STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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 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** 41699 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of their individuality for four of 24 sampled residents (Resident 26,27, and 213). The facility failed to: a. Ensure privacy curtain was drawn while providing care with Resident 26 and 27. b. Ensure Resident 213 indwelling urinary bag was covered completely with a privacy bag. These deficient practices had the potential to feel embarrassed and affect the self-esteem, self-worth, sense of independence and psychosocial well-being for Resident 26,27, and 213. Findings: a.During a review of Resident 26's Admission Order, the Admission Record indicated Resident 26 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and peripheral vascular disease (refers to any disease or disorder of the circulatory system). During a review of Resident 26's Minimum Data Sheet (MDS- a comprehensive assessment and care screening tool) dated 05/16/2024 indicated Resident 26 had no cognitive (ability to think, understand, learn, and remember) impairment and requires assistance for all activities of daily living. During a review of Resident 26's care plan titled Needs partial/moderate assistance for dressing and personal hygiene dated 09/02/2022, indicated interventions including to allow choices with activities of daily living to preserve self-worth/self-esteem. During an observation on 08/07/2024 at 9:58 a.m., observed privacy curtain not drawn, Resident 26's left breast expose and can be seen when passing in the hallway. During a review of Resident 27's Admission Order, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus, difficulty in waking, and chronic kidney disease (a long-term condition where the kidneys cease functioning). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's MDS dated [DATE] Indicated Resident 27 had no cognitive impairment and requires assistance for all activities of daily living. During a review of Resident 27's care plan titled Needs maximum assistance/dependent on staff on bathing, dressing and personal hygiene dated 06/18/2024, indicated interventions including to allow choices with activities of daily living to preserve self-worth/self-esteem, dress and change as needed, dress in clean and appropriate attire, assure proper clothing is available. During an observation on 08/06/2024 at 12:14 p.m., observed privacy curtain not drawn, Resident 27's back wearing incontinent brief (diaper) and can be seen when passing in the hallway. During an interview on 08/07/2024 at 2:11 p.m., Certified Nursing Assistant (CNA 1) stated when resident's privacy curtain was not drawn, and residents were expose that was a privacy and dignity issues and that can also affect the psychosocial being of the resident. During an interview on 08/08/2024 at 10:47 a.m., the Registered Nurse (RN 1) supervisor stated privacy curtain must be drawn when providing personal care to the resident to protect privacy and dignity to any resident. 44898 b.During a review of Resident 213's Admission record, the Admission Record indicated Resident 213 was admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of the bladder (a problem in the brain, spinal cord or central nervous system that causes loss of control of the bladder), urinary tract infection(an infection in any part of the urinary system), hematuria (the presence of blood in the urine), and difficulty walking. During a review of Resident 213's History and Physical (H&P), dated 7/26/2024, the H&P indicated, Resident 213 had the capacity to understand and make decisions. During a review of Resident 213's MDS dated [DATE], the MDS indicated Resident 213 needed supervision or touching assistance with eating. The MDS indicated Resident 213 needed substantial to maximal assistance with oral hygiene, dressing, personal hygiene, and transferring. The MDS indicated Resident 213 was dependent on staff for toileting, showering, putting on and taking off footwear, and getting on or off a toilet. During an observation on 8/7/2024 at 10:17 am, Resident 213 was lying in bed with a indwelling urinary bag hanging from the right side of the bed. Resident 213's indwelling urinary bag was not covered fully with a privacy bag and the urine was exposed for visitors and other residents to see. During an interview on 8/07/2024 at 10:27 am with Certified Nurse Assistant (CNA) 7, CNA 7 stated Resident 213 has a indwelling urinary catheter. CNA 7 kneeled down to cover Resident 213 exposed urinary bag with the privacy bag. CNA 7 stated the urinary bag was supposed to be covered with a privacy bag for privacy and dignity. During an interview on 8/8/2024 at 4:19 pm with the Infection Preventionist Nurse (IPN), IPN stated the use of the privacy bag was to cover the urinary bag. IPN stated the urinary bag has to be fully covered with the privacy bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/9/2024 at 1:35 pm with the Director of Nursing (DON), the DON stated the purpose of a privacy bag was to maintain the resident's dignity. During the review of facility's policy and procedure (P&P) titled Quality of Life-Dignity undated, indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be always treated with dignity and respect. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During a review of the facility's policy and procedure (P&P) titled Quality of Life-Dignity, undated, the P&P indicated, Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. 46415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview, and record review, the facility staff failed to ensure call light was within reach for two of three sampled residents (Resident 12 and Resident 16). This deficient practice had the potential for Resident 12 and 16 not to receive necessary assistance when needed, and experienced loss of self-esteem. Findings: During a review of Resident 16's Admission Order, the Admission Record indicated Resident 12 was admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), unspecified dementia (loss of memory, language, problem-solving and other thinking abilities), and anxiety disorder (excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 16's Minimum Data Sheet (MDS- a standardized assessment and care screening tool) dated 04/02/2024 indicated Resident 16 had severe cognitive (ability to learn, understand, and make decisions) impairment and requires assistance for all activities of daily living. During a review of Resident 16's care plan titled Potential for falls or injury due to resident dependent on staff for activities of daily living dated 10/22/2022, with interventions including to keep call light available and answer promptly. During an observation on 08/08/2024 at 8:11 a.m., and 9:42 a.m., observed Resident 16's call light was on the floor and not within reach. During a review of Resident 12's Admission Order, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus, heart failure (heart does not pump enough blood for your body's needs), and schizoaffective disorder (mental health disorder in which people interpret reality abnormally). During a review of Resident 12's Minimum Data Sheet dated 07/05/2024 indicated Resident 12 had no cognitive impairment and requires assistance for all activities of daily living. During a review of Resident 12's care plan titled Needs maximum assistance and dependent on staff for bed mobility, toilet use, transfer and locomotion dated 07/02/2024, interventions including to keep call light available and answer promptly. During an observation on 08/08/2024 at 8:12 a.m., and 9:22 a.m., observed Resident 12's call light was on the floor and not within reach. During an interview on 08/08/2024 at 9:53 a.m., the Director of Staff Development (DSD) stated if resident cannot reach the call light to ask for help, it will make them feel frustrated and affect their psychosocial wellbeing. Residents (in general) may feel like less important and unwanted. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/08/2024 at 10:07 a.m., Certified Nursing Assistant (CNA 2) stated call light should be within reach to prevent fall and injury and to ensure Resident 12 and 16's needs will be provided in a timely manner. During an interview on 08/08/2024 at 10:49 a.m., Registered Nurse (RN 1) stated if residents' call light was not within reach, Resident 12 and 16 will not be able to call for help when needed and had the potential to affect their psychosocial wellbeing and delayed the care needed. During the review of facility's policy and procedure (P&P) titled Answering the Call Light undated, indicated: The purpose of this procedure is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure you check these residents frequently.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 41699 Based on interview and record review, the facility failed to ensure a resident Minimum Data Set ([MDS] a comprehensive assessment and care screening tool) assessment was transmitted within 14 days after completion for two of 14 sampled residents (Resident 69 and 83). This deficient practice had the potential to the delay in identifying resident care concerns needing individualized care plan, delay in providing residents interventions necessary to provide quality care and delay in the reimbursement process. Findings: During a review of MDS submission form for Resident 69 dated 05/16/2024 and Resident 83 dated 06/24/2024, indicated the assessment completion was late and it was more than fourteen days beyond what was required. During an interview on 08/07/2024 at 1:48 p.m., the MDS Coordinator stated Resident 69 and 83's MDS discharge assessment from the hospital was submitted after fourteen days and the regulation requires to submit within fourteen days. The MDS Coordinator admitted that there was a late submission of Resident 69 and 83's discharge assessment. MDS Coordinator stated failure to submit assessment timely can affect the quality measures, plan of care and the assessment will not be as accurate if submitted after 14 days. During a record review of Centers for Medicare and Medicaid Services (CMS) Submission Report dated 08/07/2024, indicated both Resident 69 and 83's final validation report for assessment completion date was more than 14 days required and was late. During the review of facility's policy and procedure (P&P) titled MDS Completion and Submission Timeframes undated, indicated Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.

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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** 44088 Based on interview and record review the facility failed to ensure one of 24 sampled resident (Resident 90) was assessed for change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) or functional status which without immediate intervention, may result in complications or death) and physician informed when Resident 90 called 911 (a phone number used to contact emergency services) on [DATE], and [DATE]. This failure resulted in Resident 90 calling 911 and transferred to general acute care hospital (GACH) on [DATE] for abdominal pain and fecal impaction (large, hard mass of stool gets stuck in the rectum and cannot pass out). On [DATE] Resident 90 was hospitalized for stercoral colitis (a rare form of inflammatory colitis (inflammation in the colon, causing symptoms such as urgent, painful, runny, or bloody stools) that can develop as a result of chronic constipation (a problem with passing stool). Resident 90 was hospitalized again on [DATE] for abdominal pain and chronic constipation. Findings: During a review of Resident 90's Admission Record, the Admission Record, the Admission Record indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastroenteritis (inflammation that spreads from the stomach into the intestines, causing pain vomiting [throwing up] and diarrhea {loose stool}), colitis (swelling of inflammation of the large intestines), and myocardial infarction (a heart attack that occurs when blood flow deceases or stops in one of the arteries of the heart). During a review of Resident 90's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 90 needed substantial to maximal assistance with eating, oral hygiene, personal hygiene, sitting, and laying. The MDS indicated Resident 90 was dependent on nursing staff for transferring, toileting bathing, and dressing. During a review of Resident 90's History and Physical (H&P), dated [DATE]. The H&P indicated Resident 90 had the capacity to understand and make decisions. During an interview on [DATE] at 10:00 a.m. with Resident 90, Resident 90 stated he called 911 three times due to abdominal pain and constipation and was transferred to the hospital on [DATE]. Resident 90 stated he was in the hospital and underwent manual disimpaction (when a person uses their fingers to remove stool from the rectum). (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 [DATE] at 11:40 am with Licensed Vocational Nurse (LVN) 7, Resident 90's Nursing Progress Notes, dated [DATE] was reviewed. The Nursing Progress Notes indicated, on [DATE] at 1:09 am Resident 90 asked for tramadol (pain medication -used to treat moderate to severe chronic pain) and was told the pain medication was not scheduled to be given and received Tylenol (pain medication). The Nursing Progress Notes indicated on [DATE] at 3:35 am Resident 90 called 911 for abdominal pain ranging from three to seven out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) and was given tramadol. LVN 7 stated on [DATE] Resident 90 called 911. LVN 7 stated Resident 90 was transferred to GACH for abdominal pain on [DATE] and returned back to the facility on [DATE] at 11:45 am. LVN 7 stated there was no documentation of a COC done in Resident 90's medical record. LVN 7 stated Resident 90 should have a COC documented so Resident 90's pain could be monitored and treated. During a concurrent interview and record review on [DATE] at 12:00 pm with LVN 7, Resident 90's Medication Administration Record (MAR), dated [DATE] was reviewed. The MAR indicated on [DATE] at 9:32 am, Resident 90 was given tramadol 50 milligram (mg-unit of measurement) by mouth for pain. The MAR indicated tramadol was ordered to be given every eight hours as needed for severe pain. LVN 7 stated the next dose should have been given at 1:09 am when Resident 90 asked for pain medication and was told the medication was not due yet. LVN 7 stated on [DATE] at 9:45 am Resident 90 called 911 because he wanted to go to the bathroom. LVN 7 stated 911 came because Resident 90 was unable to poop. LVN 7 stated there was no documentation of a COC done and does not see documentation of notification of Resident 90's physician. During an interview on [DATE] at 9:43 am with Registered Nurse Supervisor (RNS) 1 , RNS 1 stated Resident 90 was hospitalized on [DATE] after calling 911 for complaints of feeling, hot, nauseated and yelling for help. RNS 1 stated Resident 90 returned back to the facility on [DATE]. RNS 1 stated there was no documentation of Resident 90's physician being notified and documentation of a change of condition. RNS 1 stated on [DATE] at 9:45 pm Resident 90 called 911 again and was hospitalized because he was unable to poop, RNS 1 stated there was no documentation of Resident 90 being assessed prior to calling 911 no documentation of the doctor being notified about Resident 90's unable to have a bowel movement, and no documentation of Resident 90 having a change of condition. RNS 1 stated the COC should have been documented so Resident 90's condition could be monitored. RNS 1 stated the doctor should have been notified on [DATE], [DATE] and [DATE] to relay Resident 90's problem and receive further orders from the physician as needed. RNS 1 stated Resident 90 should have been assessed to know the condition of the resident. RNS 1 stated if the resident was not assessed staff will not be able to meet the resident's needs. RNS 1 stated Resident 90 refused medication for constipation and stated he wanted to go to the hospital. RNS 1 stated there was no documentation noted in Resident 90's chart that the physician was notified of Resident 90 refusing medication for constipation. During an interview on [DATE] at 1:38 pm with the Director of Nursing, the DON stated when Resident 90 was complaining of abdominal pain, nausea (the urge to vomit), feeling hot and unable to have bowel movement Resident 90 was having a change of condition. The DON stated nursing staff did not have time to assess Resident 90 for a change in condition. The DON stated when the nursing staff found out Resident 90 was having a change of condition the paramedics had already arrived to transport Resident 90 to the hospital. The DON stated the doctor was not notified when Resident 90 was having a COC. The DON stated when a resident was being transferred to the hospital a COC should be done. The DON stated Resident 90 was hospitalized on [DATE] and diagnosed with stercoral colitis. (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 90's Order Summary, dated [DATE], the Order Summary indicated, Resident 90 returned to the facility from the GACH with a diagnoses of abdominal pain, .fecal impaction (a solid, immobile bulk of feces that can develop in the rectum) and nausea. During a review of Resident 90's GACH record dated [DATE], indicated Resident 90 was admitted for stercoral colitis. During a review of Resident 90's Radiology Report, dated [DATE], the Radiology Report indicated Resident 90 had retained stool in the colon, including a rectal stool ball measuring 7.9 centimeters transverse, with mild stranding (elongated, or twisted and plaited resembling a rope) to the rectum which may be secondary to impaction and stercoral colitis. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) The Nurse Supervisor/Charge Nurse will notify the residents Attending Physician or On-Call Physician when there has been refusal of treatment or medications (i.e., two (2) or more consecutive times) a need to transfer the resident to a hospital/treatment center. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (Interact Version 4.0) Communication Form . The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Based on interview and record review the facility failed to ensure one of 24 sampled resident (Resident 90) was assessed for change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) or functional status which without immediate intervention, may result in complications or death) and physician informed when Resident 90 called 911 (a phone number used to contact emergency services) on [DATE], and [DATE]. This failure resulted in Resident 90 calling 911 and transferred to general acute care hospital (GACH) on [DATE] for abdominal pain and fecal impaction (large, hard mass of stool gets stuck in the rectum and cannot pass out). On [DATE] Resident 90 was hospitalized for stercoral colitis (a rare form of inflammatory colitis (inflammation in the colon, causing symptoms such as urgent, painful, runny, or bloody stools) that can develop as a result of chronic constipation (a problem with passing stool). Resident 90 was hospitalized again on [DATE] for abdominal pain and chronic constipation. Findings: During a review of Resident 90's Admission Record, the Admission Record, the Admission Record indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastroenteritis (inflammation that spreads from the stomach into the intestines, causing pain vomiting [throwing up] and diarrhea {loose stool}), colitis (swelling of inflammation of the large intestines), and myocardial infarction (a heart attack that occurs when blood flow deceases or stops in one of the arteries of the heart). (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 90's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 90 needed substantial to maximal assistance with eating, oral hygiene, personal hygiene, sitting, and laying. The MDS indicated Resident 90 was dependent on nursing staff for transferring, toileting bathing, and dressing. During a review of Resident 90's History and Physical (H&P), dated [DATE]. The H&P indicated Resident 90 had the capacity to understand and make decisions. During an interview on [DATE] at 10:00 a.m. with Resident 90, Resident 90 stated he called 911 three times due to abdominal pain and constipation and was transferred to the hospital on [DATE]. Resident 90 stated he was in the hospital and underwent manual disimpaction (when a person uses their fingers to remove stool from the rectum). During a concurrent interview and record review on [DATE] at 11:40 am with Licensed Vocational Nurse (LVN) 7, Resident 90's Nursing Progress Notes, dated [DATE] was reviewed. The Nursing Progress Notes indicated, on [DATE] at 1:09 am Resident 90 asked for tramadol (pain medication -used to treat moderate to severe chronic pain) and was told the pain medication was not scheduled to be given and received Tylenol (pain medication). The Nursing Progress Notes indicated on [DATE] at 3:35 am Resident 90 called 911 for abdominal pain ranging from three to seven out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) and was given tramadol. LVN 7 stated on [DATE] Resident 90 called 911. LVN 7 stated Resident 90 was transferred to GACH for abdominal pain on [DATE] and returned back to the facility on [DATE] at 11:45 am. LVN 7 stated there was no documentation of a COC done in Resident 90's medical record. LVN 7 stated Resident 90 should have a COC documented so Resident 90's pain could be monitored and treated. During a concurrent interview and record review on [DATE] at 12:00 pm with LVN 7, Resident 90's Medication Administration Record (MAR), dated [DATE] was reviewed. The MAR indicated on [DATE] at 9:32 am, Resident 90 was given tramadol 50 milligram (mg-unit of measurement) by mouth for pain. The MAR indicated tramadol was ordered to be given every eight hours as needed for severe pain. LVN 7 stated the next dose should have been given at 1:09 am when Resident 90 asked for pain medication and was told the medication was not due yet. LVN 7 stated on [DATE] at 9:45 am Resident 90 called 911 because he wanted to go to the bathroom. LVN 7 stated 911 came because Resident 90 was unable to poop. LVN 7 stated there was no documentation of a COC done and does not see documentation of notification of Resident 90's physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:43 am with Registered Nurse Supervisor (RNS) 1 , RNS 1 stated Resident 90 was hospitalized on [DATE] after calling 911 for complaints of feeling, hot, nauseated and yelling for help. RNS 1 stated Resident 90 returned back to the facility on [DATE]. RNS 1 stated there was no documentation of Resident 90's physician being notified and documentation of a change of condition. RNS 1 stated on [DATE] at 9:45 pm Resident 90 called 911 again and was hospitalized because he was unable to poop, RNS 1 stated there was no documentation of Resident 90 being assessed prior to calling 911 no documentation of the doctor being notified about Resident 90's unable to have a bowel movement, and no documentation of Resident 90 having a change of condition. RNS 1 stated the COC should have been documented so Resident 90's condition could be monitored. RNS 1 stated the doctor should have been notified on [DATE], [DATE] and [DATE] to relay Resident 90's problem and receive further orders from the physician as needed. RNS 1 stated Resident 90 should have been assessed to know the condition of the resident. RNS 1 stated if the resident was not assessed staff will not be able to meet the resident's needs. RNS 1 stated Resident 90 refused medication for constipation and stated he wanted to go to the hospital. RNS 1 stated there was no documentation noted in Resident 90's chart that the physician was notified of Resident 90 refusing medication for constipation. During an interview on [DATE] at 1:38 pm with the Director of Nursing, the DON stated when Resident 90 was complaining of abdominal pain, nausea (the urge to vomit), feeling hot and unable to have bowel movement Resident 90 was having a change of condition. The DON stated nursing staff did not have time to assess Resident 90 for a change in condition. The DON stated when the nursing staff found out Resident 90 was having a change of condition the paramedics had already arrived to transport Resident 90 to the hospital. The DON stated the doctor was not notified when Resident 90 was having a COC. The DON stated when a resident was being transferred to the hospital a COC should be done. The DON stated Resident 90 was hospitalized on [DATE] and diagnosed with stercoral colitis. During a review of Resident 90's Order Summary, dated [DATE], the Order Summary indicated, Resident 90 returned to the facility from the GACH with a diagnoses of abdominal pain, .fecal impaction (a solid, immobile bulk of feces that can develop in the rectum) and nausea. During a review of Resident 90's GACH record dated [DATE], indicated Resident 90 was admitted for stercoral colitis. During a review of Resident 90's Radiology Report, dated [DATE], the Radiology Report indicated Resident 90 had retained stool in the colon, including a rectal stool ball measuring 7.9 centimeters transverse, with mild stranding (elongated, or twisted and plaited resembling a rope) to the rectum which may be secondary to impaction and stercoral colitis. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) The Nurse Supervisor/Charge Nurse will notify the residents Attending Physician or On-Call Physician when there has been refusal of treatment or medications (i.e., two (2) or more consecutive times) a need to transfer the resident to a hospital/treatment center. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (Interact Version 4.0) Communication Form . The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. (continued on next page)

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	056192	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44898 Based on interview and record review the facility failed to ensure one of 24 sampled resident (Resident 90) was assessed for change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) or functional status which without immediate intervention, may result in complications or death) and physician informed when Resident 90 called 911 (a phone number used to contact emergency services) on [DATE], and [DATE]. This failure resulted in Resident 90 calling 911 and transferred to general acute care hospital (GACH) on [DATE] for abdominal pain and fecal impaction (large, hard mass of stool gets stuck in the rectum and cannot pass out). On [DATE] Resident 90 was hospitalized for stercoral colitis (a rare form of inflammatory colitis (inflammation in the colon, causing symptoms such as urgent, painful, runny, or bloody stools) that can develop as a result of chronic constipation (a problem with passing stool). Resident 90 was hospitalized again on [DATE] for abdominal pain and chronic constipation. Findings: During a review of Resident 90's Admission Record, the Admission Record, the Admission Record indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastroenteritis (inflammation that spreads from the stomach into the intestines, causing pain vomiting [throwing up] and diarrhea {loose stool}), colitis (swelling of inflammation of the large intestines), and myocardial infarction (a heart attack that occurs when blood flow deceases or stops in one of the arteries of the heart). During a review of Resident 90's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 90 needed substantial to maximal assistance with eating, oral hygiene, personal hygiene, sitting, and laying. The MDS indicated Resident 90 was dependent on nursing staff for transferring, toileting bathing, and dressing. During a review of Resident 90's History and Physical (H&P), dated [DATE]. The H&P indicated Resident 90 had the capacity to understand and make decisions. During an interview on [DATE] at 10:00 a.m. with Resident 90, Resident 90 stated he called 911 three times due to abdominal pain and constipation and was transferred to the hospital on [DATE]. Resident 90 stated he was in the hospital and underwent manual disimpaction (when a person uses their fingers to remove stool from the rectum). (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 [DATE] at 11:40 am with Licensed Vocational Nurse (LVN) 7, Resident 90's Nursing Progress Notes, dated [DATE] was reviewed. The Nursing Progress Notes indicated, on [DATE] at 1:09 am Resident 90 asked for tramadol (pain medication -used to treat moderate to severe chronic pain) and was told the pain medication was not scheduled to be given and received Tylenol (pain medication). The Nursing Progress Notes indicated on [DATE] at 3:35 am Resident 90 called 911 for abdominal pain ranging from three to seven out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) and was given tramadol. LVN 7 stated on [DATE] Resident 90 called 911. LVN 7 stated Resident 90 was transferred to GACH for abdominal pain on [DATE] and returned back to the facility on [DATE] at 11:45 am. LVN 7 stated there was no documentation of a COC done in Resident 90's medical record. LVN 7 stated Resident 90 should have a COC documented so Resident 90's pain could be monitored and treated. During a concurrent interview and record review on [DATE] at 12:00 pm with LVN 7, Resident 90's Medication Administration Record (MAR), dated [DATE] was reviewed. The MAR indicated on [DATE] at 9:32 am, Resident 90 was given tramadol 50 milligram (mg-unit of measurement) by mouth for pain. The MAR indicated tramadol was ordered to be given every eight hours as needed for severe pain. LVN 7 stated the next dose should have been given at 1:09 am when Resident 90 asked for pain medication and was told the medication was not due yet. LVN 7 stated on [DATE] at 9:45 am Resident 90 called 911 because he wanted to go to the bathroom. LVN 7 stated 911 came because Resident 90 was unable to poop. LVN 7 stated there was no documentation of a COC done and does not see documentation of notification of Resident 90's physician. During an interview on [DATE] at 9:43 am with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 90 was hospitalized on [DATE] after calling 911 for complaints of feeling, hot, nauseated and yelling for help. RNS 1 stated Resident 90 returned back to the facility on [DATE]. RNS 1 stated there was no documentation of Resident 90's physician being notified and documentation of a change of condition. RNS 1 stated on [DATE] at 9:45 pm Resident 90 called 911 again and was hospitalized because he was unable to poop, RNS 1 stated there was no documentation of Resident 90 being assessed prior to calling 911 no documentation of the doctor being notified about Resident 90's unable to have a bowel movement, and no documentation of Resident 90 having a change of condition. RNS 1 stated the COC should have been documented so Resident 90's condition could be monitored. RNS 1 stated the doctor should have been notified on [DATE], [DATE] and [DATE] to relay Resident 90's problem and receive further orders from the physician as needed. RNS 1 stated Resident 90 should have been assessed to know the condition of the resident. RNS 1 stated if the resident was not assessed staff will not be able to meet the resident's needs. RNS 1 stated Resident 90 refused medication for constipation and stated he wanted to go to the hospital. RNS 1 stated there was no documentation noted in Resident 90's chart that the physician was notified of Resident 90 refusing medication for constipation. During an interview on [DATE] at 1:38 pm with the Director of Nursing, the DON stated when Resident 90 was complaining of abdominal pain, nausea (the urge to vomit), feeling hot and unable to have bowel movement Resident 90 was having a change of condition. The DON stated nursing staff did not have time to assess Resident 90 for a change in condition. The DON stated when the nursing staff found out Resident 90 was having a change of condition the paramedics had already arrived to transport Resident 90 to the hospital. The DON stated the doctor was not notified when Resident 90 was having a COC. The DON stated when a resident was being transferred to the hospital a COC should be done. The DON stated Resident 90 was hospitalized on [DATE] and diagnosed with stercoral colitis. (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 90's Order Summary, dated [DATE], the Order Summary indicated, Resident 90 returned to the facility from the GACH with a diagnoses of abdominal pain .fecal impaction (a solid, immobile bulk of feces that can develop in the rectum) and nausea. During a review of Resident 90's GACH record dated [DATE], indicated Resident 90 was admitted for stercoral colitis. During a review of Resident 90's Radiology Report, dated [DATE], the Radiology Report indicated Resident 90 had retained stool in the colon, including a rectal stool ball measuring 7.9 centimeters transverse, with mild stranding (elongated, or twisted and plaited resembling a rope) to the rectum which may be secondary to impaction and stercoral colitis. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) The Nurse Supervisor/Charge Nurse will notify the residents Attending Physician or On-Call Physician when there has been refusal of treatment or medications (i.e., two (2) or more consecutive times) a need to transfer the resident to a hospital/treatment center. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (Interact Version 4.0) Communication Form . The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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** 41699 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 12) received continues oxygen therapy via nasal canula) a device that delivers extra oxygen through a tube and into your nose). This deficient practice had the potential to affect Resident 12's breathing and could cause desaturation (low blood oxygen concentration) from not receiving adequate amount of oxygen and a fire hazard. Findings: During a review of Resident 12's Admission Order, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and schizoaffective disorder (a mental health condition). During a review of Resident 12's Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 07/05/2024 indicated Resident 12 had no cognitive (ability to think, understand, learn, and remember) impairment and requires assistance for all activities of daily living. During a review of Resident 12's care plan titled Continuous oxygen for shortness of breath due to chronic respiratory failure and lesion of the lung dated 07/02/2024 indicated interventions including to administer oxygen as prescribed and monitor for effectiveness. During an observation on 08/06/2024 at 12:11 p.m., observed Resident 12's nasal cannula was on top of her bed. Resident 12's oxygen concentrator was on, and the nasal cannula was not on Resident 12's nostril. During an observation on 08/08/2024 at 9:22 a.m., and 11:40 a.m., observed Resident 12's nasal cannula was on top of her bed. Resident 12's oxygen concentrator was on, and the nasal cannula was not on Resident 12's nostril. During an interview on 08/08/2024 at 11:43 a.m., Resident 12 stated the staff sometimes forgot to put the nasal cannula back to her nostril after personal care was provided. Resident 12 stated her call light was on the floor and she was unable to call staff to put her nasal cannula back to her nostril. During an interview on 08/08/2024 at 1:33 p.m., the Director of Staff Development (DSD) stated oxygen concentrator must be turn off when not in use for safety and prevent fire and conserve energy. During an interview on 08/08/2024 at 2:01 p.m., the Licensed Vocational Nurse (LVN 2) stated that licensed staff should ensure Resident 12 oxygen nasal cannula was in her nostril to get the oxygen therapy needed. LVN 2 stated oxygen concentrator must be off when not in use because it was a fire hazard and for safety purposes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the review of facility's policy and procedure (P&P) titled Oxygen Administration undated, indicated: The purpose of this procedure is to provide guidelines for safe oxygen administration. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, etc.) from the immediate area where the oxygen is to be administered. Place the call light within easy reach of the resident. Instruct the resident, his/her family, visitors, and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the Oxygen Safety handout.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to provide social services to three out of five sample residents (Resident 37, 93 and 94) by: a Failing to follow up on the advanced directive for Resident 37. b. Failed to follow up with dentures for Resident 93. c. Ensure Resident 94 was seen by a podiatrist (a provider who specializes in caring for the feet, ankles, and lower legs). This deficient practice had the potential to cause conflict with a resident's wishes regarding healthcare, delay the delivery of care and services, and affect the resident's psychosocial negatively. The failure of resident 94 not seen by podiatrist resulted in not having her toenail cut for six months and experience pain on her right 5th toe. Findings: a. During a review of Resident 37's Face Sheet (Admission record), the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including muscular dystrophy (group of diseases that cause progressive weakness and muscle mass loss), traumatic brain injury (TBI: a sudden, external, physical assault damages the brain) and gastroesophageal reflux disease (GERD: chronic acid reflux), During a review of Resident 37's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 7/5/2024, the MDS indicated Resident 37's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 37 is dependent on putting on/removing his footwear, required maximal assistance on all aspects of activities of daily living (ADL: toilet/oral/personal hygiene, transfer in the shower, chair/bed-to-chair transfer) aside from eating, which he required supervision. The MDS indicated Resident 37 has impairments on both of the upper extremities (arms/shoulders) and has an impairment on one side of his lower extremities. The MDS indicated Resident 37 utilized a wheelchair. During a review of Resident 37's History and Physical (H&P), the H&P indicated Resident 37 has the capacity to understand and make decisions. During a review of Resident 37's California Power of Attorney for Health Care and Health Care Instruction Form (document to assign an individual regarding your care), the California Power of Attorney form indicated an agent (individual that will make healthcare decisions in the future) that was selected, but the document did not have any dates and signatures nor did it include when the education regarding an Advanced Directive was proved to Resident 37. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/8/2024 at 12:41p.m. with Social Service Director 1 (SSD 1), SSD 1 stated she received the California Power of Attorney form two days ago and made a referral to the Ombudsman (government employee that advocates for residents). SSD 1 stated there are no dates documented on the California Power of Attorney form. SSD 1 stated Resident 37 did not have an advance directive since he wasat the facility in 2015. SSD 1 stated Resident 37 should have an advance directive to ensure he has someone that will be able to make decisions regarding his care when warranted. SSD 1 stated if the resident does not have an advance directive, she will respect their decision and will continue to educate them. B . During a review of Resident 93's Face Sheet, the Face Sheet indicated Resident 93 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including type II diabetes mellitus (diseases that affects the way the body processes blood sugar) with other circulatory (blood vessels that deliver nutrients and oxygen to the cells in the body) complications and metabolic encephalopathy (a chemical imbalance in the blood that affects the brain). During a review of Resident 93's MDS dated [DATE], the MDS indicated Resident 93's cognitive skills were mildly impaired. The MDS indicated Resident 93 required moderate assistance on all aspects of ADL's and required setup for eating. The MDS indicated Resident 93 did not have any impairments on both the upper and lower extremities and utilized a wheelchair. During a review of the Onsite Skilled Dental Care document, the onsite skilled dental care document indicated on 3/12/2024, Resident 93 had an initial X-ray done. Another onside skilled dental care document on 6/4/2024 indicated Resident 93 had a full mouth debridement (dental procedure that removes plaque building and debris from the teeth and gum) but does not mention anything regarding dentures. During an interview with 8/6/2024 at 3:06p.m. with Resident 93,. Resident 93 stated the staffs knew about his dentures since February 2024. Resident 93 stated he wanted to live in comfort and not in negligence and expressed his frustration. Resident 93 stated he has been going through the emotions of being told the facility is working on it, but nothing has happened. Resident 93 stated on 8/13/2024 he will get partial dentures for the upper and lower and stated the facility did not help him look for dentists. During an interview on 8/7/2024 at 1:33p.m. with SSD 1, SSD 1 stated Resident 93 had not mentioned anything about his dentures. During a concurrent interview and record review of the Onsite Skilled Dental Care notes on 8/8/2024 at 12:21p.m. with SSD 1, SSD 1 stated on 6/4/2024 Resident 93 had a full mouth debridement SSD 1 stated the dentist comes as needed and on the last visit on 3/12/2024, she was certain they had done an X-ray for his dentures SSD 1 stated she will follow up sometimes as needed and will follow up if the family asks for dentures or if the resident is losing weight SSD 1 stated she did not follow up from the last dental consult on 3/12/2024 to 6/4/2024 as she prefers to speak to the dental consultant in person on the day the service is provided regarding the resident's status, but there were no updates. SSD 1 stated she knew about Resident 93's dentures since February 2024 and stated she had verbal follow ups with the dental assistant, but there is no documentation to indicate this statement occurred. SSD 1 stated she should have documented when she followed up with the dental assistant so that she can keep track of the resident's dental status. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 94's Admission Record, the Admission Record indicated, Resident 94 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (a condition in which the body fails to process glucose (sugar) correctly), dorsalgia (back or spine pain), mononeuropathy of the lower limbs (nerve damage in the legs), and repeated falls. During a review of Resident 94's History and Physical (H&P), dated 12/8/2023, the H&P indicated Resident 94 had fluctuating capacity to understand and make decisions. During an interview on 8/07/2024 at 9:39 am with Resident 94, Resident 94 stated she wanted her toenails trimmed and does not remember the last time she was seen by a podiatrist. Resident 94 stated she has pain in her right toes and just wants her toenails trimmed. During an interview on 8/8/2024 at 1:27 pm with the Social Services Director (SSD), the SSD stated residents were seen by the podiatrist every two months or every 61 days. SSD stated the last time Resident 94 was seen by the podiatrist was on 2/2/2024 and the toenails were trimmed. SSD stated it was her responsibility and the nursing staff to ensure residents were seen by the podiatrist. SSD stated Resident 94 had a pending authorization from her health insurance that was placed on 7/19/2024 for a podiatrist visit. During an interview on 8/9/2024 at 9:24 am with Registered Nurse Supervisor (RNS) 1, RNS 1 stated if authorization was pending and the resident needs to see the podiatrist the facility will call a podiatrist to see the resident right away. RNS 1 stated if authorization was pending the podiatrist should have been called the next day but was not done for this resident. RNS 1 stated residents need to be seen by a podiatrist to address any issues. RNS 1 stated podiatrist comes approximately every month. RNS 1 stated Resident 94 should have been seen sooner by the podiatrist. RNS 1 stated nurses and social services were responsible to make sure residents were seen by the podiatrist. During an interview on 8/9/2024 at 2:43 pm, with the Director of Nursing (DON), the DON stated every two months residents were seen by a podiatrist. The DON stated it was important to provide foot and nail care especially for Resident 94 who has diabetes. During a review of the facility's policy and procedure (P&P) titled, Social Service Policy & Procedure Ancillary Services, undated, the P&P indicated, It is the policy of this facility to obtain dental, optometry, ophthalmology, podiatry, audiology (ENT) and psychological/psychiatric services for residents who present with or request a need for these ancillary services . All residents will be assessed for ancillary needs upon admission, and reassessed quarterly and as needed . All residents will have access to ancillary services . If the needed service is not covered by the resident's insurance, facility will attempt to obtain services, for example, through community program, private charity, or a government assistance program. During a review of the facility's P&P titled, Social Services, undated, the P&P indicated the Director of Social Services is a qualified social worker and is responsible for an adequate record system for obtaining, recording, and filing of social service data .the social services department is responsible for maintaining appropriate documentation for referrals and providing social service data summaries to such agencies, making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the resident's needs). (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Resident Rights, undated, the P&P indicated federal and state laws guarantee certain basic rights to all residents of this facility .these rights include the resident's right to a dignified existence.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to ensure psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were not used unnecessarily for one of three sampled residents (Resident 24) by failing to ensure a resident did not receive routine and as needed psychotropic drugs unless the medication was necessary to treat a diagnosed specific condition that was documented in the clinical record for Resident 24. This deficient practice had the potential to result in the use of unnecessary psychotropic drugs for Resident 24 and can lead to side effects and adverse consequences such as a decline in quality of life and functional capacity. Findings: During a review of Resident 24's Admission Record, the Admission Record indicated, Resident 24 was admitted to the facility on [DATE] with diagnosis including a mental state in which you are confused, disoriented, and not able to think or remember clearly), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 24's Admission Record, the Admission Record indicated, schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), and major depressive disorder (a common and serious medical illness that negatively affects how person feel, the way the person think and how person act), and anxiety disorder (persistent and excessive worry that interferes with daily activities) were added to diagnosis list on 5/22/2024 as new diagnosis. During a review of Resident 24's History and Physical (H&P), dated 9/25/2023, the H&P indicated, Resident 24 had the capacity to understand and make decisions. (continued on next page)

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Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 6/26/2024, the MDS indicated Resident 24 required moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, toileting hygiene shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for eating , roll left and right, sit to lying, lying to sitting on side of bed. The MDS Section N (medications) indicated, Resident 24 was taking antipsychotic (a group of drugs that have been used for treating a variety of mental disorders), antianxiety (A drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress), and opioid (A class of drug used to reduce moderate to severe pain) medications. The MDS section E (Behavior) indicated, Resident 24 had no hallucinations (an experience involving the apparent perception of something not present) or delusions (an unshakable belief in something that's untrue) and no physical, verbal other behavioral symptoms. The MDS section E indicated, Resident 24 had no behavior or rejecting care or wandering. During a review of Resident 24's General Acute Care Hospital (GACH), dated 9/15/2023, the GACH H&P indicated, Resident 24 did not have history of mental illnesses. During a review of Resident 24's Order Summary Report (OSR), dated 8/8/2024, the OSR indicated, monitor episodes of schizoaffective disorder manifested by mood swing and record total number of episodes in each shift were ordered on 5/24/2024. The OSR indicated, monitor episodes of schizoaffective disorder manifested by angry outburst and record total number of episodes in shift were ordered on 5/24/2024. The OSR indicated, monitor episodes of schizoaffective disorder manifested by paranoid ideation and record total number of episodes in each shift were ordered on 5/24/2024. The OSR indicated, monitor episodes of depression manifested by verbalization of sadness and record total number of episodes in each shift were ordered on 5/21/2024. During a review of Resident 24's OSR, dated 8/8/2024, the OSR indicated, Depakote (a medication to treat seizure and schizoaffective disorder) 125 milligram (mg) two capsules orally two times a day for schizoaffective disorder manifested by mood swing and angry outburst was ordered on 5/24/2024. The OSR indicated, Escitalopram Oxalate (a medication to treat depression) 10 mg one tablet by mouth one time a day for depression manifested by verbalization of sadness was ordered 5/21/2024. The OSR indicated, Risperdal (a medication to treat schizoaffective disorder and mood disorder) 1mg one tablet two times a day for schizoaffective disorder manifested by paranoid ideation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/8/2024, at 9:51 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 24's Medication Administration Record (MAR) dated from 6/1/2024 to 7/31/2024 was reviewed. The MAR indicated, there was no episode of verbalizing sadness, mood swing, paranoid ideation, and anger outburst from 6/1/2-24 to 7/31/2024. RNS 1 stated, schizoaffective disorder and major depression were recently added to diagnosis list on 5/22/2024 and they were not presented upon admission. RNS 1 stated, there was no episode documented on 6/2024 and 7/2024. RNS 1 stated, he recalled there was an incident on 7/27/2024. RNS 1 stated, Resident 24 was physically and verbally aggressive with staff. RNS 1 stated, Licensed Vocational Nurse (LVN) should have notified the doctor and monitor the behavior on MAR. RNS 1 stated, he agreed monitoring mood swing, anger outburst, and paranoid ideation were not specific behaviors. RNS 1 stated if the specific behaviors were not monitored, the residents who were taking antipsychotic medications would not receive proper Gradual Dose Reduction ([GDR- Consideration of a possible decrease in the dosage of the medication, discontinuation of the drug, or change to a necessary drug with minimal or fewer side effects). During a review of Resident 24's GDR, dated 7/22/2024, the GDR indicated, it was clinically contraindicated because target symptoms returned or worsened. During an interview on 8/8/2024, 12:30 p.m., with Psychiatry Physician's Assistant (PPA)1, PPA 1 stated, GDR should have attempted if the resident has no behavioral episode or reasonable number of episodes such as two or three episodes per month to prevent giving psychotropic medication excessively. PPA 1 stated, the goal was giving psychotropic medication as little as possible to control the behavior. PPA 1 stated, psychosis behaviors were like behaviors of dementia. PPA 1 stated, schizoaffective disorder was added to diagnosis, because of the regulation requirement for prescribing antipsychotic drug that required justifiable diagnosis. PPA 1 stated, healthcare practitioners should rule out those diagnosis before giving psychotropic medications to avoid giving unnecessary medications, but reality was different. PPA 1 stated, his decision for not doing GDR was based on reports from staff and staff did tell him the resident was having lots of behavior issues, but now he realized they did not document as they said. PPA 1 stated, documentation conflicted with staff's report. PPA 1 stated, the monitoring should be specific to target behaviors. PPA 1 stated, this would lead to unnecessary medication. PPA 1 stated, our goal should be providing proper amount or minimum dosage to control behaviors, otherwise, resident would suffer from unnecessary side effect. During an interview on 8/9/2024, at 9:20 a.m., with Director of Nursing (DON), DON stated, the facility should have attempted GDR for Residents 24 based on his behavioral episodes. DON stated, Resident 24 had dementia and should have considered before giving psychotropic medication. DON stated psychotropic medication use should be minimized if it was possible. DON stated, staff should have documented behavioral issue as it occurred on MAR because GDR was based on these data. DON stated, it was important to monitor specific behaviors to evaluate the effectiveness of antipsychotic medications to provide minimum effective dose for Resident 24. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Policies, undated, the P&P indicated, All residents receiving routine and/or PRN medication (s) prescribed for the control of a specific behavior or manifestation of a disordered thought process shall be monitored for effectiveness and for side effects The residents Plan of Care shall include the specific behavior(s), stated in objective and measurable terms, for which the medication is prescribed, the goal of therapy, and the common side effects of the medication. The staff shall monitor and record the occurrence of each of the specifically identified aberrant behavior (s) in the resident's health record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P itled, Tapering Medications and Gradual Drug Dose Reduction, undated, the P&P indicated, After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction. Residents who use anti-psychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, to discontinue these drugs. Policy Interpretation and Implementation The Attending Physician and staff will identify target symptoms for which a resident is receiving various medications. The staff will monitor for improvement in those target symptoms and provide the Physician with that information. During a review of the facility's P&P titled, Unnecessary Medications, undated, the P&P indicated, Each resident must receive, and the Facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Unnecessary Drug: General -Each resident's medication regimen must be free from unnecessary drugs. An unnecessary drug is any drug used: In excessive doses., including duplicate therapy; or For excessive duration. Or without adequate monitoring; or Without adequate indications for its us.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 it was free of a medication error rate of five percent or greater as evidenced by the identification of four medication errors out of 28 opportunities for errors, to yield a facility medication error rate of 10.71 percent for three of three randomly selected residents (Resident 90, 310, and 81). This deficient practice had the potential for increased pain, side effects, poor wound healing, and stomach irritation. Findings: During a review of Resident 90's Admission Record (Face sheet), the face sheet indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to gastroenteritis (inflammation that spreads from the stomach into the intestines, causing pain vomiting and diarrhea), colitis (swelling of inflammation of the large intestines), and myocardial infarction (a heart attack that occurs when blood flow deceases or stops in one of the coronary arteries of the heart). During a review of Resident 90's History and Physical (H&P) dated [DATE]. The H&P indicated Resident 90 had the capacity to understand and make decisions. During a review of Resident 90's Order Summary, dated [DATE], the Order Summary indicated, Lidocaine External Patch 5 percent apply to the left shoulder topically one time a day for left shoulder pain, on at 9 am and off at 9 pm. During an observation and interview on [DATE] at 8:59 am., Licensed Vocational Nurse (LVN) 7, LVN 7 stated the Lidocaine patch is not available for Resident 90. LVN 7 stated she will contact the doctor and notify the pharmacy. LVN 7 stated she informed the Resident and the nurse practitioner the lidocaine patch will be late. LVN 7 stated the Lidocaine patch is for Resident 90's left shoulder pain. LVN 7 stated Resident 90's left shoulder pain will increase if Resident 90 does not get the Lidocaine patch and will not be able to move his arm. During a review of Resident 310's Face sheet the face sheet indicated Resident 310 was originally admitted to the facility on [DATE] with diagnoses of but not limited to glaucoma (a group of eye diseases that causes damage to the optic nerve), cataracts (a cloudy area in the lens of the eye that can lead to a decreases in vision of the eye), legal blindness (a vision impairment), and pressure ulcers (injuries to the skin and tissue below the skin that are due to pressure on the skin for a long time of being confined to a bed or chair). During a review of Resident 310's Minimum Data Set (MDS- a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated [DATE], the MDS indicated Resident 310 usually had difficulty communicating some words or finishing thoughts but is able to if prompted or given time. The MDS indicated Resident 310 missed some parts or the intent of messages but comprehends most conversations. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 310's Order Summary, dated [DATE], the Order Summary indicated, brimonidine tartate 0.2 % one drop in the right eye three times a day for glaucoma. During an observation and interview on [DATE] at 9:19 am., LVN 7 administered one eyedrop in Resident 310's right eye and administered one eyedrop in Resident 310's left eye. LVN 7 stated she put one eye drop in the right eye and gave the medication in left eye too. LVN 7 stated the eye drop was only for the right eye. During a review of Resident 81's Face sheet, the face sheet indicated Resident 81 was originally admitted to the facility on [DATE] with diagnoses of but not limited to acute kidney failure (a condition when the kidneys suddenly stop working), end stage renal disease (occurs when chronic kidney disease- the gradual loss of kidney function reaches an advanced) dependence on renal dialysis (a machine that removes blood from your body, filters it through a dialyzer(artificial kidney) and returns the cleaned blood back to the body), and hyperkalemia (an elevated level of potassium in the blood). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 had the ability to express ideas and wants and had the ability to understand others. During a review of Resident 81's Order Summary dated [DATE], the Order Summary indicated, calcium acetate oral tablet 667 mg give two capsules by mouth three times a day to lower the phosphorus level and give with meals. During an observation on [DATE] 9:58 am, in Resident 81's room, LVN 7 gave Resident 81 Calcium Acetate 667 mg 2 capsules with water. LVN 7 stated the Calcium Acetate was given late and is supposed to be given with a meal. During an interview on [DATE] at 2:52 pm with the Director of Nursing (DON), the DON stated not following the doctor's order is a medication error. The DON stated when a medication is given in error the resident is monitored for any side effects of the medication. DON stated licensed nursing staff need to call the pharmacy five days prior to running out of the medication. DON stated medications that are given with meals are given at 7:15 am, 12 pm and 5:15 pm. DON stated if the calcium acetate was given at 9 am it is considered late and could cause an upset stomach. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview and record review, the facility failed to ensure three of three randomly selected residents (Resident 90, 310, and 81) by not administering Resident 90's lidocaine patch, by giving Resident 310 eyedrops in the wrong eye and by not giving Resident 81's calcium acetate with a meal. This deficient practice had the potential for Resident 90 experiencing increased pain, Resident 310 had the potential to develop side effects from receiving eyedrop in the wrong eye and Resident 81 experiencing stomach irritation from not receiving calcium acetate with meals. Findings: During a review of Resident 90's Admission Record (Face sheet), the face sheet indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to gastroenteritis (inflammation that spreads from the stomach into the intestines, causing pain vomiting and diarrhea), colitis (swelling of inflammation of the large intestines), pancreatic cyst (fluid filled growths in the pancreas (an organ behind the stomach that functions as a gland and is part of the digestive system and the endocrine system). During a review of Resident 90's History and Physical (H&P) dated 7/8/2024. The H&P indicated Resident 90 had the capacity to understand and make decisions. During a review of Resident 90's Order Summary dated 7/5/2024, the Order Summary indicated, Lidocaine External Patch 5 percent apply to the left shoulder topically one time a day for left shoulder pain, on at 9 am and off at 9 pm. During an observation and interview on 8/8/2024 at 8:59 am., Licensed Vocational Nurse (LVN) 7 stated the Lidocaine patch is not available for Resident 90. LVN 7 stated she will contact the doctor and notify the pharmacy. LVN 7 stated she informed the Resident and the nurse practitioner the lidocaine patch will be late. LVN 7 stated the Lidocaine patch is for Resident 90's left shoulder pain. LVN 7 stated Resident 90's left shoulder pain will increase if Resident 90 does not get the Lidocaine patch and will not be able to move his arm. During a review of Resident 310's Face sheet, the face sheet indicated Resident 310 was originally admitted to the facility on [DATE] with diagnoses of but not limited to glaucoma (a group of eye diseases that causes damage to the optic nerve), cataracts (a cloudy area in the lens of the eye that can lead to a decreases in vision of the eye), legal blindness (a vision impairment), and pressure ulcers (injuries to the skin and tissue below the skin that are due to pressure on the skin for a long time of being confined to a bed or chair). During a review of Resident 310's Minimum Data Set (MDS- a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 5/3/2024, the MDS indicated Resident 310 usually had difficulty communicating some words or finishing thoughts but is able to if prompted or given time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 310's Order Summary dated 8/1/2024, the Order Summary indicated, brimonidine tartate 0.2 % one drop in the right eye three times a day for glaucoma. During an observation and interview on 8/8/2024 at 9:19 am., LVN 7 administered one eyedrop in Resident 310's right eye and administered one eyedrop in Resident 310's left eye. LVN 7 stated she put one eye drop in the right eye and gave the medication in left eye too. LVN 7 stated the eye drop was only for the right eye. During a review of Resident 81's Face sheet, the face sheet indicated Resident 81 was originally admitted to the facility on [DATE] with diagnoses of but not limited to acute kidney failure (a condition when the kidneys suddenly stop working), end stage renal disease (occurs when chronic kidney disease- the gradual loss of kidney function reaches an advanced state) dependence on renal dialysis (a machine that removes blood from your body, filters it through a dialyzer(artificial kidney) and returns the cleaned blood back to the body) During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 had the ability to express ideas and wants and had the ability to understand others. During a review of Resident 81's Order Summary, dated 11/23/2024, the Order Summary indicated, calcium acetate oral tablet 667 mg give two capsules by mouth three times a day to lower the phosphorus level and give with meals. During an observation on 8/8/2024 9:58 am, in Resident 81's room, LVN 7 gave Resident 81 Calcium Acetate 667 mg 2 capsules with water. LVN 7 stated the Calcium Acetate was given late and is supposed to be given with a meal. During an interview on 8/9/2024 at 2:52 pm with the Director of Nursing (DON), the DON stated not following the doctor's order is a medication error. The DON stated when a medication is given in error the resident is monitored for any side effects of the medication. DON stated licensed nursing staff need to call the pharmacy five days prior to running out of the medication. DON stated medications that are given with meals are given at 7:15 am, 12 pm and 5:15 pm. DON stated if the Calcium acetate was given at 9 am it is considered late and could cause an upset stomach. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation and interviews, the facility failed to appropriately store medications that required refrigeration for two of two sampled residents (Resident 80 and 5). This deficient practice had the potential for loss of strength of the medications, and the potential for the residents to receive ineffective medication dosages. Findings: a. During a review of Resident 80's Face Sheet (Admission record), the Face Sheet indicated Resident 80 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Type two (2) diabetes mellitus (DM: body has trouble controlling blood sugar)with diabetic neuropathy (nerve damage caused by diabetes), and anemia (not having enough healthy red blood cells to carry oxygen throughout the body). During a review of Resident 80's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 7/11/2024, the MDS indicated Resident 80's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 80 is dependent on ambulating 10 feet (ft) and required maximal assistance on all aspects of activities of daily living (ADL: oral/toilet hygiene, bathing, transfer from chair/bed-to-chair) except for eating. The MDS indicated Resident 80 did not have any impairments on both the upper and lower extremities (arms and legs) and utilized a wheelchair and walker. b. During a review of Resident 5's Face Sheet (Admission record), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including Type two (2) diabetes mellitus (DM: body has trouble controlling blood sugar), hyperlipidemia (high levels of fat particle in the blood), and peripheral vascular disease (PVD: circulatory condition that reduces blood flow to limbs due to narrowed blood vessels), During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 5 required moderate assistance for bathing and toilet hygiene and required moderate assistance on all aspects of ADL, and required supervision for eating. The MDS indicated Resident 5 did not have any impairments on both the upper and lower extremities (arms and legs) and utilized a wheelchair and walker. During a concurrent interview and observation of the Medication Cart one (1) in Nursing Station 1 on 8/9/2024 at 3:57p.m. with Licensed Vocational Nurse 5 (LVN 5), there was an unopened vial of Insulin Glargine (brand name: Lantus: medication to treat diabetes) Solution 100 unit (measure that shows the concentration of a substance in a specific amount)/milliliters (mL: unit of volume) inject 50 units subcutaneously (area between skin and muscle) at bedtime for diabetes mellitus Resident 80. The medication instruction indicated to refrigerate before use and discard 28 days after date opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, there was an Insulin 10 units subcutaneously once daily and inject 12 units subcutaneous at bedtime for DM in pen form with an unopened date for Resident 5. The insulin pen indicated to refrigerate before use. LVN 5 stated Resident 5's insulin pen was open however did not have an opened date. LVN 5 stated insulin is supposed to be in the refrigerator and should be disposed properly since it is unknown how long the insulin has been in the Medication Cart 1 and will affect the potency of the medication. During a review of the facility's P&P titled, Storage of Medications, undated, the P&P indicated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs shall be stored in an orderly manner in cabinets. Drawers, carts, or automatic dispensing systems. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of 24 sampled residents (Resident 87) food preferences were honored and documented. This failure resulted in Resident 87's not receiving food items of Resident 87's choice and preference. Findings: During a review of Resident 87s Admission Record (Face Sheet), the Face Sheet indicated Resident 87 was admitted to the facility originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to diabetes mellitus (a group of diseases that affect how the body uses blood sugar), obesity, chronic kidney disease (the gradual loss of kidney function) and hyperlipidemia (high cholesterol). During a review of Resident 87's History and Physical (H&P), dated 7/18/2024, the H&P indicated Resident 87 had the capacity to understand and make decisions. During a review of Resident 87's MDS, dated [DATE], the MDS indicated, Resident 87 needed partial to moderate assistance with eating. The MDS indicated Resident 87 needed substantial to maximal assistance with oral hygiene, upper body dressing, personal hygiene, rolling from left to right, moving from a sitting position to a lying position, and moving from a lying position to a sitting position. The MDS indicated Resident 87 was dependent on staff for toileting, bathing, lower body dressing, putting on and taking off footwear, sitting, standing, and transferring. During a review of Resident 87's Order Summary, dated 7/17/2024, the Order Summary indicated, Resident 87 was on a regular renal diet with regular texture, thin regular liquid consistency and no salt on the tray. During an interview on 8/6/2024 at 10:44 am with Resident 87, Resident 87 stated the kitchen staff did not ask food likes, dislikes, and preferences. Resident 87 stated she ask for meal substitutes, but the message does not get relayed to the kitchen. Resident 87 stated she does not like mocha mix and wants regular milk and does not drink low-fat or 2 % milk. During a review of Resident 87's Dietary Profile, dated 7/19/2024, The Dietary Profile indicated, Resident 87's likes were scrambled eggs, coffee, oatmeal and breakfast meat, there was no documentation for food dislikes. The Dietary Profile indicated Resident 87 usually had milk and dairy products. During a concurrent interview and record review 8/06/24 at 2:52 PM with the Dietary Supervisor (DS), Resident 87's Nutritional Review Screening, dated 7/25/2024 was reviewed. The Nutritional Review Screening indicated, there was no documentation for food dislikes and no documentation of exactly what Resident 87's food preferences were. DS stated food preferences, likes and dislike are documented upon admission, as needed, when there is a change, and if the resident is sending food back not eaten. DS stated Resident 87 is getting mocha mix because she does not like milk. (continued on next page)

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	056192	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/06/2024 at 3:19 pm with the Registered Dietician (RD), RD stated on 7/20/2024 upon admission Resident 87 diet was supposed to be changed back to regular milk and does not know why Resident 87 is still receiving Mocha Mix. RD stated the beverage did not get changed on Resident 87's diet. During a review of Resident 87's breakfast menu, dated 8/6/2024, the breakfast menu indicated Resident received four fluid ounces of Mocha mix. The breakfast menu indicated Resident 87's dislike was coffee. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, undated, the P&P indicated, Substitutes for all foods dislikes will be given from the appropriate food group .Food preferences will be obtained as soon as possible through resident screen. This screening must be completed within 7 days of admission the FNS Director .Updating of food preferences will be done as the resident's needs change and/or during quarterly review. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences/Diet Liberalization, undated, the P&P indicated, Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the Dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a microscope) that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for 106 out 108 total residents in the facility by not: A. Ensuring Foods were dated, labeled, and discarded before the used by date (expiration dates). B. Ensuring Dietary Aid (DA) 2 performed hand hygiene (washing hands) and changed gloves between tasks during tray line (Resident's trays are assembled and check for accuracy before food is delivered to them). C. Ensuring [NAME] 2 took off her wristwatch that was not covered with gloves during tray line. These failures had the potential to affect residents and result in pathogen (germ) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, and can lead to other serious medical complications and hospitalization . Findings: A. During a concurrent observation and interview on 8/6/2024, at 8:22 a.m., with [NAME] 1, in dry storage room [ROOM NUMBER], there were food items that were not dated, properly sealed, and discarded before the used by date as follows: a.Opened and used vanilla pudding mix in zip lock bag with Receiving Date (RD- the day of delivery) of 6/27/2024, Open Date (OD) of 8/3/2024, and no Used By (UB). b.Opened and used lemon gelatin mix wrapped with plastic wrap which was inside of a large plastic container with RD of 4/11/2024, no OD, and no UB. c.Opened and used Nilla wafer cookies in zip lock bag with RD of 7/25/2024, no OD and no UB. d.Opened and used potatoes chips in a plastic bin with no RD, OD of 7/31/2024, no UB. The Lid of the plastic bin was not closed tightly. e.Opened and used linguine pasta in a plastic bin with RD of 5/16/2024, no OD and no UB. The Lid of the plastic bin was not closed tightly. f.Opened and used fettuccine pasta in a plastic bin with RD of 5/13/2024, OD of 5/16/2024 and no UB. The Lid of the plastic bin was not closed tightly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g.Opened and used lasagna in a plastic bin with RD of 5/16/2024, no OD and no UB. The Lid of the plastic bin was not closed tightly. h.Opened and used Blueberry muffin mix in zip lock bag with RD of 4/2/2024, OD of 6/5/2024, and no UB. Cook 1 stated, all food items should have been labeled with receiving date when the facility got delivery from vendors. [NAME] 1 stated, all food items should have open date and used by date (expiration date). During an interview on 8/6/2024, at 8:29 a.m., with Dietary Supervisor (DS), DS stated, it was all dietary staff (including herself) responsibility to check all food items for labels, dates, properly stored and sealed. DS stated these practices were important to make sure all food items were in good condition because the residents consumed these food items. DS stated, all lids should be closed tightly to prevent contamination (the unwanted pollution of something by another substance). DS stated, she would provide in-service for dry food storage guidelines, because once the food items were opened, there should be different shelf life (a time limit on how long a product can be stored before it becomes unsuitable for consumption or use). DS stated, all staff should refer Dry Goods Storage Guidelines for shelf life after opening and labeled UB date on food items. During a concurrent observation and interview on 8/6/2024, at 8:45 a.m., with DS, in refrigerator #1, there were food items that were not dated, properly sealed, and discarded before the used by date as follows: a.Breadcrumbs in a metal bin covered with plastic wrap with preparation date of 8/2/2024 and no UB. b.Cloves of garlic in a plastic bottle container with no RD, OD of 7/31/2024, and no UB. c.Cilantro in unsealed plastic bag with RD of 7/24/2024 and no UB. DS stated, all food items should be dated, and dietary staff should follow Refrigerated Storage Guide to ensure safety of perishable items that required refrigeration. DS stated, she could not find the produce storage guideline and breadcrumbs UB information. DS stated, she could not tell me how long breadcrumbs, cloves of garlic, and cilantro could last in refrigerator. During a review of the facility's Policy and Procedure (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated, Dry bulk foods should be stored in seamless metal or plastic containers with tight covers, Labels should be visible, and the arrangement should permit rotation of supplies so that oldest items will be used first. All food will be dated-month, day, year. All food products will be used per the times specified in the Dry Food Storage Guidelines, Dry food items which have been opened will be tightly closed, labeled, and dated. During a review of the facility's P&P titled, Dry Goods Storage Guidelines, dated 2023, the P&P indicated, pudding mixes' shelf life (the period during which a material may be stored and remain suitable for use) was three months after opening. The P&P indicated; gelatin mix's shelf life was three months after opening. The P&P indicated; potatoes chips' shelf life was one week after opening. The P&P indicated; dry pasta's shelf life was one year after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, the P&P indicated, . All refrigerated foods are to be kept the amount of time per the Refrigerated Storage Guidelines , Produce will be delivered frequently and rotated in the order it is delivered to assure that a fresh product is used, free of any wilting or Spoilage. During a review of the facility's P&P titled, Produce Storage Guidelines, undated, the P&P indicated, diced or open cloves of garlic's shelf life was three days. [NAME] like parsley's shelf life was three to five days. During a review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, the P&P indicated All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered to facility needs to be marked with a received date. B. During a concurrent observation and interview on 8/6/2024, at 11:45 a.m., with DA 2 during tray line, DA 2 went to Refrigerator #3 and grabbed the doorknob while wearing her gloves. DA 2 took out small bowls of fruit salads and placed them in an ice filled plastic bin without changing gloves. DA 2 went to ice machine and scooped ice without changing gloves or washing her hands. DA 2 pour ice cubes into the plastic bin and put scooper back without washing hands or changing gloves. DA 2 handed the fruit salad bowls to another DA without washing hands or changing gloves. DA 2 stated, she should have washed her hands and changed gloves between tasks to prevent cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another). During a review of the facility's Policy and Procedure (P&P) titled, Handwashing, dated 2023, the P&P indicated All employees will be instructed in the proper procedure of hand washing. Employee hands must be washed frequently in the hand washing sink or designated sink for hand washing. During a review of the facility's P&P titled, Glove Use Policy, dated 2023, the P&P indicated, The appropriate use of gloves is essential in preventing food borne illnes, Gloved hands are considered a food contact surface that can get contaminated or soiled. Disposable gloves are a single use item and should be discarded after each use, and especially before handling clean food items ,Wash hands when changing to a fresh pair. Gloves must never be used in place of hand washing. When Gloves need to be changed, Before beginning a different task. C. During a concurrent observation and interview on 8/6/2024, at 12:30 a.m., with [NAME] 2 during tray line, cook 2 was wearing gold wristwatch and half of it was not covered with her gloves while assisting [NAME] 1 to checking the temperature for tray line. [NAME] 2 stated, she was not sure if she could wear her wristwatch in the kitchen during preparing meal. During an interview on 8/6/2024, at 12:33 p.m., with Registered Dietitian (RD), RD stated, all staff should perform hand hygiene and wear Personal Protective Equipment ([PPE]- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) such as gloves properly to prevent spreading germs and cross contamination. RD stated, Jewelry and wristwatch should be off during the meal preparation for infection control purpose. During a review of the facility's P&P titled, Dress Code, dated 2023, the P&P indicated, No excessive jewelry, just wedding rings on hand, non-dangling earrings on ears, and wristwatch. Wristwatch and wedding rings need to be covered with gloves when handling food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 46415 Based on observation, interview and record review, the facility failed to implement infection control measures by failing to: A. ensure gowns were worn for two of 24 sampled residents (Resident 4 and Resident 213) when changing bed linen and touching the urinary catheter bag (a receptacle that serves as a container or collector for urine as it leaves the body and passes through the catheter tube). B. remove gloves from the dispensing box before administering medication to Resident 25. C. Ensure placing correct isolation signage and following proper Personal Protective Equipment ([PPE]- equipment used to prevent or minimize exposure to hazards) requirement for Resident 62. These failures resulted in compromised infection control measures to prevent infectious disease among residents, staff, and visitors. Findings: a. During a review of Resident 4's Face Sheet (Admission record), 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 gastrostomy (a procedure to make a hole into the stomach through the abdomen to insert a feeding tube), malignant neoplasm of pharynx (cancer that develops in the throat), radiation therapy (treatment that uses beams of intense energy to kill cancer cells) During a review of Resident 4's Minimum Data Set (MDS- a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 6/11/2024, the MDS indicated Resident 4 needed supervision or touching assistance with eating, and oral hygiene. The MDS indicated Resident 4 needed partial to moderate assistance with upper body dressing, transferring sitting, standing, and walking. The MDS indicated Resident 4 needed substantial to maximal assistance with toileting, showering, lower body dressing, taking off and putting on footwear, and personal hygiene. During a review of Resident 213's Face Sheet, the Face Sheet indicated Resident 213 was admitted to the facility on [DATE] with diagnoses of but not limited to neuromuscular dysfunction of the bladder (a problem in the brain, spinal cord or central nervous system that causes loss of control of the bladder), urinary tract infection(an infection in any part of the urinary system), hematuria (the presence of blood in the urine), and difficulty walking. During a review of Resident 213's MDS, dated [DATE], the MDS indicated Resident 213 needed supervision or touching assistance with eating. The MDS indicated Resident 213 needed substantial to maximal assistance with oral hygiene, dressing, personal hygiene, and transferring. The MDS indicated Resident 213 was dependent on staff for toileting, showering, putting on and taking off footwear, and getting on or off a toilet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/6/2024 at 11:32 am in Resident 4's room, there was a sign by the door indicating Enhanced Based Precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). Certified Nursing Assistant (CNA) 1 was assisting Resident 4 with ADLs and changing the bed linen for Resident 4. CNA 1 was not wearing a gown in an Enhanced Barrier Precaution room. During an interview on 8/6/2024 at 11:49 am with Certified Nursing Assistant 1, CNA 1 stated Resident 4 had gastrointestinal tube. CNA 1 stated PPEs (personal protective equipment is protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from infection) are kept inside the resident's room. CNA 1 stated that gowns and gloves are worn in EBP room. CNA 1 stated she wears a gown with other EBP residents but did not for Resident 4 because she was in rush and she forgot. CNA 1 stated PPE is worn in EBP rooms to protect the resident and to protect staff from infection, blood, or bodily fluids. During an observation on 8/7/24 10:17 am in Resident 213 room, there was a sign by the door indicating Enhanced Based Precautions. Resident 213 was lying in bed with a foley bag hanging from the right side of the bed. During an interview on 8/7/2024 at 10:27 am with CNA 7, CNA 7 stated Resident 213 has a foley for EBP and kneeled to cover Resident 213 urinary catheter with a privacy bag without wearing a gown. CNA 7 stated she is supposed to wear a gown and forgot to wear a gown. CNA 7 stated wearing a gown in a EBP room is for everybody's protection for infection control. During an interview on 8/8/2024 at 4:19 pm with the Infection Preventionist Nurse (IPN), IPN stated EBP are for residents with MDRO, wounds, Foley catheter (a sterile tube inserted into the bladder to drain urine), g-tube (gastric tube is a surgically placed device that offers direct access to the stomach through a surgical cut in the left upper side of the abdomen used for feeding), and dialysis (a machine that removes blood from your body, filters it through a dialyzer(artificial kidney) and returns the cleaned blood back to the body). IPN stated a mask, gown, and gloves are worn during close contact with residents to help protect from increased risk of infection, recurrent infection, and exposure to bodily fluids. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, undated, the P&P indicated Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). EBPs involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. b. During a review of Resident 25's Face Sheet , the Face Sheet indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including atherosclerosis, are related osteoporosis (a bone disease that causes the structure and strength of bone to change), cervicalgia (pain in or around the spine beneath the head), low backpain, and cervical disc degeneration (a condition affecting the neck's spinal disc that causes pain and discomfort). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25's MDS dated [DATE], the MDS indicated Resident 25's cognitive skills were intact. The MDS indicated Resident 25 is dependent on chair/bed to chair transfer, toilet hygiene, and shower transfer, required maximal assistance on dressing, personal hygiene, sit to stand, required moderate assistance for oral hygiene, and required supervision for eating. The MDS indicated Resident 25 did not have any impairments on both the upper and lower extremities and utilized a wheelchair. During a medication administration observation on 8/8/2024 at 9:12a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 was observed removing her gloves after applying Lidocaine External Cream four (4) percent (%) on the bilateral lower extremities topically (on the skin) two times a day for neuropathy (nerves that are located outside of the brain and spinal are damaged). LVN 4 she was seen reaching into her right pocket and removed gloves from her pocket and proceeded to administer the next medication. During an interview on 8/8/2024 at 9:20a.m. with LVN 4, LVN 4 stated putting gloves in her pocket is not a standard practice since we do not know what is inside the pocket and can contaminate the gloves, exposing residents to infection. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, undated, the P&P indicated when applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. c. During a review of Resident 62's Face sheet , the Face sheet indicated, Resident 62 was initially admitted to the facility on [DATE] and last readmission was 7/27/2024 with diagnosis including extended spectrum beta lactamase ([ESBL]- enzymes produced by some bacteria that may make them resistant to some antibiotics) resistance, sepsis (a serious condition in which the body responds improperly to an infection), multiple pressure injuries (the breakdown of skin integrity due to pressure) and dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 required dependent assistance (from two or more staff for roll left and right, sit to lying, lying to sitting on side of bed, toilet hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, upper body dressing, and maximal assistance from one staff for oral hygiene. The MDS indicated eating was not attempted due to medical condition or safety concerns. During a concurrent observation and record review on 8/6/2024, at 11:38 a.m., with LVN 3, there was signage placed on the wall of the Resident 62's room next to the door. The signage indicated, red cohort isolation (isolation for airborne infection) which required N 95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles), goggle, gown, and gloves before entering the Resident 62's room. LVN 3 entered the room after using hand sanitizer and wearing gloves only. LVN 3 did not wear N 95 respirator, goggle, and gown while providing care. LVN 3 stated, the signage was incorrect, because Resident 62 did not have airborne (infectious agents transmitted by air) infection. LVN 3 stated, Resident 62 should be contact isolation for ESBL in urine which required gown and gloves. LVN 3 stated, he should have checked the isolation signage and should have worn the gown and gloves before entering the room. LVN 3 stated, it was important to wear proper PPE to protect himself and the resident from infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/2024, at 11:42 a.m., with IPN, IPN stated, Resident 62 had ESBL in urine and the resident's condition did not require N-95 and goggle as the signage indicated. IPN stated, Resident 62 should be contact isolation instead. IPN stated, incorrect signage would mislead staff to wear incorrect PPE and there would be risks for improper treatment and isolation. IPN stated, it was important to place correct isolation signage and wear proper PPE to prevent ineffective infection control. During an interview on 8/9/2024, at 9:20 a.m. with Director of Nursing (DON), DON stated, infection control was important to protect residents and staff. DON stated, staff should place right isolation and wearing PPE according to isolation protocol to reserve unnecessary use of PPE and effective infection control. During a review of Resident 62's Order Summary Report (OSR), dated 7/31/2024, the OSR indicated, contact isolation for ESBL in urine was ordered on 7/29/2024. During a review of the facility's Policy and Procedure (P&P) titled, Isolation - Categories of Transmission-Based Precautions, undated, the P&P indicated, Staff and visitors will wear glov.es.(.clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves will be removed, and hand hygiene performed before leaving the room. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is remove. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, undated, the P&P indicated prevention of Infection: a. important facets of infection prevention including implementing appropriate isolation precautions when necessary. 46537

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to implement antibiotic stewardship program (measures used by the facility to ensure antibiotics [drug to treat infection] are used only when necessary and appropriate) for three of four sampled residents (Resident 12, 78, and 100) This failure had the potential to put Resident 12,78 and 100 at risk for antibiotic resistance (not effective to treat infection) and inappropriate use of antibiotic. Findings: 1.During a review of Resident 12's Admission record, the Admission Record indicated Resident 12 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including pneumonia (lung infection that causes the lungs to fill with fluid or pus leading to inflammation), difficulty walking, and localized edema (swelling caused by fluid building up in the body's tissues). During a review of Resident 12's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 7/5/2024, the MDS indicated Resident 12's cognitive (ability to think, understand, learn, and remember) skills were intact. The MDS indicated Resident 12 was dependent on putting on/off footwear, required maximal assistance on transferring from chair/bed-to-chair, rolling, lying side to side, dressing, bathing, and toilet hygiene, required moderate assistance on personal/oral hygiene, and required supervision for eating. During a review of Resident 12's laboratory (lab) results report, the lab results report indicated on 4/5/2024 at 7:31a.m., Resident 12's white blood count (WBC: type of cell that helps fight infections and disease) was 6.8 thousand of cells per microliter (cells/?L) (reference range is 4.0 to 10.5). During a review of Resident 12's Change of Condition (COC) Evaluation dated 4/3/2024, the COC indicated Resident 12's left foot noted to have redness, warm, swelling, and tender to the touch. Resident 12's blood pressure was 116/66 millimeters of mercury (mm/Hg- a unit used to measure pressure [normal range 120/80 or lower]), temperature was 97.4 Fahrenheit (F) (normal range 97 F to 99 F), pain level zero (0) out of 10 with no mental status changes, functional status, and respiration. The nursing notes indicated an order from the Physician's Assistant 1 (PA 1) for Clindamycin Hydrochloride (HCL: an antibiotic used to treat a wide variety of bacterial infections) oral capsule 300 milligram (mg: a unit of measurement for mass) one capsule by mouth three times a day for left foot cellulitis (a deep bacterial infection of the skin) for 10 days. During a review of Resident 12's Radiology Results Report (formal document that summarizes the results of an imaging test) dated 4/4/2024, the radiology report indicated Resident 12's left food had no fractures, dislocations, free from trauma with no changes in the soft tissues and had minor left foot degenerative joint disease (chronic condition that occurs when the tissues in a joint break down over time). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's McGeer's Criteria for Infection Control Surveillance (a document to identify whether the symptoms meet the criteria for definitive infection) dated 4/3/2024, the McGeer's criteria indicated the type of infection was other infections (left foot cellulitis) with an onset date of 4/3/2024 due to signs and symptoms of redness, swelling, warm, and tender to touch. There was a new note indicating a different antibiotic was ordered: Keflex (generic name: Cephalexin: antibiotic medication that treats bacterial infections) oral capsule 500 mg one capsule by mouth every eight hours for left foot cellulitis for seven days. During a review of the Medication Administration Record (MAR: electronic documentation that records the medications given) in April 2024, the MAR indicated Clindamycin HCL was discontinued on 4/4/2024. During a concurrent interview and record review on 8/8/2024 at 5:03 p.m. with Infection Preventionist Nurse (IPN), IPN stated Resident 12 was admitted on [DATE] and on 4/3/2024, Resident 12 had a left foot cellulitis due to redness, swelling, warm to the touch, and was on antibiotic treatment Keflex 500mg for every eight hours for seven days. IPN stated Resident 12's lab results dated 4/5/2024 indicated her WBC was 6.8. IPN stated when there was an inflammation (a response from the body's immune system to an irritant like an infection or injury), there will be an increase in WBCs, but Resident 12's WBC was within range. IPN stated she followed McGeer's Criteria and indicated Resident 12 met the criteria for antibiotics. IPN stated she would know whether the antibiotic was working based on the skin reassessment, decrease in size of the cellulitis, and based on labs. 2. During a review of Resident 78's Admission Record, the Face Sheet indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including coronary angioplasty (procedure to open clogged vessels in the heart), congestive heart failure (CHF: complex condition that occurs when the heart cannot pump blood efficiently), cardiac pacemaker (battery operated implantable device to help regulate the heart rhythm), and irritant contact dermatitis due to friction (inflammation of skin from repeated exposure to something). During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78's cognitive skills were mildly impaired. The MDS indicated Resident 78 was dependent on all aspects of performing activities of daily living (ADL: toileting, oral/personal/toilet hygiene, dressing, transferring from chair/bed to chair and required maximal assistance for eating. During a review of the McGeer's Criteria for Infection Control Surveillance dated 7/13/2024, the McGeer's criteria indicated the Resident 78 had a respiratory tract infection. Resident 78 temperature was 98 F with a heart rate of 60 (normal range of 60 to 100), blood pressure of 138/92, respiration rate of 18 (normal range 12 to 20), heart rate of 60, and zero out of 10 pain level. Resident 78 had a chest x-ray due to wheezing (a high-pitched whistling sound made when air moves through narrowed tubes in the lungs) and showed a lower left lobe (one of two lobes in the left lung) infiltrate (accumulation in a tissue or cells of foreign substances in excessive amounts). Resident 78 was ordered Levaquin (antibacterial medication to treat bacterial infections) 500mg. Resident 78 did not have a cough or fever and signs and symptoms noted were wheezing and generalized weakness. During a review of the MAR in July 2024, the MAR indicated Resident 78 received Levaquin Oral Tablet 500mg (Levofloxacin) one tablet by mouth in the evening for left lower lobe infiltrate for seven days from 7/13/2024 to 7/19/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the COC dated 7/31/2024, the COC indicated Resident 78 had a right arm cellulitis with a blood pressure of 122/74, heart rate of 70, temperature of 97.5 F with an oxygen level of 98 percent (%). The COC did not indicate Resident 78 had any mental, functional, respiratory, or cardiac changes and remained at baseline (initial measurement of a condition that prior to any changes). The note indicated Resident 78 was to receive Clindamycin HCL oral capsule 300 mg three times a day for 10 days for right arm cellulitis. During a review of the MAR in August 2024, the MAR Resident 78 received Clindamycin Hydrochloride (HCL: an antibiotic used to treat a wide variety of bacterial infections) from 8/1/2024 to 8/6/2024. During a review of Resident 78's lab results report, the lab results report indicated on 7/15/2024 at 9:12a.m., Resident 78's white blood count (WBC: type of cell that helps fight infections and disease) was 3.0 thousand of cells per microliter (cells/?L) (reference range is 4.0 to 10.5). Another lab report dated 7/12/2024 at 4:47p.m. indicated Resident 78's WBC was 3.9 (cells/?L). During a concurrent interview and record review on 8/8/2024 at 4:53p.m. with IPN, IPN stated Resident 78 was admitted to the facility on [DATE] and on 7/13/2024 Resident 78 had a respiratory tract infection due to a result of her chest x-ray indicating left lower infiltrates. IPN stated on the McGeer's Criteria documented on 7/13/2024, instead of selecting respiratory tract infection, the infection for lower respiratory tract infection should have been selected and was documented incorrectly. IPN stated the COC dated 7/13/2024 indicated Resident 78 was having signs and symptoms of wheezing with a WBC of 3.9. IPN stated she would have selected pneumonia as the infection despite Resident 78 not having an actual diagnosis of pneumonia. IPN stated the chest x-ray met the McGeer's Criteria, but only one of the respiratory subcriteria was met when two were required to meet the criteria. IPN stated the doctor prescribed antibiotics Levaquin 500 mg for seven days since the resident was properly diagnosed and the orders were carried out. IPN additionally stated the charge nurses will document after the last antibiotics have been administered, but not all antibiotics require post monitoring. 3. During a review of Resident 100's Admission record, indicated Resident 100 was admitted to the facility on [DATE] with diagnoses including cellulitis (common and potentially serious bacterial skin infection) of right upper limb (arms/shoulder), unstageable (when the stage is undeterminable) pressure ulcer (bed sore caused by prolonged pressure on one specific area) of the sacral (bottom of the spine) region, local infection of the skin and subcutaneous (deepest layer of the skin closest to the muscle) tissue, irritant contact dermatitis due to friction (inflammation of skin from repeated exposure to something), and cellulitis of groin (area between the stomach and the thigh). During a review of Resident 100's MDS dated [DATE], the MDS indicated Resident 100's cognitive skills were intact. The MDS indicated Resident 100 required moderate assistance for bathing, chair/bed to chair transfer, dressing upper (arms and shoulders) and lower body (legs and hips) dressing, toilet hygiene, required supervision for oral/personal hygiene, and required set up for eating. During a review of the Order Summary Report (Physician Order), the order summary indicated an active order date on 6/19/2024 for Clindamycin Hydrochloride (HCL: an antibiotic used to treat a wide variety of bacterial infections) oral capsule 300mg one capsule by mouth two times a day for the left buttock until 9/11/2024. The order summary additionally indicated an active order on /19/2024 for Rifampin (medication used to treat a wide selection of bacterial infections) oral capsule 300mg one capsule by mouth every 12 hours for left buttock until 9/11/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Treatment Administration Record (TAR: electronic documentation for treatments administered to the resident), the TAR indicated Resident 100 has been receiving treatment for left buttock superficial area (old puncture like site) cellulitis area: cleanse with normal saline (NS: mixture of salt and water used to clean wounds), pat dry, apply bacitracin (topical antibiotic ointment to treat minor skin injuries such as cuts, scrapes, and burns) ordered on 6/19/2024. Resident 100 additionally received treatment for his surgical line wound to clean with normal saline and apply bacitracin with an order date of 6/14/2024. During a review of Resident 100's lab results report, the lab results report indicated on 7/18/2024 at 1:58p.m. , Resident 100's white blood count (WBC: type of cell that helps fight infections and disease) was 7.6 thousand of cells per microliter (cells/?L) (reference range is 4.0 to 10.5). During a review of the General Acute Care Hospital (GACH) hospital record dated 5/19/2024, the hospital record indicated Resident 100 was admitted to the hospital due to a bug bite on the right forearm with ulcerating and draining wound with severe pain with movement and had a WBC of 24.8 on 5/19/2024. The wound culture taken indicated a positive Group A streptococcus (GAS: type of bacteria that causes infections in the skin and soft tissue) Resident 100's discharge summary on 5/24/2024 indicated the WBC on 5/23/2024 at 9.4. During a review of the McGeer's Criteria for Infection Control Surveillance dated 5/25/2024, the McGeer's criteria indicated the Resident 100 had cellulitis, soft tissue, or wound infection with a temperature of 97.2 F, heart rate of 74 and respirations of 18. Resident 1000 had heat, redness, swelling, and tenderness at the affected site. The antibiotic stated on 5/25/2024 included Clindamycin HCL 150mg three capsules by mouth three times a day for right forearm cellulitis for five days (until 5/30/2024) and Doxycycline Monohydrate (antibiotic that treats many types of bacterial infections) oral capsule 100mg by mouth every 12 hours for right forearm cellulitis for 90 days. During a review of the GACH hospital record dated 6/8/2024, the hospital record indicated Resident 100 was admitted to the hospital due to progressive purulent discharge (thicky milky fluid from wound that indicates infection) and pain from the buttocks and behind the legs that was worsening the last four days with a WBC of 10.6. The WBC taken on 6/9/2024 indicated 7.7 and Resident 100's discharge summary on 6/11/2024 indicated new medications for Clindamycin 300mg one capsule two times a day for three months and Rifampin 300mg oral capsule one capsule two times a day for three months. During a review of the McGeer's Criteria for Infection Control Surveillance dated 6/11/2024, the McGeer's criteria indicated the Resident 100 had cellulitis on the bilateral groin with a blood pressure of 127/63, heart rate of 66, and respirations of 16. Resident 100 had redness, warmth, swollen, and tenderness at the affected site. Initial order indicated to clean the bilateral groin with Dakin's full strength zero-point 5 (0.5) topical solution (used to prevent and treat skin and tissue infections) and apply Clindamycin 1% topical solution twice a day, Clindamycin HCl 300mg one capsule by mouth two times a day and Rifampin oral capsule 300mg one capsule by mouth every 12 hours bilateral inguinal (groin) region for three months. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the McGeer's Criteria for Infection Control Surveillance dated 6/19/2024, the McGeer's criteria indicated Resident 100 had cellulitis with a temperature of 97.4 F, heart rate of 67, respiration of 18, and symptoms of heat, redness, swelling, tenderness, and serous drainage at the affected site. The notes indicated on 6/19/2024, the oral antibiotics will be given to the left buttock area per assessment of 3.7 centimeter (cm: unit of length) by 2.8cm superficial area with scant serous drainage, tender to touch, warm, redness, and slightly swollen. Rifampin oral capsule 300mg will be given every 12 hours for the left buttock wound site and Clindamycin HCl oral capsule 300mg two times a day for left buttock. During a review of the wound assessments for Resident 100, the wound assessment indicated the following: 8/6/2024: Left scrotal region open wound with measurements of 3.0 by 0.4 indicated moderate serous drainage with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics by mouth and topical bacitracin. 7/30/2024: Left scrotal region open wound with measurements of 3.5 by 0.4 indicated moderate serous drainage serous with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics by mouth and topical bacitracin. 7/23/2024: Left scrotal region open wound with measurements of 3.5 by 0.4 indicated moderate serous drainage with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics by mouth and topical bacitracin. 7/16/2024: Left scrotal region open wound with measurements of 3.5 by 0.4 indicated moderate serosanguinous drainage with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics Rifampin and Clindamycin by mouth and topical bacitracin. 7/9/2024: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Left scrotal region open wound with measurements of 3.5 by 0.4 indicated light serous drainage with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics Rifampin and Clindamycin by mouth and topical bacitracin. 7/2/2024: Left scrotal region open wound with measurements of 3.7 by 0.4 indicated scant serous drainage with no order and was pink and treatment to remain on antibiotics by mouth and topical bacitracin. Left buttock superficial cellulitis with measurements of 3.0 by 2.6 indicated scant serous drainage with no order and was pink with treatment to remain on antibiotics Rifampin and Clindamycin by mouth and topical bacitracin. During an interview on 8/6/2024 at 10:41a.m. with Resident 100, Resident 100 stated he has cellulitis and has had drainage on the scrotum and buttocks and indicated it has not gotten better. Resident 100 stated he receives a few antibiotics, but they were not working and believes the facility should do blood culture or take samples. Resident 100 expressed the doctors were not assessing him properly. During an interview on 8/8/2024 at 4:31p.m. with IPN, IPN stated the purpose of an antibiotic stewardship was to have a reason for every antibiotic to ensure they are diagnosing the resident properly as you do not want to over administer antibiotics as the over usage of antibiotics can make the resident become resistant and dependent on antibiotics and can cause additional infections. During a concurrent interview on 8/9/2024 at 10:10a.m. with Director of Staff Development (DSD) and Registered Nurse Supervisor 2 (RNS 2), DSD stated the McGeer's Criteria was a tool used to help identify whether it was a true infection however at times it was upon the doctors discretion, depend on the resident, and if a resident was admitted to the facility with antibiotics, the antibiotics will be continued at the facility until the end date and will notify the doctor. RNS 2 stated to identify whether an antibiotic has worked or not was to reassess the skin, see if there was no swelling or pain, and depending on the infection, check the labs for WBC or culture. During an interview on 8/9/2024 at 10:16 a.m. with RNS 2, RNS 2 stated from 6/11/2024 to 9/11/2024, Resident 100 will be getting antibiotics due to underlying health conditions and was imperative he receives the antibiotics to prevent sepsis and the nurses will document any changes to the resident since he will be using antibiotics long term. RNS 2 residents on antibiotics requires a McGeer's Criteria. During a concurrent interview and record review on 8/9/2024 at 10:57 a.m. with RNS 2, RNS 2 stated the hospital record on 6/8/2024 indicated Resident 100 had a WBC of 7.7 and the dermatology (medicine dealing with skin) had recommended the antibiotic due to recurrent sites and complicated wound infections. RNS 2 stated Resident 100 came back to the facility on [DATE] and indicated they do not necessarily need a wound culture, and if there were any culture and sensitivity, the hospital will inform the facility. RNS 2 stated on his second hospitalization on [DATE], a wound culture was not recommended. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the wound culture on 8/9/2024 at 11:16 a.m. with RNS 2, RNS 2 stated the wound consult assessment for the left buttock size went as followed: 8/6/2024: 3.0 by 2.6 7/30/2024: 3.0 by 2.6 7/23/2024: 3.0 by 2.6 7/16/2024: 3.0 by 2.6 RNS 2 stated the wound size has been the same, but the appearance may look better. RNS 2 stated the WBC for 7/18/2024 was 7.6 which was in normal range. RNS 2 stated if the infectious site was improving with no puss or drainage, the resident would still require antibiotics, however they can do a culture and sensitivity test at that time to determine whether the resident would continue requiring the antibiotic or not. During a review of the facility's policy and proedures (P&P) titled, Antibiotic Stewardship, undated, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. When a culture and sensitivity (C&S) is ordered lab results will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued; and changed to antibiotic orders based on C&S will be reviewed by the facility infection preventionist or a pharmacist. During a review of the facility's P&P titled, Infection Prevention and Control Program, undated, the P&P indicated antibiotic stewardship: culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities .medical criteria and standardized definitions of infections are used to help recognize and manage infections. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews.