a new application on [DATE] and was still waiting to hear back from CDPH. The DSD stated she did not know how to fill out the application and did not ask anyone for help. During an interview on [DATE] at 11:03 a.m. with the administrator (ADM). The ADM stated the DSD is responsible for educating the Certified Nursing Assistants (CNA's) and that he had only found out in April that the nurse assistant training program had expired on [DATE] and that the facility had sent in a new application on [DATE] and that the facility was still waiting to hear back from the CDPH. The ADM stated that the CNA's would not be able to get their certificates renewed because their education program had been denied but he felt there were other qualified staff that could educate the CNA's. During a review of the DSD job description dated [DATE], the DSD job description indicated the DSD duties included plan, develop, evaluate, and coordinate educational on the job training programs. Secure, develop and maintain records and reports, instructional manuals, reference materials etc., pertinent to in-service educational programs. During a review of the facility's policy and procedure (P&P) titled Staff Development Program dated , d+[DATE] the P&P indicated staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. The primary objective of our facility's staff development program is to ensure that staff have the knowledge. Skills and critical thinking are necessary to provide excellent resident care.

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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. 49889 Based on interview and record review the facility failed to ensure an annual performance review was conducted for two of two sampled Certified Nursing Assistants (CNA 1 and CNA 2). This deficient practice had the potential for the facility not to be able to assess areas of weakness identified in performance reviews and skills necessary to provide nursing services to assure resident safety. Findings: During a concurrent interview and record review on 4/23/2025 at 11:03 a.m. with the Director of Staff Development Consultant (DSDC), reviewed CNA 1 and CNA 2's employee files. The DSDC stated that she could not find any performance evaluations for CNA 1 and CNA 2. The DSDC stated that CNA's performance evaluations should be done annually. The DSDC stated staff were in-serviced based on the outcomes of their performance evaluations. The DSDC stated we need to educate our staff to assist residents needs and to prevent any negative outcomes to the residents. During a concurrent interview and record review on 4/23/2025 at 11:03 a.m. with the Administrator (ADM). Reviewed CNA 1 and CNA 2's employee files. The ADM stated there were no performance evaluations found for CNA 1 and CNA2. The ADM stated performance evaluations were done annually to point out the growth and the weaknesses in the staff. During a review of the facility's policy and procedures (P&P) titled Performance Evaluation, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period and at least annually thereafter. The written performance evaluations will contain the directors and or supervisor's remarks and suggestions, any action that should be taken (e.g., further training, etc.), and goals.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 The facility failed to ensure the Narcotic and Hypnotic Record have a prefilled licensed nurse signature in a designated signature box for narcotics reconciliation for one of seven facility medication carts (a mobile storage unit used in healthcare settings to safely and efficiently transport and store medications and medical supplies). This deficient practice had the potential for loss of accountability, which affected the controls against drug loss, diversion, or theft. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE], with diagnoses including heart failure (the heart cannot pump enough blood to meet the body's needs) and respiratory failure (the lungs cannot adequately provide oxygen to the blood or eliminate carbon dioxide). During a review of Resident 20's Minimum Data Set ([MDS], resident assessment tool), dated 3/18/25, the MDS indicated, Resident 20 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with toileting hygiene, shower/bath self, and personal hygiene. During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was admitted to the facility on [DATE], with diagnoses including respiratory failure and heart failure. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 20 was dependent (helper does all the effort) with toileting hygiene, shower/bath self, and personal hygiene. During a concurrent interview and record review on 4/24/2025 at 11:36 a.m. with License Vocational Nurse (LVN 3), reviewed Resident 20 and Resident 34's Narcotic and Hypnotic Record, dated 4/24/2025. The Narcotic and Hypnotic Record indicated, on 4/24/2024, there were no licensed staff initials in the box for Resident 20's Tramadol 0.5 milligrams, and Resident 34's Hydrocodone (an opioid pain reliver) 5-325 milligrams to demonstrate the medication was administered. LVN 3 stated there was no documentation on the Narcotic and Hypnotic Record dated 4/24/2025 that indicated Resident 20 received the Tramadol analgesic prescribed to manage moderate to moderately severe pain) 0.5 milligrams and Resident 34 received Hydrocodone 5-325 milligrams on 4/24/2025. LVN 3 stated that she was responsible for documenting immediately after administering medications to the residents. LVN 3 stated that it was important to document immediately to avoid potential errors from giving the residents a repeat dose which could cause the resident to be over medicated and die. During an interview on 4/25/2025 at 9:09 a.m. with the Director of Nursing (DON), the DON stated licensed staff were responsible for documenting immediately after administering medications in order to avoid giving the residents double doses of medication which could cause the residents breathing problems, low blood pressure, or death. (continued on next page)

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F 0755 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, Administering Medications, dated 2019, the P&P indicated, As required or indicated for a medication, the individual administering the medication records in the resident's medical record: .The signature and title of the person administering the drug.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review, the facility failed to ensure that medication error rate was less than five percent (%). 14 medication errors out of 30 total opportunities contributed to an overall medication error rate of 46.67 percent (%) for one of three residents (Resident 3) observed during medication administration (MedPass). The deficient practice of failing to administer medications in accordance with the physician orders increased the risk that Residents 3 may experience adverse reactions, complications, that could lead to a decline in the residents' condition, harm, or hospitalization . Findings: During a review of Resident 3's Admission Record, the Admission Record indicated, Resident 3 was originally admitted to the facility on [DATE] with diagnoses including chronic kidney disease (a condition where the kidney gradually lose their ability to function properly, typically over several months or years), hypertension (HTN-high blood pressure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone, usually due to infection). During a review of Resident 3's History and Physical (H&P), dated 3/29/2025, the H&P indicated, Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-resident assessment tool), dated 3/23/2025, the MDS indicated, Resident 3 needed substantial to maximal assistance with transferring to a chair and shower. The MDS indicated Resident 3 needed partial to moderate assistance with showering, lower body dressing, personal hygiene and the ability to stand from a sitting position. The MDS indicated Resident 3 needed supervision or touching assistance with toileting, putting on and taking off footwear and walking. During a review of Resident 3's Medication Administration Record (MAR), dated 4/1/2025 to 4/30/2025 indicated, Resident 3 received the following medications: 1. Furosemide (water pill) 40 milligram (mg-unit of measurement) by mouth two time a day for hypertension 2. Isosorbide Mononitrate (medication for hypertension) 30 mg extended release 24 hours one tablet orally in the morning for hypertension 3. Hydralazine (medication for hypertension) 50 mg two tablets by mouth three times a day for hypertension. 4. Ascorbic Acid (vitamins) 500 mg by mouth two times a day 5. Aspirin enteric coated (EC) 81 mg by mouth one time a day for deep vein thrombosis (blood clot) . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Ferrous Sulfate (medication for anemia [low blood count]) 325 mg by mouth two times a day for anemia. 7. Magnesium Oxide (minerals) 400 mg oral one tablet a day. 8. Insulin Glargine (medication used to treat DM) 8 units subcutaneously (under the skin, or into the tissues just beneath the skin) in the morning for diabetes mellitus. 9. Amlodipine Besylate (medication for hypertension) 10 mg orally in the morning for hypertension. 10. Apixaban (blood thinner) 2.5 mg one tablet by mouth twice a day for prophylaxis deep vein thrombosis. 11. Finasteride 5mg one tablet by mouth one time a day for urinary retention. 12. gabapentin 300 mg one capsule orally two times a day for neuropathic pain (type of chronic pain). 13. docusate (stool softener) 100 mg one capsule orally two times a day for bowel management. 14. allopurinol 100mg orally two times a day for gout (type of arthritis [inflammation or destruction of one or more joints, causing pain, stiffness, and swelling]). During a concurrent observation and interview during medication pass on 4/25/2025 at 11:21 a.m., with Licensed Vocational Nurse (LVN) 1, in front of resident room, Resident 3 was seated in a wheelchair in front of the door. LVN 1 stated she was running late administering Resident's 3 medication. LVN 1 stated the doctor was notified Resident 3's medications will be administered late. During an interview and record review on 4/25/2025 at 8:21 p.m., with the Director of Nursing (DON), reviewed the facility's policy and procedure (P&P), titled Medication Administration Schedule, date revised 11/2020. The P&P indicated medications given daily, every morning, two times a day and three times a day the first dose is given at 9 a.m. The P&P indicated insulin ordered daily was given at 9 a.m., The DON stated scheduled medications should be administered within one hour of their prescribed time, unless otherwise specified. During a review of the facility's policy and procedure (P&P) titled Administering Medications, date revised 4/2019, the P&P indicated, .Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by the resident need and benefit, not staff convenience. Factors that are considered include enhancing optimal therapeutic effect of the medication, preventing potential medication or food interactions and honoring resident choices and preferences, consistent with his or her care plan .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49889 Based on observation, interview, and record review the facility failed to ensure fresh fruits were stored properly when an open container with a cantaloupe, and honeydew melon, dated fresh fruit [DATE] expires on [DATE]. This failure had the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites). Findings: During a concurrent observation in the walk-in refrigerator on [DATE] at 8:16 am and interview with the Cook, it was observed an open container with a half of a cantaloupe with a date of [DATE] on the skin of the fruit and a half of a honeydew melon in a plastic bag dated [DATE] the container was dated fresh fruit [DATE], expires on [DATE]. The cook stated that each fruit should have an open date and a use by date to ensure the food is fresh. The cook stated there is a potential for stomach issues if food is served out of date. During an interview on [DATE] at 9:11a.m., with the dietary supervisor (DS), The DS stated that they are now using labels with open and best buy dates. The DS stated that open and best buy dates are needed to prevent food born illness. During an interview on [DATE] at 9:05 am with the Infection Preventionist Nurse (IPN), the IPN stated that all perishable food items need to have an open date and use-by date. The IP stated there is a potential for a gastrointestinal (GI) infection when food is not stored properly. During an interview on [DATE] at 10:38 am with the administrator (ADM) the Adm stated best by and use by dates are needed so that we do not serve expired foods. The ADM stated there is potential for GI concerns. During a review of the facility's policy and procedure (P&P) titled labeling and dating of foods dated 2023, the P&P indicated newly open food items need to be closed and labeled with an open date and use by date that follows the various storage guidelines within this section specially refrigerated storage. All prepared foods need to be covered, labeled and dated. Items can be individual or bulk stored on a tray with masking tape if going to be used for meal service.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45269 Based on interview and record review, the facility's Quality Assurance Performance Improvement (QAPI- a data driven proactive approach to improvement used to ensure services are meeting quality standards) failed to maintain and develop an effective plan to correct identified and potential problems by failing to: 1.To provide an effective oversight of the facility and implementation of the facility's plan of correction (POC- specific corrective actions the facility will take to address the deficiencies and the timeline for completion) of the deficient practice regarding pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and quality of care (providing the best possible healthcare to residents focusing on safety, effectiveness, and desired health outcomes). These failures had the potential to negatively impact on the care of the residents and individualized needs of the residents not being met. Findings: During a review of facility's CMS 2567 (survey report that documents and justifies a nursing home's compliance with federal health requirements) Recertification Survey dated 4/26/2024, the CMS 2567 indicated the facility failed to assess resident's pressure injury (and initiate wound care treatment in a timely manner. The CMS 2567 Plan of Correction (POC) indicated the Director of Nursing /designee will assign a nursing staff to monitor that weekly skin sweep was performed. The CMS 2567 's POC indicated any new skin change will have a change in condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) with follow-up monitoring for 72 hours and more. CMS 2567 indicated the facility failed to assess resident tongue and administer mouthwash used for dry mouth and throat as ordered by the physician. The facility's POC included assigning nursing staff to monitor any changes in condition with mouth assessments. Repeat deficient practices on pressure injury and quality of care were identified during the recent Recertification Survey conducted on 4/22/2025 to 4/25/2025. During an interview on 04/25/2025, at 8:21 p.m. with the Director of Nursing (DON), the DON stated the facility still perform Wound Meeting every Monday and Friday and had started doing skin sweep (thorough inspection of residents' skin by looking for signs of damage or infection) last January 2025. The DON stated the facility provided in-services to the certified nursing assistants (CNA) and restorative nursing assistants (RNAS) on how to properly document. The DON agreed that the implementation plan of correction was not working, and the facility will continue educating staff to help track and identify any problems in residents' care and condition. During an interview on 4/25/2025, at 8:30 p.m. with the Administrator (ADM), the ADM stated the purpose of QAPI was to improve the quality of care in the facility by making plans and reassessing plan of actions. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) Program Govemance and Leadership revised 3/2020, the P&P indicated The quality assurance and performance is overseen and Implemented by the QAPI committee which implemented a system to correct potential and actual Issues In quality of care. The P&P indicated QAPI committee is responsible for coordinating the development implementation, monitoring and evaluation of performance improvement projects to achieve specific goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to observe infection control practices by failing to: a. Assess and monitor Resident 78's midline catheter (a long, thin , flexible tube inserted into a large vein in the upper arm with the tip just below the armpit used to provide venous access for medications, fluids and blood products) dressing . Resident 78's midline dressing was soiled and soaked with blood. These failures had the potential to result in the spread of diseases and infection to the facility staff, residents, and visitors. Findings: a. During a review of Resident 78's Admission Record, the Admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] to the facility with diagnoses that included pneumonia (an infection/inflammation in the lungs), candidiasis (fungal infection caused by an imbalance of healthy bacteria and yeast in the body), dependence on respirator (a person requires a mechanical breathing machine to support their breathing because they can no longer breathe independently), dependence on renal dialysis (relying on dialysis treatments to sustain life when one's kidneys have failed to properly filter waste and excess fluid from the blood), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and tracheostomy(medical procedure where a hole is created in the neck to allow access to the windpipe for breathing). During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 4/5/2025, the MDS indicated Resident 78 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills and was dependent (helper does all the effort) on staff with rolling from lying on back to left or right side on the bed, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. During a review of Resident 78's Physician Order Summary Report dated 4/20/2025, the Physician Order Summary Report indicated to assess midline site for signs and symptoms of infection every shift and notify the physician if noted every shift. During an observation on 4/22/2025, at 1:36 p.m. in Resident 78's room, midline catheter dressing located on the right upper arm of Resident 78 was soiled, gauze covered by a transparent semi permeable dressing (TSM - dressing preventing entry of bacteria and other contaminants) was soaked with bright red blood and was dated 4/19/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/24/2025, at 8:21 a.m. with Registered Nurse (RN 2) in Resident 78's room, RN 2 stated Resident 78's midline catheter dressing was soiled , gauze covering the site was saturated with dried brown blood and was s dated 4/19/2025. RN 2 stated the registered nurses are responsible in assessing and monitoring the site of the midline catheter and the dressing should be changed anytime the dressing was dirty, bloody to prevent infection. RN 2 stated Resident 78 could be at risk for infection in the midline catheter site. During an interview on 4/25/2025, at 8:51 a.m. with Infection Preventionist Nurse (IPN), IPN stated the RNs should have monitored and checked the midline catheter site and changed the dressing as soon they saw the dressing was saturated with blood to prevent the risk of infection. During an interview on 4/25/2025, at 6:30 p.m. with the Director of Nursing (DON), the DON stated if the midline catheter dressing was soiled and bloody, the RNs should have changed the dressing to prevent infection. During a review of facility's policy and procedure (P&P), titled Central Venous Catheter Care and Dressing Changes, revised 03/2022, the P&P indicated To change the dressing if it becomes damp, loosened or visibly soiled, at least every 2 days for sterile gauze dressing (including under a transparent semi-permeable membrane dressing) and immediately if the dressing or site appeared compromised. 45981

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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** 44898 Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship for one of one sampled resident (Resident 84). Resident 84 was prescribed an antibiotic drug without meeting the McGeer Criteria (a set of clinical definitions used for surveillance in long-term care facilities (LTCF) These McGeer criteria require more diagnostic information, such as positive laboratory tests, to meet the criteria for definitive infection.), after being screened for a urinary tract infection (UTI- an infection in the bladder/urinary tract). This failure had the potential to result in Resident 84 developing antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 84's Admission Record (Face Sheet) , the Face Sheet indicated, Resident 84 was admitted to the facility on [DATE] with diagnoses of but not limited to nontraumatic intracranial hemorrhage 9bleeding within the brain not caused by trauma or surgery), respiratory failure (a condition where the lungs struggle to adequately exchange oxygen and carbon dioxide with the blood, resulting in low oxygen levels an/or high carbon dioxide levels), hyperlipidemia (elevated levels of lipids like cholesterol and triglycerides in the blood) and dysphagia (difficulty swallowing). During a review of Resident 84's Minimum Data Sheet (MDS-a resident assessment tool) , dated 3/23/2025, the MDS indicated Resident 84 rarely and never had the ability to express wants, thoughts and understand others. The MDS indicated Resident 84 was dependent on nursing staff for oral hygiene, toileting, showering and dressing. The MDS indicated Resident 84 was dependent on nursing staff for personal hygiene and transferring. The MDS indicated Resident 84 did not attempt to sit, lie down, stand and walk due to medical condition or safety. During a concurrent interview and record review on 4/25/25 at 8:35 AM with Infection Preventionist Nurse (IPN), Resident 84's Infection Screening Evaluation, dated 3/26/2025. The Infection Screening Evaluation indicated there was no documentation of Resident 84 presenting any symptoms of an infection. IPN stated Resident 84 did not meet the Mc Geer's Criteria when the infection screening evaluation was done on 3/26/2025. IPN stated Resident 84 did have a fever, difficulty urinating, or increased urine output The IPN stated when antibiotics are prescribed, and the McGreer Criteria is not met it would be considered unnecessary use of the antibiotic and can kill the normal flora in the resident's body and the ability to fight infections. During a record review of Resident 84's Physician Orders. The Physician Orders indicated on 3/26/2025 to 4/5/2025 Resident 84 had an order for Augmentin Oral Tablet 875-125 MG (Amoxicillin &Pot Phone Clavulanate) Give 1 tablet via G-Tube every 12 hours for UTI (urinary tract infection) for 10 Days 1st dose from E KIT (emergency kit). During an interview on 4/25/2025 at 8:03 PM with the Director of Nursing (DON), the DON stated if the McGeer Criteria is not followed residents can develop resistance to antibiotics or receive the wrong antibiotic. (continued on next page)

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F 0881 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 Antibiotic Stewardship, date revised 12/2026, the P&P indicated when a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available, signs and symptoms, when symptoms were first observed, resident's hydration, status, current medication list, allergy information, infection type, any orders for warfarin and results of last INR, last creatinine clearance or serum creatinine, if available; and time of the last antibiotic dose.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to ensure that the facility's Certified Nursing Assistants (CNAs) were provided with approved training when their nurse assistant training program expired on [DATE]. This failure had the potential to affect the residents' quality of life due to lack of knowledge. Findings: During a concurrent interview on [DATE] at 9:30 a.m. with the Director of Staff Development (DSD), and record review of the facility's Nurse Assistant Training Program Notice dated [DATE]. The nurse assistant training program notice indicated communication notices were sent on [DATE] and [DATE] outlining the documents or revisions required to complete the application. A Resume with verifiable qualification, one year of verifiable experience in teaching adults or completion of a course of teaching adults was needed. The DSD stated that she was aware that the facility's Nurse Assistant Training Program had expired on [DATE] and that she had just sent in a new application on [DATE] and was still waiting to hear back from the state. The DSD stated she did not know how to fill out the application and did not ask anyone for help. During an interview on [DATE] at 11:03 a.m. with the administrator (ADM). The ADM stated the DSD is responsible for educating the Certified Nursing Assistants (CNA's) and that he had only found out in April that the nurse assistant training program had expired on [DATE] and that the facility had sent in a new application on [DATE] and that the facility was still waiting to hear back from the state. The ADM stated that the CNA's would not be able to get their certificates renewed because their education program had been denied but he felt there were other qualified staff that could educate the CNA's. During a review of the DSD job description dated [DATE], the DSD job description indicated the DSD duties included plan, develop, evaluate, and coordinate educational and on the job training programs. Secure, develop and maintain records and reports, instructional manuals, reference materials etc., pertinent to in-service educational programs. During a review of the facility's policy and procedure (P&P) titled Staff Development Program dated , d+[DATE] the P&P indicated staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. The primary objective of our facility's staff development program is to ensure that staff have the knowledge. Skills and critical thinking necessary to provide excellent resident care.