STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056218	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to obtain informed consent for psychotropic medications (drugs that affect a person's mental state) from one of five sampled residents (Resident 45) responsible party (RP), informed consent was obtained from Resident 45's family member (FM) 2, who was not Resident 45's RP. This deficient practice resulted in Resident 45 receiving sertraline (a medication used to treat depression) and aripiprazole (a medication used to treat mental disorders, including depression) without her knowledge or explicit consent. This deficient practice also placed Resident 45 at risk for experiencing unwanted adverse effects of the medication, including increased risk of suicidal thoughts and other mental status changes. Findings: During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility on [DATE], and most recently readmitted Resident 45 on 4/16/2024. Resident 45's admitting diagnoses included depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 45's History and Physical (H&P), dated 7/3/2024, the H&P indicated Resident 45 had the capacity to understand and make medical decisions. During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 10/22/2024, the MDS indicated Resident 45 had mild cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 45 required supervision to total dependence on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 45's Admission Agreement Signature Sheet, dated 4/16/2024, the document indicated Resident 45 signed her own consent for treatment. During a review of Resident 45's discontinued physician orders, dated 4/16/2024 to 11/7/2024, the orders indicated Resident 45 received Aripiprazole 5 milligrams (mg, unit of measurement) twice a day for psychosis. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 45's Informed Consent for Aripiprazole, dated 4/16/2024, the document indicated consent was not obtained from Resident 45. The document indicated informed consent was obtained by FM 2. During a review of Resident 45's active physician orders, dated 4/16/2024, the orders indicated Resident 45 was to receive Sertraline 100 mg at bedtime for depression. During a review of Resident 45's Informed Consent for Sertraline 100 mg at bedtime depression, dated 4/16/2024, the document indicated consent was not obtained from Resident 45. The document indicated informed consent was obtained by FM 2. During a review of Resident 45's active physician orders, dated 11/7/2024, the orders indicated Resident 45 was receiving Aripiprazole 5 mg in the evening for psychosis. During a review of Resident 45's care plan titled [Resident 45] uses . Sertraline [related] to depression, dated 4/17/2024, the care plan indicated staff were to monitor Resident 45 for adverse reactions associated with sertraline including suicidal thoughts, muscle cramps, dizziness, fatigue, inability to sleep, and decline in ADL ability. The care plan further indicated staff were to educate the resident and resident's family about the risks, side effects, and/or toxic symptoms of Sertraline. During a review of Resident 45's care plan titled [Resident 45] uses . Aripiprazole [related to] depression, dated 4/17/2024, the care plan indicated staff were to educate the resident and resident's family about the risks, side effects, and/or toxic symptoms of Aripiprazole. During an interview on 12/4/2024 at 9:42 a.m., with Resident 45, Resident 45 stated facility staff did not tell her she was receiving Sertraline or Aripiprazole. Resident 45 stated she did not recall providing informed consent for staff to administer the medications. Resident 45 stated she was not aware of the associated side effects and risks associated with the medications. During an interview on 12/4/2024 at 10:13 a.m., with FM 2, FM 2 stated she did not recall providing informed consent for the facility to administer Sertraline and Aripiprazole to Resident 45. FM 2 stated she was never designated to act on Resident 45's behalf and stated Resident 45 was responsible for making decisions for herself. During an interview on 124/2024 at 11:30 a.m., with the facility's Consultant Pharmacist, the Pharmacist stated Sertraline and Aripiprazole were associated with cardiac (heart) problems and metabolic disorders (a condition that occurs when the body's chemical reactions are abnormal). During an interview on 12/4/2024 at 3:13 p.m., with the Director of Nursing (DON), Resident 45's Informed Consents for Sertraline and Aripiprazole, and Resident 45's Admission Agreement, all dated 4/16/2024, were reviewed. The DON stated the Admission Agreement indicated Resident 45 had decision making capacity and stated Resident 45's informed consents indicated FM 2, not Resident 45, consented for the administration of Sertraline and Aripiprazole. The DON stated Resident 45 was supposed to be informed of the indication for and possible adverse effects associated with the medication. The DON stated Resident 45 should have been the individual to provide informed consent. The DON stated it was Resident 45's right to be informed of her treatment plan. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Informed Consents, dated 12/2018, the P&P indicated it was the facility's policy to uphold the rights and dignity of the facility's residents, including their right to make informed decisions about their care. The P&P further indicated the facility was supposed to maintain a written record of the resident's decision to consent to psychotropic medications for every resident receiving psychotropic medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to accommodate the needs of one of eight sampled resident's (Resident 23) by not placing the call within reach and not providing an appropriate call light device. This deficient practice prevented Resident 23 from communicating with staff and had the potential to delay appropriate care, treatment, and services. Findings: During a review of Resident 23's Admission Record, dated 12/5/2024, the admission record indicated Resident 23 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or an inability to move on one side of the body) following cerebrovascular disease (CVA-stroke, loss of blood flow to a part of the brain) affecting the right dominant side, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), hypertension (HTN-high blood pressure) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 23's History and Physical (H&P) dated 9/1/2024, the H&P indicated Resident 23 had the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 10/11/2024, the MDS indicated Resident 23's cognition (ability to think, remember, and reason) was moderately impaired. The MDS also indicted Resident 23 required maximal assistance (helper does more than half the effort) for eating, oral hygiene and personal hygiene and was dependent (helper does all the effort) toileting and bathing. The MDS indicated Resident 23 required a wheelchair for mobility (the ability to freely move or be moved). During a review of Resident 23's care plan titled High Risk for Falls, dated 1/6/2024 and revised 10/28/2024, the care plan indicated Resident 23 would be free of falls. The care plan interventions indicated to be sure Resident 23's call light was within reach, encourage the resident to use the call light for assistance as needed, provide prompt responses to all requests for assistance, anticipate and meet the resident's needs. During an observation on 12/2/2024 at 10:35 a.m., in Resident 23's room, Resident 23 was observed lying in bed. Resident 23 was awake, on his back and covered with a blanket. Resident 23 had both arms under the blanket. Resident 23's call light was placed at ear level on the left side of the pillow attached to the sheet. During a concurrent observation and interview on 12/2/2024 at 10:51 a.m., in Resident 23's room, Resident 23 was observed calling out for help. Resident 23 stated he could not reach his call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/2/2024 a 10:53 a.m., in Resident 23's room, Certified Nursing Assistant (CNA) 1 entered Resident 23's room and ask if she could help. CNA 1 observed Resident 23 lying in bed with the call light placed at the resident's left side next to his head and attached to the sheet. CNA 1 unclipped the call light and placed it on Resident 23's chest. CNA 1 stated Resident 23 could not reach the call light in the area it had been placed. Resident 23 was asked if he was able to use the call light now that it was placed in his lap. Resident 23 struggled to take his hands from under the blankets and attempted to push the call light with the thumb on his left hand. Resident 23 was unable to push the button. CNA 1 stated Resident 23 usually yelled out when he needed assistance and never used the call light. CNA 1 stated Resident 23 should have had access to a call light and the call light should have been located where the resident could reach it. CNA 1 stated it was not appropriate for a Resident 23 to have to yell out to get assistance. CNA 1 stated she did not know Resident 23 was unable to push the button to the call light. CNA 1 stated she now understood why Resident 23 yelled out for help instead of using his call light. CNA 1 stated she should have asked Resident 23 if he could use the call light he had been given. CNA 1 stated Resident 23 needed a paddle call light (a type of call button that looks like a small, flat paddle, which patients can easily press with their hand or arm to alert staff when they need assistance, especially if they have limited mobility) and would inform the charge nurse. During an interview on 12/4/2024 at 1:54 p.m., with the Director of Nursing (DON), the DON stated Resident 23 needed a call light within reach and the right type of call light so that he could call out for his needs. The DON stated he would reassess Resident 23 and have the maintenance staff change the resident's call light to one he could better utilize. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure on Call Light, dated 4/14/2017, the P&P indicated, it is this facility's policy to ensure presence of a resident call system with the use of a call light. The P&P indicated the staff would assess the resident's ability to use a regular call light and keep the call light within easy reach of the resident. During a review of the facility's (P&P) titled, Policy and Procedure on Resident Accommodation of Needs, not dated, the P&P indicated, upon admission or readmission to the facility, the licensed nurse shall make an assessment of the resident's basic needs including but not limited to medical, physical, mental, and psychosocial needs. In addition, members of the interdisciplinary team should also make an assessment of resident's individual needs and preferences. The P&P indicated plans of care should include approaches that would modify or remove resident's weaknesses or weak points for example furniture and other fixture in the immediate environment of the resident should be arranged in such a manner as to compensate for resident's disability. The P&P indicated except when the health and safety of the individual resident or other residents in the facility is involved and is at risk of jeopardy, the facility should make reasonable attempts at accommodating resident's needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure the residents' medical records were updated to show documentation clarifying if a resident has an advance directive (a legal document indicating resident preference on end-of-life treatment decisions) or not for two out of eight residents (Resident 6 and 35), when: 1. Facility did not complete the advance directive acknowledgement form (ADAF, part of an advance directive, a legal document that allowed a person to specify their medical care wishes and who should make decisions for them if they could not) for Resident 6. 2. Facility did not obtain the ADAF for Resident 35 within 24 hours of admission in accordance with the facility's Policy and Procedure (P&P) titled, Advance directives. These deficient practices had the potential to result in confusion in the care and services for Resident 6 and 35 and placed the residents at risk of receiving unwanted treatment and not receiving appropriate care based on wishes. Findings: 1. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to facility on 5/2/2024 and readmitted on [DATE]. Resident 6's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), history of falling, and heart failure (HF- a heart disorder which caused the heart to not pump the blood efficiently). During a review of Resident 6's History and Physical (H&P), dated 5/3/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 6's cognitive (the ability to think and process information) skills for daily decision making was mildly impaired. The MDS indicated Resident 6 required supervision with oral hygiene and upper body dressing, moderate assistance (helper did less than half the effort) for toileting hygiene, lower body dressing, and personal hygiene, and substantial/maximal assistance (helper did more than half the effort) for showering /bathing, and putting on/ taking off footwear. The MDS indicated Resident 6 required supervision to roll left and right; moderate assistance to sit to lying and lying to sitting on side of bed; substantial/maximal assistance for chair/bed-to-chair transfer and toilet transfer; and was dependent (helper did all the effort) for tub/ shower transfer. The MDS indicated Resident 6 had impairment on the lower extremities and used a wheelchair for mobility device. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/3/2024 at 8:56 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 6's ADAF, dated 7/5/2024, was reviewed. The ADAF did not have Resident 6's representative, or witnesses' signatures. LVN 3 stated the ADAF was not complete because it only had the interpreter's signature, and was missing initials, witness signatures, and a date. LVN 3 stated a completed form would need the signature of the resident, witness, or whoever completed the form. LVN 3 stated the negative outcome of an incomplete ADAF was that the form was inactive, and it would affect the resident's care. LVN 3 stated Resident 6 would not be able to receive care according to the recommendation from the resident's designated decision maker. LVN 3 stated the charge nurse was responsible making sure the ADAF was complete. 2. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnoses included DM, HTN, epilepsy (a brain disease where nerve cells did not signal), and dementia (a progressive state of decline in mental abilities). During a review of Resident 35's H&P, dated 10/3/2024, the H&P indicated Resident 35 did not have the capacity to understand and make decisions. During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making was intact. The MDS indicated Resident 35 required substantial/maximal assistance with upper body dressing and was dependent with eating, oral hygiene, toileting hygiene, showering /bathing, lower body dressing, putting on/ taking off footwear, and personal hygiene. The MDS indicated Resident 35 required substantial/maximal assistance to roll left and right; and was dependent with sitting to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/ shower transfer. During a concurrent interview and record review on 12/3/2024 at 2:12 p.m. with LVN 3, Resident 35's both physical (chart) and electronic medical records were reviewed, the medical records indicated there was no ADAF. LVN 3 stated an advance directive was a legal document to provide instruction for medical care for a resident who unable to communicate their own wishes. LVN 3 stated Resident 35 needed the ADAF, and it could possibly delay necessary care without the ADAF in the resident's medical records. LVN 3 stated the charge nurse was responsible for ensuring the ADAF availability. During an interview on 12/3/2024 at 2:41 p.m. with the Director of Staff Development (DSD), the DSD stated the ADAF should be available in the resident's chart because it contained the resident's information. The DSD stated it was the procedure to keep the ADAF in the chart for easier access when it came to an emergency. During a review of the facility's P&P titled Advance directives, undated, the P&P indicated An acknowledgement to this right shall also be completed by the resident or his/her surrogate decision maker (refer to Advance Directive Acknowledgement form). Forward the acknowledgement and include it in the resident's medical file (chart) and business file within 24 hours of admission. If for any reason, the advance directive acknowledgement is not completed within 24 hours of admission, it shall be the responsibility of the Admissions Coordinator or designee to document in the resident's file reasons for such delay. Advance Directive Acknowledgement that remains incomplete after five days of admission shall be forwarded to facility Administrator for necessary actions.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, facility staff failed to report an allegation of resident-to-resident verbal abuse to the State Agency, for two of four sampled residents (Resident 3 and Resident 30), after directly observing the abuse incident on 12/29/2024. This failure resulted in delayed notification of the State Agency, and the subsequent timeliness of their investigations. The failure also increased the potential for additional resident-to-resident abuse incidents to occur. Findings: During a review of Resident 3's Admission Record, the record indicated Resident 3 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 3's admitting diagnoses included dementia (a progressive state of decline in mental abilities) and lack of coordination. During a review of Resident 3's History and Physical (H&P), dated 11/4/2022, the H&P indicated Resident 3 did not have the capacity to understand or make decisions. During a review of Resident 3's Minimum Data Assessment (MDS, a resident assessment tool), dated 10/22/2024, the MDS indicated Resident 3 had severe cognitive impairments (a condition that affects a person's ability to think, learn, and remember). The MDS indicated Resident 3 was dependent on staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily), and mobility while in bed. During a review of Resident 3's Change of Condition (COC) Assessment, dated 12/30/2024, the assessment indicated Resident 3's roommate (Resident 30) threw a blanket at her face and yelled at her on 12/29/2024. During a review of Resident 30's Admission Record, the record indicated Resident 30 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 30's admitting diagnoses included dementia, and mood disorder (a mental health condition that affects a person's emotional state). During a review of Resident 30's H&P, dated 10/20/2024, the H&P indicated Resident 30 did not have the capacity to understand or make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 had severe cognitive impairments. The MDS indicated Resident 30 did not have any impairments to any of her arms or legs. The MDS indicated Resident 30 required supervision or touch assistance from staff to transition from a sitting to standing position. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's COC Assessment, dated 12/29/2024, the assessment indicated an unidentified staff observed Resident 30 throw a blanket at Resident 3's face and yell at her on 12/29/2024. During an interview, on 1/14/2025 at 3:04 PM, with the Administrator (ADM), the ADM stated the resident-to-resident altercation between Resident 3 and Resident 30, that occurred on 12/29/2024, was not reported to the State Agency because Resident 30 (the alleged abuser) had a diagnosis of dementia. During a concurrent interview and record review, on 1/16/2025 at 1:46 PM, with the ADM, the facility's policies and procedures (P&Ps) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating (revised 4/2021) and Policy and Procedure on Patient Abuse and Prevention (undated) were reviewed. The ADM stated that neither of the P&Ps indicated that incidents or allegations of suspected abuse did not need to be reported to the State Agency. The ADM stated it was important to report all allegations of abuse timely to ensure that investigations could be conducted and residents' rights were preserved. The ADM stated the resident-to-resident altercation between Resident 3 and Resident 30, which occurred on 12/29/2024, was reported to the State Agency on 1/15/2024. During a review of the facility P&P titled Policy and Procedure on Patient Abuse and Prevention (undated), the P&P indicated verbal abuse was considered abuse regardless of the alleged abuser's age, ability to comprehend, or disability. The P&P did not indicate an exception for alleged abusers with a diagnosis of dementia. During a review of the facility P&P titled Resident to Resident Altercation (12/2017), the P&P indicated it was the facility's policy to provide an environment that kept residents safe from abuse. The P&P indicated incidents of resident-to-resident altercations were to be reported to the appropriate agencies as indicated in the facility's abuse reporting policy. During a review of the facility P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating (revised 4/2021), the P&P indicated incidents of abuse were to be reported immediately to the facility ADM. The P&P further indicated the ADM (or the individual making the allegation of abuse) was to report the abuse immediately to the state licensing/certification agency responsible for surveying/licensing the facility. The P&P indicated immediately was defined as within two hours if the allegation involved abuse. The P&P did not indicate an exception to reporting if the alleged abuser had a diagnosis of dementia.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47286 Based on interview and record review, the facility did not ensure the Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals with a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) assessment was accurate, and that determination for necessity of potential necessary services, was completed for one of one sampled resident (Resident 45). This deficient practice had the potential for Resident 45 to not receive the required services and care needed for their diagnosed mental disorders. Findings: During a review of Resident 45's Admission Record, the Admission Record indicated the facility admitted Resident 45 on 3/19/2024, and most recently readmitted Resident 45 on 4/16/2024. Resident 45's admitting diagnoses included depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 10/22/2024, the MDS indicated Resident 45 had mild cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 45 required supervision to total dependence on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 45's PASRR Level I Screening, dated 4/16/2024, the PASRR did not reflect Resident 45's diagnoses of depression and psychosis. The PASRR Level I Screening indicated it was negative. During a review of Resident 45's untitled record, dated 4/16/2024, indicated a PASRR Level II Mental Health Evaluation was not required because Resident 45's PASRR Level I Screening was negative. During a concurrent interview and record review, on 12/4/2024 at 2:48 p.m., with the Director of Nursing (DON), Resident 45's Admission Record and PASRR Level I Screening dated 4/16/2024 were reviewed. The DON stated Resident 45's diagnoses of depression and psychosis, indicated on the Admission Record, were not reflected on the PASRR Level I Screening dated 4/16/2024. The DON stated the PASRR should be accurate because it helps to identify if the resident might need additional services. The DON stated an accurate assessment and screening was also necessary to ensure that admission to the facility was appropriate. The DON stated the facility was supposed to review the PASRR for accuracy, and if deemed inaccurate, a new PASRR should have been submitted. During a review of the facility's policy and procedure (P&P) titled Pre-Admission Screening and Resident Review (PASSR), dated 12/2017, the P&P indicated the purpose of the PASRR screenings was to help ensure that individuals who have a mental disorder or intellectual disabilities were not inappropriately placed in nursing homes for long term care.

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Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure care plans were developed for four of 21 sampled residents when the following occurred: 1. Resident 45 did not have a care plan addressing diagnoses of depression and psychosis. 2. Resident 58 did not have a fall risk care plan. 3. Resident 32 did not have a care plan for the use of a low air loss (LAL) mattress (a mattress designed to distribute body weight evenly and reduce pressure on specific areas of the body). 4. Resident 77 did not have a care plan for the use of a LAL mattress. These deficient practices placed Residents 45, 58, 32, and 77 at risk for avoidable complications due to staff not having defined and resident-specific interventions for provision of care. Findings: 1. During a review of Resident 45's Admission Record, the Admission Record indicated the facility admitted Resident 45 on 3/19/2024, and most recently readmitted Resident 45 on 4/16/2024. Resident 45's admitting diagnoses included depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 10/22/2024, the MDS indicated Resident 45 had mild cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 45 required supervision to total dependence on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility. During a concurrent interview and record review, on 12/4/2024 at 2:48 p.m., with the Director of Nursing (DON), Resident 45's Admission Record and all active care plans were reviewed. The DON stated Resident 45's Admission Record indicated Resident 45 had diagnoses of depression and psychosis and stated there were no care plans in the resident's medical record for those diagnoses. The DON stated the care plans would include goals for the care being provided and include pharmacologic (medications) and non-pharmacologic interventions to address Resident 45's depression and psychosis. The DON stated that without a care plan, staff would be unable to know if interventions were effective and if goals for Resident 45's care were being achieved. 2. During a review of Resident 58's Admission Record, the Admission Record indicated the facility admitted Resident 58 on 10/3/2022, and most recently readmitted Resident 58 on 9/13/2024. Resident 58's admitting diagnoses included dementia (a progressive state of decline in mental abilities), psychosis, lack of coordination, and abnormalities of gait (manner of walking) and mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58 had severe cognitive impairment. The MDS indicated Resident 58 required partial to moderate assistance from staff when performing personal hygiene activities, dressing her lower body, transferring between bed and a chair, and getting on and off the toilet. During a review of Resident 58's Fall Risk Evaluations, dated 9/13/2024 and 10/7/2024, the evaluations indicated Resident 58 was at risk for falls. The evaluations further indicated that a prevention protocol was supposed to be initiated immediately and documented on the care plan. During a concurrent observation and interview on 12/3/2024 at 3:35 p.m., with Certified Nursing Assistant (CNA) 2, at Resident 58's bedside, Resident 58 was observed lying in bed. CNA 2 stated Resident 58 did not have any fall indicators at her bedside or on her person to indicate she was a fall risk. CNA 2 stated Resident 58 was not at risk for falls. CNA 2 stated she looked for fall risk indicators to identify if a resident was at risk for falls, and if present, she would conduct more frequent rounding or take added precautions to prevent falls. During a concurrent interview and record review on 12/3/2024 at 3:42 p.m., with Registered Nurse (RN) 1, Resident 58's Admission Record, Fall Risk Evaluations dated 9/13/2024 and 10/7/2024, and current care plans were reviewed. RN 1 stated Resident 58's diagnoses, including lack of coordination and abnormalities of gait and mobility, placed the resident at risk for falls. RN 1 stated Resident 58's Fall Risk Evaluations indicated the resident was at risk for falls and indicated a fall risk care plan should be documented. RN 1 reviewed Resident 58's care plans and stated the resident did not have a care plan addressing the resident's risk for falls. RN 1 stated Resident 58 was supposed to have a fall risk care plan. RN 1 stated the care plan would include interventions, including fall risk indicators, which would notify staff of the need for added precautions. RN 1 stated the lack of a fall risk care plan was a safety risk to Resident 58 and placed the resident at risk for falls. 48131 3. During a review of Resident 32's Admission Record, dated 12/5/2024, the admission record indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 32's diagnoses included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN - high blood pressure), asthma (a chronic lung disease in which the airways in the lungs become narrowed and swollen, making it difficult to breathe), and obstructive sleep apnea (OSA - when the walls of the throat become blocked while sleeping, which can prevent air from moving through the windpipe). During a review of Resident 32's History and Physical (H&P), dated 9/1/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 had the ability to usually be understood and usually understood others. The MDS indicated Resident 32 required partial assistance (helper does less than half the effort) with eating, substantial assistance (helper does more than half the effort) with oral and personal hygiene and was dependent (helper does all the effort) for toileting hygiene. The MDS indicated Resident 32 required a wheelchair for mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's care plans, the care plans did not include a care plan and interventions related to Resident 32's LAL mattress. During a concurrent observation, interview, and record review, on 12/4/2024 at 2:02 p.m., with Licensed Vocational Nurse (LVN 2), Resident 32's care plans were reviewed. LVN 1 stated she was the treatment nurse for Resident 32. LVN 2 acknowledged there was no care plans or interventions for Resident 32's LAL mattress. LVN 2 stated a LAL mattress care plan should have been initiated for Resident 32 and there should have been documentation to indicate the LAL mattress would be continued as a prophylaxis (to prevent) and adjusted according to Resident 32's comfort level. LVN 2 stated errors could be made when the LAL mattress care plan, interventions, and settings were not documented which could cause further injury instead of helping the resident. During an interview on 12/4/2024 at 2:14 p.m. with the Director of Nursing (DON), the DON stated the air mattress should be set according to the resident's weight and everything regarding the air mattress should be care planned. The DON stated if Resident 32 wanted to keep the air mattress for comfort after her pressure ulcer resolved, it must be documented, and a care plan done with the right setting for her comfort per the device. 45009 4. During an observation on 12/2/2024 at 1:47 p.m., in Resident 77's room, the LALM was set for a person that weighed 320 pounds. During a review of Resident 77's Admission Record, the admission record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 77's diagnoses included depression (a progressive state of decline in mental abilities) and left femur (thigh bone, is the only bone in the thigh) fracture (broken bone). During a review of Resident 77's H&P dated 5/29/2024, the H&P indicated Resident 77 had the capacity to understand and make decisions. During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 77 required supervision for oral hygiene and upper body dressing, and partial assistance (helper does less than half the effort) for toileting hygiene, lower body dressing, and personal hygiene. During a review of Resident 77's Order Summary Report dated 5/30/2024, the order summary report indicated Resident 77 had an order for LALM for skin maintenance and pressure injury prevention. During a review of Resident 77's Weight Summary dated 12/3/2024, the weight summary indicated Resident 77 weighed 161 pounds on 12/3/2024. During a review of Resident 77's electronic medical record, unable to locate a care plan for the use of LALM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/2024 at 1:01 p.m. with Registered Nurse (RN 1), RN 1 stated the use of a LALM should be part of Resident 77's care plan because it indicated the plan of care when a resident uses a LALM. RN 1 stated if it was not care planned it would affect the continuation of care. RN 1 stated it was important to develop a care plan for the use of a LALM because it indicated goals and interventions for residents. RN 1 stated the facility did not provide an in-service training on LALM use. During a review of the facility's policy and procedure (P&P) titled Care Plan, undated, the P&P indicated the facility shall ensure development of a comprehensive care plan for each resident to meet his/her medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment. During a review of the facility's P&P titled Pressure Reducing Mattress dated April 2022, the P&P indicated, a specialty mattress will be obtained for pressure relief of residents that have pressure injury or at risk of pressure injury. The P&P indicated the purpose of the pressure reducing mattress was to maintain skin integrity and to promote healing of existing pressure injuries. The P&P indicated to set the pressure reducing mattress according to resident's height and weight and consider referring to the manufacturer's guidance. The P&P indicated to consider having the information on the pressure ulcer reducing mattress as part of the physician orders or plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to revise the care plans for two of 21 sampled residents when the following occurred: 1. Resident 44's fall care plan was not revised following his first fall on 5/19/2024. 2. Resident 17's fall care plan was not revised following her first fall on 6/14/2024, and second fall on 6/21/2024. These deficient practices resulted in Resident 44 sustaining a second fall on 8/22/2024, and a third unwitnessed fall on 9/14/2024. The above deficient practice also resulted in Resident 17 sustaining a third unwitnessed fall on 8/3/2024. Findings: 1. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 44's admitting diagnoses included history of falling and anxiety disorder. During a review of Resident 44's History and Physical (H&P), dated 3/25/2024, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 44 had severe cognitive impairment (problems with the ability to think, learn, remember, and make decisions), inattention, and disorganized thinking. The MDS indicated Resident 44 required substantial to maximal assistance from staff to transition from a sitting to standing position, transferring from bed to chair or chair to bed, and to transfer on and off the toilet. During a review of Resident 44's care plan titled High risk for falls, initiated 3/26/2024, the care plan indicated a care goal that Resident 44 would not sustain serious injury. Staff interventions included following the facility fall protocol, reviewing information on past falls, attempting to determine the cause of falls, and altering and/or removing potential causes of falls. During a review of Resident 44's Change of Condition (COC) assessment, dated 5/19/2024, the assessment indicated Resident 44 sustained a fall. During a review of Resident 44's Interdisciplinary Team (IDT) Assessment, dated 6/24/2024, the assessment indicated staff were to indicate if Resident 44 had any safety issues or risks, including a history of falls in the previous 180 days. The assessment did not indicate a history of falls, including Resident 44's fall from 5/19/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 44's care plan titled High risk for falls, initiated 3/26/2024, the care plan indicated interventions for fall prevention were not revised following Resident 44's fall on 5/19/2024. During a review of Resident 44's COC assessment, dated 8/22/2024, the assessment indicated Resident 44 was found with his face down on the floor. The assessment indicated Resident 44 reported he fell from his bed. The assessment indicated Resident 44 sustained a forehead wound measuring 3.8 centimeters (cm, measurement of length) by 3.8 cm, with surrounding redness to his skin. During a review of Resident 44's care plan titled High risk for falls, initiated 3/26/2024, the care plan indicated interventions for fall prevention were not revised following Resident 44's fall on 8/22/2024. During a review of Resident 44's COC assessment, dated 9/14/2024, the assessment indicated Resident 44 was found with his face down on the floor. The assessment indicated Resident 44 reported he fell from his bed. The assessment indicated Resident 44 reported moderate pain to his head. During a review of Resident 44's care plan titled High risk for falls, initiated 3/26/2024, the care plan indicated interventions for fall prevention were not revised following Resident 44's fall on 9/14/2024. During a concurrent interview and record review, on 12/3/2024 at 2:57 p.m., with Registered Nurse (RN) 1, Resident 44's care plan initiated 3/26/2024, and COC assessments dated 5/19/2024, 8/22/2024, and 9/14/2024 were reviewed. RN 1 stated the COC assessments indicated Resident 44 sustained three falls following initiation of his fall risk care plan on 3/26/2024. RN 1 stated the care plan interventions should have been revised following each of Resident 44's falls. RN 1 stated revision of the care plan was for the safety of Resident 44 and to prevent additional falls. RN 1 also reviewed Resident 44's IDT assessment, dated 6/24/24, and stated the assessment was not accurate and should have reflected that Resident 44 was at risk for falls and had a history of falls. RN 1 stated the IDT assessment should have addressed Resident 44's fall from 5/19/2024 to facilitate care plan revisions and potentially prevent additional falls. 2. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 17's admitting diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), dementia (a progressive state of decline in mental abilities), history of falling, lack of coordination, and abnormalities of gait and mobility. During a review of Resident 17's H&P, dated 8/11/2024, the H&P indicated Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 had severe cognitive impairment. The MDS indicated Resident 17 required partial to moderate assistance from staff to transition from a sitting to standing position, transferring from bed to chair or chair to bed, and to transfer on and off the toilet. The MDS indicated Resident 17 required partial to moderate assistance to walk 150 feet once standing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17's care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, created 2/15/2024, the care plan indicated staff were to provide preventive intervention to minimize Resident 17's potential for injury. During a review of Resident 17's COC assessment, dated 6/14/2024, the assessment indicated Resident 17 was found on the floor in her room. Resident 17 told staff she fell . The assessment indicated Resident 17 reported a pain score of 7 (on a scale of 1 to 10, with 10 being excruciating pain) to the right side of her head. The assessment indicated Resident 17 was transferred to the hospital following the fall. During a review of Resident 17's care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, created 2/15/2024, the care plan indicated there were no revisions made to the fall prevention interventions following Resident 17's fall on 6/14/2024. During a review of Resident 17's COC assessment, dated 6/21/2024, the assessment indicated Resident 17 sustained another fall. During a review of Resident 17's care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, created 2/15/2024, the care plan indicated there were no revisions made to the fall prevention interventions following Resident 17's fall on 6/21/2024. During a review of Resident 17's COC assessment, dated 8/3/2024, the assessment indicated Resident 17 was found on the floor, with a bleeding wound on the top of her head. The assessment indicated Resident 17 reported moderate pain to her head and back. The assessment indicated Resident 17 was transferred to General Acute Care Hospital (GACH) 1 via emergency services. During a review of Resident 17's GACH 1 record, dated 8/3/2024, the record indicated Resident 17 was brought to the hospital by ambulance after she fell on the back of her head while walking. The records indicated Resident 17 was reporting head and lower back pain and suffered a puncture wound (wounds that are usually narrower and deeper than a cut or scrape, that can extend into deeper tissue layers) to the scalp. The record indicated imaging tests revealed Resident 17 had broken bones to her sacral region and indicated Resident 17 required a higher level of care. During a review of Resident 17's care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, created 2/15/2024, the care plan indicated there were no revisions following Resident 17's fall on 8/3/2024. During a concurrent interview and record review, on 12/4/2024 at 1:17 p.m., with RN 1, Resident 17's Admission Record, COC assessments dated 6/14/2024, 6/21/2024, and 8/3/2024, and fall risk care plan were reviewed. RN 1 stated Resident 17's Admission Record indicated she had diagnoses of osteoarthritis, osteoporosis, dementia, lack of coordination, and abnormal gait and mobility which placed her at risk for falls and injury. RN 1 stated Resident 17's COC assessments indicated she sustained falls, and stated the care plan indicated there were no revisions to the care plan interventions following the falls. RN1 stated Resident 17's fall care plan should have been revised to prevent additional falls and prevent further injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Fall Risk and Prevention Assessment, updated 3/2018, indicated the interdisciplinary team was supposed to develop appropriate plans of care to address risk for falls, and plans of care were supposed to include interventions that would remove, change, or modify risk factors for falls or further falls. The P&P indicated the care plans were supposed to be reviewed and updated to reflect the current condition of the resident. During a review of the facility's P&P titled Care Plan, undated, the P&P indicated the resident's care plans were supposed to show evidence of the facility's effort to address or manage risk factors. The P&P indicated care plans were supposed to be reviewed whenever necessary, including in the event of a significant change in the resident's status and condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to meet professional standards of quality of care for one out of eight residents (Resident 62) by failing to document the following on Resident 62's Medication Administration Record (MAR): 1. The administration of pantoprazole (medicine treated conditions that caused too much stomach acid) on 10/4/2024, 10/14/2024, and 10/16/2024 at 6:30 a.m. 2. The administration of insulin lispro (a fast-acting, human-made insulin [a hormone that removed excess sugar from the blood, could be produced by the body or given artificially via medication]) on 10/4/2024, 10/14/2024, and 10/16/2024 at 6:30 a.m. 3. Coronavirus disease (COVID-19, an infectious disease caused by the SARS-CoV-2 virus) and vital signs (measurements of the body's most basic functions) monitoring on 10/3/2024, 10/13/2024, 10/15/2024, and 10/21/2024 during the night shift; and on 10/7/2024, 11/17/2024, and 12/2/2024 during the evening shift. 4. Pain monitoring on 10/3/2024, 10/11/2024, 10/13/2024, 10/15/2024, 10/20/2024, and 10/21/2024 during the night shift; and on 10/7/2024 and 12/2/2024 during the evening shift. 5. Significant side effect (unwanted undesirable effects that were possibly related to a drug) monitoring of anticoagulant (a substance that was used to prevent and treat blood clots in blood vessels) use on 10/3/2024 during the night shift; and on 10/7/2024 and 12/2/2024 during the evening shift. 6. Significant side effects of sedative/ hypnotic (a class of drugs used to induce and/or maintain sleep) medication monitoring on 10/3/2024 during the night shift and on 10/7/2024 during the evening shift. 7. Monitor and document Resident 62's numbers of hours of sleep for the use of trazodone (a drug used to treat depression [a constant feeling of sadness and loss of interest]) at bedtime for inability to sleep on 10/8/2024. 8. Document Resident 62's number of hours of sleep on 12/2/2024. 9. Side effects of pain medication on 12/2/2024 during the evening shift. 10. Side effects of anti-depressant (prescription medicines to treat depression [constant feeling of sadness and loss of interest]) medication monitoring on 12/2/2024 during the evening shift. These deficient practices could have potentially delayed necessary care for Resident 62. Findings: (continued on next page)

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Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 62's Admission Record, the record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), anemia (a condition where the body did not have enough healthy red blood cells), and depression. During a review of Resident 62's History and Physical (H&P), dated 5/16/2024, the H&P indicated Resident 62 had the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool), dated 9/27/2024, the MDS indicated Resident 62's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 62 required partial/moderate assistance (helper did less than half the effort) with upper body dressing and personal hygiene; substantial/maximal assistance (helper did more than half the effort) with toileting hygiene and lower body dressing; and was dependent (helper did all the effort) with showering/bathing. The MDS indicated Resident 62 was dependent for toilet transfer and tub/ shower transfer. During a review of Resident 62's Oder Summary Report with active orders as of 12/5/2024, the report indicated the followings orders: 1. Pantoprazole 40 milligram (mg, unit of measurement) one time a day 30 minutes before breakfast, dated 10/8/2024. 2. Insulin Lispro as per sliding scale (the increasing administration of the insulin dose based on the blood sugar level) before meals and at bedtime, dated 10/7/2024. 3. COVID-19 and vital signs monitoring every shift, dated 10/8/2024. 4. Monitor pain every shift, dated 10/8/2024. 5. Monitor significant side effects of anticoagulant medication every shift, dated 11/6/2024. 6. Monitor and record hour of sleeping every evening and night shift, dated 11/6/2024. 7. Trazodone 50 mg at bedtime, dated 10/8/2024. 8. Monitor side effects of pain medication every shift, dated 11/6/2024. 9. Monitor significant side effects of anti-depressant medication every shift, dated 11/6/2024. During a review of Resident 62's care plan titled The resident has GERD (gastroesophageal reflux disease, chronic digestive condition that occurs when stomach contents regularly flow back up into the esophagus), revised on 12/4/2024, the care plan indicated interventions to give medications as ordered. During a review of Resident 62's care plan titled At risk for complications from DM, revised on 4/8/2024, the care plan indicated interventions were to give medications as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/2024 at 12:10 p.m. with Registered Nurse (RN) 1, Resident 62's MARs, dated 10/1/2024 - 12/31/2024, were reviewed. The MAR indicated the followings: 1. No documentation for pantoprazole administration on 10/4/2024 (ordered on 9/6/2024), 10/14/2024, and 10/16/2024 at 6:30 a.m. 2. No documentation for insulin lispro administration on 10/4/2024(ordered on 5/14/2024), 10/14/2024, and 10/16/2024 at 6:30 a.m. 3. No documentation for COVID-19 and vital signs monitoring every shift on 10/3/2024 (ordered on 5/13/2024), 10/13/2024, 10/15/2024, and 10/21/2024 night shifts; 10/7/2024 (ordered on 5/13/2024), 11/17/2024, and 12/2/2024 evening shift. 4. No documentation for pain monitoring every shift on 10/3/2024 (ordered on 5/13/2024), 10/11/2024, 10/13/2024, 10/15/2024, 10/20/2024, and 10/21/2024 night shifts; 10/7/2024 (ordered on 5/13/2024), 12/2/2024 evening shift. 5. No documentation for significant side effects of anticoagulant medication monitoring every shift on 10/3/2024 (ordered on 5/15/2024) night shift; 10/7/2024 (ordered on 5/15/2024) and 12/2/2024 evening shift. 6. No documentation for significant side effects of sedative/ hypnotic medication monitoring every shift on 10/3/2024 night shifts and 10/7/2024 evening shift. 7. No documentation on Resident 62's hours of sleep till 11/6/2024 when trazodone 50 mg for inability to sleep was ordered on 10/8/2024. 8. No documentation for hours of sleep monitoring every evening and night shift on 12/2/2024 evening shift. 9. No documentation for side effects of pain medication monitoring every shift on 12/2/2024 evening shift. 10. No documentation for side effects of anti-depressant medication monitoring every shift on 12/2/2024 evening shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 stated it was not acceptable to have missing documentation on the MARs, as it could possibly delay necessary care and services for Resident 62. RN 1 stated the nursing staff should monitor the hours of sleep when trazodone was ordered on 10/8/2024. RN 1 stated the nursing staff would not be able to know if trazodone was effective without monitoring the hours of sleep. RN 1 stated it could possibly prolong unnecessary medication usage and increase the risk of intoxication (a temporary and reversible condition that affected the central nervous system after a person took drugs) and side effects. RN 1 stated Resident 62 might experience signs and symptoms of hypoglycemia (low blood sugar) such as paleness, dizziness, altered level of consciousness, sweating, and tremors; and hyperglycemia (high blood sugar) such as dizziness, thirstiness extreme hunger, polyuria (a condition when a person produced abnormally large amounts of urine), altered level of consciousness, and even shock (a life-threatening medical emergency when a person did not have enough blood circulating around body). RN 1 stated nurses assigned to Resident 62 and charge nurses were responsible for ensuring the MAR was complete. During a review of the facility's Policy and Procedure (P&P) titled Documentation of medication administration, revised on 4/2007, the P&P indicated A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's MAR. Administration of medication must be documented immediately after (never before) it is given. During a review of facility's P&P titled Psychoactive medication management, updated on 7/2017, the P&P indicated The MAR will be used by nursing staff to document the frequency of the behaviors, adverse reactions, and resident response on each shift.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM, a medical mattress that uses air to help prevent and treat pressure ulcers [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence]) pressure levels were adjusted according to the resident's weight for two of six sampled residents (Resident 32 and Resident 77). This deficient practice had the potential to cause the development, worsening or reinjury of pressure ulcers to Resident 32 and 77. Findings: 1. During a review of Resident 32's Admission Record, dated 12/5/2024, the admission record indicated Resident 32 was admitted to the facility initially on 8/31/2024 and readmitted on [DATE]. Resident 32's diagnoses included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension (HTN - high blood pressure). During a review of Resident 32's History and Physical (H&P), dated 9/1/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 9/7/2024, the MDS indicated Resident 32 had the ability to usually be understood and usually understood others. The MDS indicated Resident 32 required partial assistance (helper does less than half the effort) with eating, substantial assistance (helper does more than half the effort) with oral and personal hygiene and was dependent (helper does all the effort) on facility staff for toileting hygiene. The MDS indicated Resident 32 required a wheelchair for mobility (the ability of a resident to move around independently or with assistance). During a review of Resident 32's care plan titled, The resident has potential for actual impairment to skin integrity . date initiated 9/3/2024 and revised on 12/3/2024, the care plan indicated Resident 32 would not develop skin breakdown and wounds would not develop a secondary infection. The care plan indicated staff interventions included to turn and reposition Resident 32 every 2 hours and as needed and to keep the resident clean and dry. During a review of Resident 32's Braden Scale for Predicting Pressure Ulcer Risk, dated 10/7/2024, the Braden Scale for Predicting Pressure Ulcer Risk indicated Resident 32's mobility was very limited (makes occasional slight changes in body but unable to make significant changes independently) and the resident had a high risk for pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Wound Weekly Observation Tool, dated 11/1/2024, the wound observation tool indicated Resident 32 had a Stage III (full-thickness loss of skin. dead and black tissue may be visible) pressure injury to the sacrococcyx (tailbone). The wound observation tool indicated the use a LALM as a preventive measure. During a review of Resident 32's Wound Weekly Observation Tool, dated 11/15/2024, the wound observation tool indicated Resident 32 Stage III pressure injury to the sacrococcyx resolved. The wound observation tool indicated to continue the use a LALM as a preventative measure. During a review of Resident 32's Order Summary Report dated 12/5/2024, the order summary report indicated an active order on 10/8/2024 to have a LALM for skin maintenance and pressure injury prevention. The order summary report indicated to monitor placement and function of the LALM every day shift. During a review of Resident 32's Weight and Vitals Summary, dated 12/5/2024, the weights and vitals summary indicated Resident 32's weight was 224 pounds (lbs, measure of weight). on 12/2/2024. During a concurrent observation and interview on 12/2/2024 at 11:36 a.m. with Resident 32, in Resident 32's room, observed Resident 32 lying in bed on her back. Resident 32's LALM control was set to 400 lbs. Resident 32 stated the mattress was not comfortable. During a concurrent observation, interview and record review on 12/4/2024 at 2:02 p.m., with Licensed Vocational Nurse (LVN 2), Resident 32's LALM controls were observed and Resident 32's nursing notes, weights and vitals and care plans were reviewed. LVN 1 stated she was the treatment nurse for Resident 32. LVN 2 reviewed Resident 32's current weight on 12/1/2024 at 224 lbs. LVN 2 observed Resident 32's LAL mattress was set to 400 lbs. LVN 2 stated the LALM was used to prevent reinjury of the Resident 32's pressure ulcer. LVN 2 stated if Resident 32 had a pressure ulcer the LALM would be set according to the resident's weight. LVN 2 stated Resident 32's pressure ulcer was resolved so the LALM could be set according to the resident's comfort level. LVN 2 reviewed Resident 32's care plan and nursing notes, LVN 2 stated there were no care plans or interventions for the LALM. LVN 2 stated a LALM care plan should have been initiated for Resident 32 and when the pressure ulcer was discontinued, there should have been documentation to indicate the LALM would be continued as a prophylaxis (preventative) measure and adjusted according to Resident 32's comfort level. LVN 2 stated errors could be made if the LALM interventions and settings were not documented which could cause further injury instead of helping the resident. During an interview on 12/4/2024 at 2:14 p.m. with the Director of Nursing (DON), the DON stated the LALM should be set according to the resident's weight. The DON stated everything regarding the LALM should be care planned. The DON stated if Resident 32 wanted to keep the LALM for comfort after the pressure ulcer resolved, it must be documented and a care plan done with the right setting for Resident 32's comfort per the device. 45009 2. During an observation on 12/2/2024 at 1:47 p.m., in Resident 77's room, the LAL mattress was set for a person that weighed 320 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 77's Admission Record, the admission record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 77's diagnoses included depression (a progressive state of decline in mental abilities) and a left femur (thigh bone) and fracture (broken bone). During a review of Resident 77's H&P dated 5/29/2024, the H&P indicated Resident 77 had the capacity to understand and make decisions. During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 77 required supervision for oral hygiene and upper body dressing, and partial assistance (helper does less than half the effort) for toileting hygiene, lower body dressing, and personal hygiene. During a review of Resident 77's Order Summary Report dated 5/30/2024, the order summary report indicated Resident 77 had an order for LALM for skin maintenance and pressure injury prevention. During a review of Resident 77's Weight Summary dated 12/3/2024, the weight summary indicated Resident 77 weighed 161 lbs on 12/3/2024. During an interview on 112/2/1:54 with Resident 77, in Resident 77's room, Resident 77 stated she did not know why she had a special mattress as none of the facility staff discussed it with her. Resident 77 stated the bed felt uncomfortable and it was very hard to move in bed. Resident 77 stated the mattress felt weird and it prevented her from readjusting her position in bed. During an interview on 12/5/2024 at 11:22 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she did not know much about LALMs. CNA 4 stated she checked if the resident's LALM was working by pushing down on the mattress to see if it was full of air and checked to see if the pump was on. CNA 4 stated she would not know if the LALM was set correctly because she did not know how to set it up. CNA 4 stated she knew the LALM was to help residents prevent skin issues and if the LALM was not set up correctly, it might not help prevent skin issues. CNA 4 stated the facility had not provided an in-service on the use of the LALM. During an interview on 12/5/2024 at 1:01 p.m. with Registered Nurse (RN 1), RN 1 stated the use of a LAL mattress was not effective if it was not set up according to the residents' weight. RN 1 stated to prevent skin problems the LALM should provide the resident proper pressure support. RN 1 stated if the LALM was over inflated or under inflated it would cause skin issues and would be uncomfortable for the resident. RN 1 stated it was important to set the LALM correctly for the prevention and treatment of pressure ulcers and to provide comfort for bed bound residents. RN 1 stated he had not received an in service training on LALMs. During a review of the facility's user manual for LALMs, titled, Med Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System, (no date), the user manual indicated the product was designed to provide pressure redistribution while maximizing comfort to the residents. The user manual indicated the pressure level of the air mattress could be adjusted to a desired firmness based on personal comfort or weight setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Pressure Reducing Mattress dated April 2022, the P&P indicated, a specialty mattress will be obtained for pressure relief of residents that have pressure injury or at risk of pressure injury. The P&P indicated the purpose of the pressure reducing mattress was to maintain skin integrity and to promote healing of existing pressure injuries. The P&P indicated to set the pressure reducing mattress according to resident's height and weight and consider referring to the manufacturer's guidance. The P&P indicated to consider having the information on pressure ulcer reducing mattress as part of the physician orders or plan of care.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 17 and Resident 44) were free from avoidable accidents and accident hazards when the facility: 1. Did not conduct an Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) assessment following Resident 17's fall on 6/14/2024. 2. Did not develop or implement person-centered interventions to prevent Resident 17 from having repeated falls on 6/21/2024 and 8/3/2024. 3. Did not conduct an IDT in a timely manner, after Resident 44 fell on [DATE], to prevent further falls. 4. Did not develop new, person-centered, fall prevention interventions following Resident 44's fall on 5/19/2024 and subsequent falls on 8/22/2024 and 9/14/2024. 5. Failed to conduct an accurate IDT assessment on 6/24/2024 and provide individualized recommendations to prevent Resident 44 from further falls. 6. Failed to provide padded siderails for Resident 44, Resident 6, and Resident 35 as ordered by the physician. These deficient practices resulted in Resident 17 having two falls on 6/21/2024 and 8/3/2024. On 8/3/2024, Resident 17 sustained a laceration (a cut, tear, or opening in the skin) to the back of her head, a right parietal scalp hematoma (a collection of blood between the skin and skull bone on the side of the head), and fractures (broken bones) to the sacral (area near the low back and upper buttocks) and lumbar (lower back) regions, which led to a hospitalization at a general acute care hospital (GACH) for evaluation and treatment. This deficient practice also resulted in Resident 44 falling on 8/22/2024, where he sustained a forehead abrasion (a partial thickness wound caused by damage to the skin). Resident 44 fell a third time on 9/14/2024 (within 23 days from the previous fall) and complained of moderate pain (pain that can't be ignored for more than a few minutes but can be managed with effort) to his head. This deficient practice also placed Residents 44, 6, and 35 at risk for injuries. Findings: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's admitting diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), dementia (a progressive state of decline in mental abilities), history of falling, lack of coordination, and abnormalities of gait (manner of walking) and mobility. During a review of Resident 17's History and Physical (H&P), dated 8/11/2024, the H&P indicated Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2024, the MDS indicated Resident 17 had severe cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 17 required partial to moderate assistance from staff to transition from a sitting to standing position, transferring from bed to chair or chair to bed, and to transfer on and off the toilet. The MDS indicated Resident 17 required partial to moderate assistance to walk 150 feet once standing. During a review of Resident 17's Fall Risk Evaluation, dated 1/30/2024, the assessment indicated Resident 17's score was 11 (a score of 11 or higher indicated a risk for falls). During a review of Resident 17's care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, created 2/15/2024, the care plan indicated staff were to encourage Resident 17 to call for assistance. During a review of Resident 17's Change of Condition (COC) assessment, dated 6/14/2024, the COC assessment indicated on 6/14/2024 Resident 17 was found on the floor in her room. The COC assessment indicated Resident 17 told staff she fell . The COC assessment indicated Resident 17 reported a pain score of 7 (scale of 1 to 10, with 10 being excruciating pain) to the right side of her head. The COC assessment indicated Resident 17 was transferred to the GACH following the fall. During a review of Resident 17's Fall Risk Evaluation, dated 6/17/2024, the evaluation indicated Resident 17's score was 13. During a review of Resident 17's COC assessment, dated 6/21/2024, the COC assessment indicated Resident 17 had a history of fall on 6/14/2024, and 6/21/2024 with minor injury (injury unspecified). The COC assessment did not indicate any new fall interventions. During a review of Resident 17's IDT Assessment, dated 7/29/2024, the IDT assessment indicated Resident 17 had a fall on 6/14/2024 requiring hospitalization , and another fall on 6/21/2024. The IDT assessment indicated Resident 17's medical diagnoses caused her to experience confusion and forgetfulness. The IDT assessment indicated the recommendations indicated staff would continue to educate Resident 17 to use her call light for assistance and to sit up slowly before walking. During a review of Resident 17's Fall Risk Evaluation, dated 7/30/2024, the evaluation indicated Resident 17's score was 13. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 17's COC assessment, dated 8/3/2024, the COC assessment indicated on 8/3/2024, Resident 17 was found on the floor, with a bleeding wound on the top of her head. The COC assessment indicated Resident 17 complained of moderate pain to her head and back. The COC assessment indicated Resident 17 was transferred to GACH 1 via emergency services. During a review of Resident 17's GACH 1 record titled Emergency Department Note, dated 8/3/2024, the record indicated Resident 17 was brought to GACH 1 by ambulance after she fell on the back of her head. The record indicated Resident 17 had a 0.5 inch laceration to the back of her head and complaints of pain to her head and lower back. During a review of Resident 17's GACH 1 computed tomography (CT) scan (a medical imaging procedure that uses X-rays and a computer to create detailed pictures of the inside of the body) report of her chest, abdomen, and pelvis, dated 8/3/2024, the report indicated Resident 17 had a compression fracture (a break in a bone that occurs when pressure causes the bone to collapse) at lumbar spine 1 (L1, the first bone of the spine in the lumbar region of the back), and broken bones to the resident's sacral region on both sides of the body. During a review of Resident 17's GACH 1 CT scan report of the head and brain, dated 8/3/2024, the report indicated Resident 17 had a moderate right parietal scalp hematoma (a collection of blood between the skin and skull bone on the side of the head). During a review of Resident 17's GACH 1 Discharge Summary Brief, dated 8/13/2024, the note indicated Resident 17 had diagnoses of bilateral (both sides of the body) sacral fractures and L1 compression fracture. The note indicated Resident 17's fractures were determined inoperable and the resident was recommended for higher level of care. During a concurrent interview and record review, on 12/3/2024 at 2:57 p.m., with Registered Nurse (RN) 1, Resident 17's COC assessments dated 6/14/2024, 6/21/2024, and 8/3/2024, and care plan titled At risk for fall related to history of fall, weakness, dementia, osteoarthritis, osteoporosis, dated 2/15/2024, were reviewed. RN 1 stated the COC assessments indicated Resident 17 had three falls after the initiation of her fall risk care plan on 2/15/2024. RN 1 stated the care plan and COC assessments did not indicate that new, resident-centered interventions to prevent further falls had been developed or implemented after Resident 17's falls on 6/14/2024 and 6/21/2024. RN 1 stated Resident 17 was confused and forgetful. RN 1 stated Resident 17 could have benefited from the implementation of staff supervision. RN 1 stated the implementation of resident-specific interventions could have prevented Resident 17 from falling and sustaining injuries on 8/3/2024. During a concurrent interview and record review on 12/4/2024 at 3:24 p.m., with the Director of Nursing (DON), Resident 17's IDT assessments dated 7/29/2024 and 10/28/2024 were reviewed. The DON stated the IDT assessment dated [DATE] indicated a fall prevention intervention of educating the resident to call for help and to sit up slowly before walking. The DON stated the IDT assessment should have been completed at the time of Resident 17's falls on 6/14/2024 and 6/21/2024. The DON stated the fall prevention intervention was not appropriate for Resident 17 because the resident was confused and forgetful. The DON stated it was not reasonable to expect Resident 17 to remember or follow staff's instructions. The DON stated the IDT should have implemented different, and/or additional, resident-specific fall prevention interventions after Resident 17's falls on 6/14/2024 and 6/21/2024. The DON stated the failure to implement new, resident-specific fall prevention measures placed Resident 17 at risk for repeated falls and injuries. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 44's admitting diagnoses included history of falling and anxiety disorder (a condition that causes excessive fear, worry, and feelings of dread or uneasiness). During a review of Resident 44's H&P, dated 3/25/2024, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44 had severe cognitive impairment, and inattention and disorganized thinking. The MDS indicated Resident 44 required substantial to maximal assistance from staff to transition from a sitting to standing position, transferring from bed to chair or chair to bed, and to transfer on and off the toilet. During a review of Resident 44's Fall Risk Evaluation, dated 3/21/2024, the evaluation indicated Resident 44's score was 14. During a review of Resident 44's care plan titled High risk for falls, initiated 3/26/2024, indicated a care goal that Resident 44 would not sustain serious injury. Staff interventions indicated to follow the facility fall protocol, review information on past falls, attempt to determine the cause of falls, and alter or remove potential causes of falls. During a review of Resident 44's COC assessment, dated 5/19/2024, the COC assessment indicated on 5/19/2024, Resident 44 had a fall. The COC did not indicate any new documented fall interventions. During a review of Resident 44's IDT Assessment, dated 6/24/2024, the IDT assessment indicated staff were required to indicate if Resident 44 had any safety issues or risks, including a history of falls in the previous 180 days. The IDT assessment did not indicate Resident 44's history of a fall on 5/19/2024. The IDT assessment did not indicate the cause of Resident 44's fall on 5/19/2024, or if staff altered or removed potential causes of falls, as indicated on Resident 44's care plan. During a review of Resident 44's Fall Risk Evaluation, dated 6/26/2024, the evaluation indicated Resident 44's score was 13. During a review of Resident 44's COC assessment, dated 8/22/2024, the COC assessment indicated on 8/22/2024, Resident 44 was found with his face down on the floor. The COC assessment indicated Resident 44 reported he fell from his bed. The COC assessment indicated Resident 44 sustained a forehead wound measuring 3.8 centimeters (cm, measurement of length) by 3.8 cm, with surrounding redness to the skin. The COC assessment did not indicate any new documented fall interventions. During a review of Resident 44's COC assessment, dated 9/14/2024, the COC assessment indicated on 9/14/2024, Resident 44 was found with his face down on the floor. The COC assessment indicated Resident 44 reported he fell from his bed. The COC assessment indicated Resident 44 complained of moderate pain to his head. The COC assessment did not indicate any new documented fall interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review, on 12/3/2024 at 2:57 p.m., with RN 1, Resident 44's COC assessments dated 5/19/2024, 8/22/2024, and 9/14/2024, care plan titled High risk for falls, initiated 3/26/2024, and IDT assessment, dated 6/24/24, were reviewed. RN 1 stated the COC assessments indicated Resident 44 had three falls following the initiation of his fall risk care plan on 3/26/2024. RN 1 stated the care plan did not indicate new fall prevention interventions were created after Resident 44 fell on [DATE]. RN 1 stated Resident 44's IDT assessment, was inaccurate because it did not address Resident 44's fall from 5/19/2024. RN 1 stated the IDT indicated Resident 44 was at risk for falls. RN 1 stated Resident 44's fall and IDT assessment were two opportunities for the IDT to assess Resident 44 and develop resident-centered interventions to prevent additional falls. RN 1 stated no interventions were developed based on Resident 44's needs. RN 1 stated Resident 44's falls on 8/22/2024 and 9/14/2024 could have been prevented. During a review of the facility's policy and procedure (P&P) titled Fall Risk and Prevention Assessment, updated 3/2018, the P&P indicated facility staff were to assess and identify residents who were at risk for falls and develop appropriate plans of care to prevent resident falls and/or further falls. The P&P indicated residents identified as high risk for falls were supposed to be referred to the IDT for further assessment, proper intervention, and care planning to prevent falls. 49900 3. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44's admitting diagnoses included epilepsy (a chronic brain disorder that causes seizures [episodes of abnormal electrical activity in the brain]). During a review of Resident 44's active physician orders, dated 10/2/2024, the orders indicated staff were to apply padded siderails to prevent injury related to diagnosis of epilepsy. During a review of Resident 44's care plan titled Has a seizure disorder, dated 4/10/2024, the care plan indicated Resident 44 was to have padded siderails on both sides of his bed to prevent injury. During an observation on 12/2/2024 at 10:00 a.m., at Resident 44's bedside, observed Resident 44 bed with quarter-length siderails on both sides. The siderails were not padded. During an observation on 12/2/2024 at 8:47 a.m., at Resident 44's bedside, observed Resident 44's bed with quarter-length siderails on both sides. The siderails were not padded. During a concurrent observation and interview, on 12/3/2024 at 2:53 p.m., at Resident 44's bedside, with Certified Nursing Assistant (CNA) 2, Resident 44's bed was observed. CNA 2 stated she did not know Resident 44 was at risk for seizures or had a history of seizures. CNA 2 stated Resident 44 did not have padded siderails. CNA 2 stated the purpose of padded siderails was to protect Resident 44 from injury. During a concurrent interview and record review, on 12/3/2024 at 2:57 p.m., with RN 1, Resident 44's physician orders were reviewed. RN 1 stated Resident 44 was supposed to have padded siderails. RN 1 stated Resident 44 did not have padded siderails, and stated the purpose of the siderails was to prevent injury. RN 1 stated the absence of padding on the siderails increased the potential for Resident 44 to sustain injury if he had a seizure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to facility on 5/2/2024 and readmitted on [DATE] with diagnoses of diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), history of falling, and seizure. During a review of Resident 6's H&P, dated 5/3/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was mildly impaired. The MDS indicated Resident 6 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity) with oral hygiene and upper body dressing; moderate assistance (helper did less than half the effort) for toileting hygiene, lower body dressing, and personal hygiene, and substantial/maximal assistance (helper did more than half the effort) for showering /bathing and putting on/ taking off footwear. During a review of Resident 6's Order Summary Report, dated 11/5/2024, the report indicated an order, dated 7/5/2024, to apply padded side rails while in bed to prevent injury related to diagnosis of seizure. During a review of Resident 6's care plan titled The resident has a seizure disorder, revised 5/23/2024, the care plan indicated the goal was for Resident 6 to be free from injury from seizure activity. The care plan indicated staff's interventions included to apply padded side rails while in bed to prevent injury. During an observation on 12/2/2024 at 10:14 a.m., in Resident 6's room, observed Resident 6 lying on the bed with no padded side rails. During an observation on 12/3/2024 at 3:09 p.m., in Resident 6's room, observed Resident 6 lying on the bed with no padded side rails. During a concurrent observation and interview on 12/3/2024 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 6's room, observed Resident 6 s lying on the bed with no padded side rails. LVN 3 stated Resident 6 should have padded side rails. 5. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to facility on 7/13/2024 and readmitted on [DATE] with diagnoses of DM, HTN, epilepsy, and dementia (a progressive state of decline in mental abilities). During a review of Resident 35's H&P, dated 10/3/2024, the H&P indicated Resident 35 did not have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making was intact. The MDS indicated Resident 35 required substantial/maximal assistance with upper body dressing; and was dependent with eating, oral hygiene, toileting hygiene, showering /bathing self, lower body dressing, putting on/ taking off footwear, and personal hygiene. The MDS indicated Resident 35 required substantial/maximal assistance to roll left and right; and was dependent to sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/ shower transfers. The MDS indicated Resident 35 had impairment on the upper extremity (arm) and used a wheelchair for mobility. During a review of Resident 35's Order Summary Report, dated 10/5/2024, the report indicated an order, dated 10/1/2024, to apply padded side rails while in bed to prevent injury related to seizure. During a review of Resident 35's care plan titled The resident has a seizure disorder, revised 10/25/2024, the care plan indicated the goal was for Resident 35 to be free from injury related to seizure activity. The care plan indicated staff's intervention was to apply padded side rails. During an observation on 12/2/2024 at 11:38 a.m., in Resident 35's room, observed Resident 35 lying on the bed with no padded side rails. During an observation on 12/2/2024 at 3:04 p.m., in Resident 35's room, observed Resident 35 lying on the bed with no padded side rails. During an observation on 12/3/2024 at 8:50 a.m., in Resident 35's room, observed Resident 35 lying on the bed with no padded side rails. During a concurrent observation and interview on 12/3/2024 at 2:41 p.m. with LVN 3, in Resident 35's room, observed Resident 35 lying on the bed with no padded side rails. LVN 3 stated Resident 35 should have padded side rails to prevent head injury from seizure activities. LVN 3 stated the charge nurse was responsible for ensuring the presence of padded side rails. During a review of the facility's P&P titled Safety and Supervision of Residents, revised on 7/2017, the P&P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated to implement interventions to reduce accident risks and hazards shall include ensuring interventions were implemented. The P&P indicated staff shall ensure that interventions were implemented correctly and consistently to monitor the effectiveness of interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 32), received the oxygen two (2) liters per minute (LPM) via nasal cannula (NC - a device used to deliver supplemental oxygen through the nose) as ordered by the physician. This deficient practice had the potential to result in oxygen desaturation (decreased amount of oxygen in the blood) which could lead to low levels of oxygen in the body tissue (hypoxia), difficulty breathing, rapid heart rate, and confusion, including hospitalization and death. Findings: During a review of Resident 32's Admission Record, the admission record indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 32's diagnoses included atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN - high blood pressure), asthma (a chronic lung disease in which the airways in the lungs become narrowed and swollen, making it difficult to breathe), and obstructive sleep apnea (when the walls of the throat become blocked while sleeping, which can prevent air from moving through the windpipe). During a review of Resident 32's History and Physical (H&P), dated 9/1/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 9/7/2024, the MDS indicated Resident 32 had the ability to understand and be understood. The MDS indicated Resident 32 required partial assistance (helper does less than half the effort) with eating, substantial assistance (helper does more than half the effort) with oral and personal hygiene and was dependent (helper does all the effort) for toileting hygiene. The MDS indicated Resident 32 required a wheelchair for mobility (the ability of a resident to move around independently or with assistance). During a review of Resident 32's Order Summary Report, dated 12/5/2024, the order summary report indicated Resident 32 had an active order on 10/8/2024 to start oxygen at 2 LPM via NC continuously every shift. During a review of Resident 32's Order Summary Report, dated 12/5/2024, the order summary report indicated Resident 32 had an active order on 10/8/2024 to place continuous positive airway pressure ([CPAP] a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) to start at 9 p.m. until 6:30 a.m. or as needed. The order summary indicated to turn on machine, check the mode/settings and connect supplemental oxygen as ordered. During a review of Resident 32's care plan titled At risk for respiratory/aspiration (when a fluid or solid accidentally enters the windpipe and lungs) complications due to obstructive sleep apnea, revised 12/2/2024, the interventions indicated to provide Resident 32's oxygen and CPAP as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/2/2024 at 2:15 p.m. in Resident 32's room, Resident 32 had a nasal cannula connected to an oxygen concentrator (a medical device that provides extra oxygen) running at 2 LPM. The nasal cannula was connected to a humidifier (a medical device that adds moisture to supplemental oxygen), but the humidifier was not connected to the oxygen concentrator. During a concurrent observation and interview on 12/2/2024 at 2:30 p.m.in Resident 32's room, Licensed Vocational Nurse (LVN 1) confirmed Resident 32's humidifier with the oxygen tubing was disconnected from the oxygen concentrator. LVN 1 stated Resident 32 did not receive any oxygen. LVN 1 proceeded to connect the humidifier with the oxygen tubing to the concentrator. LVN 1 stated Resident 32 could have suffered difficulty breathing without the oxygen. LVN 1 stated the oxygen tubing was changed by night shift, but it was her (LVN 1) responsibility to make sure the oxygen tubing was connected properly during her shift. During an interview on 12/4/2024 at 1:58 p.m., the Director of Nursing (DON) stated Resident 32 did not receive oxygen if the humidifier with the oxygen tubing was not connected to the concentrator. The DON stated all staff were instructed to check oxygen and ensure oxygen are connected to the residents. The DON stated the licensed nurses should make sure the residents received the proper amount of oxygen. The DON stated Resident 32 could become short of breath without oxygen. During a review of the facility's undated policy and procedure (P&P) titled, Oxygen Administration, the P&P indicated, the facility must ensure that oxygen is administered to residents in accordance with the physician order. The P&P indicated monitoring of oxygen administration would be conducted and documented on the Medical Administration Record (MAR) by the licensed nurse and the Respiratory Therapist.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure residents who required dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) had failed) received services that were consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals, when the facility did not provide dialysis emergency kit (E-kit - contains supplies such as tape, clamp, and gauze to use in case the resident experienced bleeding from their dialysis access site) at the bedside, for three out of three residents (Resident 66, 36, and 63). These deficient practice placed the affected residents at risk for ineffective emergency treatment and complications of uncontrolled bleeding resulting in hospitalization and death. Findings: 1. During an observation on 12/2/2024 at 10:55 a.m., in Resident 66's room, observed Resident 66 was lying on bed with no dialysis emergency kit at bedside. During an observation on 12/2/2024 at 1:59 p.m., in Resident 66's room, observed Resident 66 was lying on bed with no dialysis emergency kit at bedside. During a review of Resident 66's Admission Record, the admission record indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of end stage renal disease (ESRD -irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), heart failure (HF-a heart disorder which caused the heart to not pump the blood efficiently), and hypertension (HTN-high blood pressure). During a review of Resident 66's History and Physical (H&P), dated 7/2/2024, the H&P indicated Resident 66 had the capacity to understand and make decisions. During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), dated 11/21/2024, the MDS indicated Resident 66's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 66 had impairments on lower extremities and used wheelchair for mobility device. The MDS indicated Resident 66 required partial/moderate assistance (helper did less than half the effort) with upper body dressing and personal hygiene; substantial/maximal assistance (helper did more than half the effort) with toileting hygiene and lower body dressing; and was dependent (helper did all the effort) with shower/ bathe self. The MDS indicated Resident 66 required partial/ moderate assistance to roll left and right; substantial/ maximal assistance to sit to lying, lying to sitting on side of bed, and chair bed-to-chair transfer; and was dependent for toilet transfer and tub/ shower transfer. During a review of Resident 66's care plan titled, At risk for renal/ dialysis complications, revised on 11/18/2024, the care plan indicated the goal was that Resident 66 would not have complications from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 36's Admission Record, the admission record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of ESRD, DM, HTN, and anemia (a condition where the body did not have enough healthy red blood cells). During a review of Resident 36's H&P, dated 10/25/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was intact. The MDS indicated Resident 36 had no impairments on extremities and used walker or wheelchair for mobility device. The MDS indicated Resident 36 required partial assistance with self-care, ambulation, and functional cognition. During a review of Resident 36's care plan titled, At risk for renal/ dialysis complications, revised on 9/25/2024, the care plan indicated the goal was that Resident 36 would not have complications from dialysis. During an interview on 12/4/2024 at 2:15 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated they monitored dialysis residents for bleeding, and she did not know about the dialysis emergency kit. During an interview on 12/4/2024 at 2:18 p.m. with the Director of Nursing (DON), the DON stated the charge nurse should know about the dialysis emergency kit, and the facility should have a policy addressing the dialysis emergency kit. 48131 3. During a review of Resident 63's Admission Record, the admission record indicated Resident 63 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN-high blood pressure). During a review of Resident 63's H&P dated 9/26/2024, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 was cognitively intact. The MDS indicated Resident 63 required partial assistance (helper does less than half the effort) with eating, oral hygiene and personal hygiene and was dependent (helper does all the effort) for toileting hygiene and bathing. The MDS indicated Resident 63 required a wheelchair for mobility (the ability of a resident to move around independently or with assistance). During a review of Resident 63's Order Summary Report, dated 12/5/2024, the order summary report indicated Resident 63 had an active order on 10/8/2024 for hemodialysis every Monday, Wednesday, and Friday at an outside dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 63's Order Summary Report, dated 12/5/2024, the order summary report indicated Resident 63 had an active order on 10/1/2024 to monitor the perm-a-cath (a flexible tube inserted into a blood vessel in the neck or upper chest to provide long-term access to the bloodstream for treatments including dialysis) on the right upper chest for signs and symptoms of infection everyday shift and as needed. During a review of Resident 63's care plan titled, readmitted with right upper chest perm-a-cath, initiated on 10/1/2024 and revised on 10/25/2024, the intervention indicated to monitor dressing for soilage, pain and re-dress as needed. The intervention indicated to notify the medical doctor of any significant changes. The care plan interventions did not include an E-kit at the bedside. During an observation on 12/3/2024 at 8:11 a.m. in Resident 63's room, Resident 63 was observed with a perm-a-cath on the right upper chest. Resident 63 did not have an E-kit at bedside for her hemodialysis perm-a-cath in case of an emergency. During a concurrent observation and interview on 12/3/2024 at 8:18 a.m., with LVN 1, in Resident 63's room, LVN 1 searched through Resident 63's bedside table for a hemodialysis E-kit. LVN 1 stated Resident 63 did not have a hemodialysis E-Kit at the bedside. LVN 1 stated hemodialysis E-Kits are important for all residents receiving hemodialysis, to have at the bedside in case the perm-a-cath or shunt (a surgical connection between an artery and a vein that allows for direct access to the bloodstream for dialysis) became displaced and bleed. LVN 1 stated the E-Kit contained supplies to stop the bleeding of a shunt or perm-a-cath and are needed in case of an emergency. During an interview on 12/4/2024 at 2:18 p.m., the DON, stated the nursing staff should be aware that an E-kit should be present at the bedside of all residents receiving hemodialysis. The DON stated the E-kits are important in case Resident 63's port-a-cath has uncontrolled bleeding. The DON stated a resident could bleed out and die if bleeding was not stopped in time. The DON stated he was aware that the current hemodialysis policy and procedure (P&P) and care plan interventions did not include having an E-kit at the bedside. The DON stated he had discussed the issue in the last Quality Assurance/Quality Assurance and Performance Improvement (QAPI -a data driven proactive approach to improvement used to ensure services are meeting quality standards) meeting and a new policy would be created and implemented for hemodialysis after discussion and review at the next QAPI meeting. The DON stated he would ensure the new policy included information regarding the E-kits at the bedside for all hemodialysis residents. The DON stated he would also in-service his nursing staff on the importance of having E-kits at the bedside. During a review of the facility's Policy and Procedure (P&P) titled Hemodialysis, care of residents, pending revision date, the P&P indicated dialysis kits should be at the bedside. During a review of the facility's P&P titled Dialysis care, undated, the P&P indicated Facility shall ensure provision of standards of care for residents on renal dialysis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47286 Based on interview and record review, the facility failed to review and act on the Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) conducted for all facility residents from 8/19/2024 to 8/20/2024. This deficient practice resulted in delays to adjustments to multiple residents' medications and/or plans of care due to lack of physician notification of the consultant pharmacist's recommendations. Findings: During a review of the MRR dated 8/9/2024 to 8/20/2024, the MRR indicated the facility's Consultant Pharmacist made recommendations for 35 of 91 facility residents reviewed. During a concurrent interview and record review on 12/4/2024 at 11:25 a.m., with the Director of Nursing (DON), the MMR dated 8/19/2024 to 8/20/2024 was reviewed. The DON stated the MRR indicated recommendations made by the facility's consultant pharmacist. The DON stated that the recommendations were not reviewed, reported to the respective residents' physicians, or acted upon. The DON stated he did not know about the recommendations until 12/4/2024. During an interview on 12/4/2024 at 11:30 a.m., with the facility's Consultant Pharmacist, the Consultant Pharmacist stated his recommendations should be acknowledged and addressed within a reasonable timeframe. The Consultant Pharmacist stated this required facility staff to notify the residents' respective physicians of the MRR recommendations or requested clarifications to allow the physicians to make informed decisions about required adjustments to the residents' plan of care. During a review of the facility's policy and procedure (P&P) titled Limited Drug Regimen Review, dated 4/2018, the P&P indicated the purpose of the P&P was to review medications and identify and potential drug interactions and minimize adverse consequences from receiving unnecessary medications. The P&P indicated that if an offsite MRR was conducted by a pharmacy consultant and recommendations were made, facility staff were supposed to contact the physician and inform them of why a change in medication was indicated. The P&P indicated the DON and/or their designee was responsible for implementation and enforcement of the P&P.

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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** 47286 Based on interview and record review, the facility failed to ensure unnecessary medications were not administered to two of five sampled residents (Resident 45 and Resident 62) when: 1. A gradual dose reduction (GDR, stepwise tapering of a medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Resident 45's sertraline (a medication used to treat depression) was not attempted. 2. Informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of Trazodone (a drug used to treat depression [a constant feeling of sadness and loss of interest]) ordered on 10/8/2024, was not obtained for Resident 62 prior to use. This deficient practice created the potential for Resident 45 to suffer unwanted adverse effects from continued administration of sertraline, including increased risk of suicidal thoughts and other mental status changes. This deficient practice also had the potential to result in Resident 62 being unaware of the adverse effects (also known as side effects, were unwanted, uncomfortable, or dangerous effects that a drug might have) related to the medication therapy, possibly causing impairment or decline in mental, physical condition, functional, and/or psychosocial status of Resident 62. Findings: 1. During a review of Resident 45's Admission Record, the Admission Record indicated the facility admitted Resident 45 on 3/19/2024, and most recently readmitted Resident 45 on 4/16/2024. Resident 45's admitting diagnoses included depression and psychosis (mental disorder characterized by a disconnection from reality). During a review of Resident 45's History and Physical (H&P), dated 7/3/2024, the H&P indicated Resident 45 had the capacity to understand and make medical decisions. During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 10/22/2024, the MDs indicated Resident 45 had mild cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 45 required supervision to total dependence on staff for activities of daily living (ADLS, activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 45's active physician orders, dated 4/16/2024, the orders indicated Resident 45 was to receive sertraline 100 mg at bedtime for depression. (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 Resident 45's care plan titled [Resident 45] uses .sertraline [related] to depression, dated 4/17/2024, the care plan indicated staff were to monitor Resident 45 for adverse reactions associated with sertraline including suicidal thoughts, muscle cramps, dizziness, fatigue, inability to sleep, and decline in ADL ability. The care plan further indicate staff were to educate the resident and resident's family about the risks, side effects, and/or toxic symptoms of Sertraline. During a review of Resident 45's Medication Administration Records (MAR), dated 5/2024 through 10/2024, the MARs indicated staff monitored Resident 45 for signs of depression and psychosis. The MARs indicated Resident 45 did not have any episodes of depression from 5/2024 through 10/2024. During a review of the Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication), dated 7/30/2024, indicated Resident 45 received aripiprazole 5 mg twice a day and sertraline 100 mg at bedtime since 4/16/2024. The MRR indicated the facility's consultant pharmacist recommended a GDR should be attempted in two separate quarters (two 3-month periods) within the first year the resident received the medication. During a review of Resident 45's psychiatric progress note, dated 7/24/2024, the progress note indicated staff reported Resident 45 had not had any behavior issues. The progress note did not indicate a GDR was attempted. During a review of Resident 45's psychiatric progress note, dated 8/23/2024, the progress note indicated Resident 45 denied experiencing any depressive feelings or symptoms of psychosis. The progress note further indicated there had been no reports of verbalized sadness or psychotic symptoms in the past month. The progress note did not indicate a GDR was attempted. During a review of Resident 45's psychiatric progress note, dated 9/9/2024, the progress note indicated there had been no episodes of verbalized sadness, delusional thoughts, or paranoid behaviors observed in the past month. The progress note did not indicate a GDR was attempted. The progress note indicated a GDR would be considered based on the next psychiatric evaluation. During a review of Resident 45's psychiatric progress note, dated 10/11/2024, the progress note indicated there had been no episodes of verbalized sadness, delusional thoughts, or paranoid behaviors observed in the past month. The progress note did not indicate a GDR was attempted. During an interview on 12/4/2024 at 9:42 a.m., with Resident 45, Resident 45 stated facility staff did not tell Resident 45 she was receiving sertraline. Resident 45 stated she was not aware of the associated side effects and risks associated with sertraline and stated she was not taking sertraline prior to her admission to the facility. During an interview on 12/4/2024 at 11:30 a.m., with the facility's Consultant Pharmacist, the Pharmacist stated sertraline was associated with cardiac (heart) problems and metabolic disorders (a condition that occurs when the body's chemical reactions are abnormal). The pharmacist stated GDRs were important to decrease residents from suffering potential adverse effects associated with unnecessary medications. The Pharmacist stated the goal was to gradually decrease the dose of the medication and eventually discontinue. The Pharmacist stated that if the resident was not displaying the behavior for which the medication was indicated, a GDR should be attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 3:03 p.m., with the Director of Nursing (DON), Resident 45's MARs dated 5/2024 through 10/2024, and psychiatric progress notes dated 7/2024 through 10/2024 were reviewed. The DON stated the MARs indicated Resident 45 did not have any episodes of depression, which was the indication for Resident 45's sertraline order. The DON stated Resident 45's psychiatric progress notes also indicated Resident 45 had not experienced any episodes of depression from 7/2024 through 10/2024. The DON stated a GDR should have been attempted and stated there was no documentation in Resident 45's medical record to indicate a GDR was unsafe or contraindicated. The DON stated the potential side effects of continued unnecessary administration of sertraline and included tardive dyskinesia (a condition affecting the nervous system, often caused by long-term use of some psychiatric drugs) and excessive sedation (a depression of consciousness in which a person cannot be aroused but responds to repeated or painful stimuli). During a review of the facility's policy and procedure (P&P) titled Dose Drug Reduction, undated, the P&P indicated it was the facility's policy to evaluate psychotropic medications (medications that affect a person's mental state) on a continuous basis and focus on length of therapy and dose. The P& indicated in the absence of adequate indication for continued use of the medication (e.g., behavior occurs only one to three days in a week or not at all), the resident should be referred to the physician or psychiatrist for possible drug dose reduction. 49900 2. During a review of Resident 62's Admission Record, the record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), anemia (a condition where the body did not have enough healthy red blood cells), and depression. During a review of Resident 62's History and Physical (H&P), dated 5/16/2024, the H&P indicated Resident 62 had the capacity to understand and make decisions. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62's cognitive skills for daily decision making was intact. The MDS indicated Resident 62 had no impairments to the extremities and used a walker or wheelchair for mobility. The MDS indicated Resident 62 required partial/moderate assistance (helper did less than half the effort) with upper body dressing and personal hygiene; substantial/maximal assistance (helper did more than half the effort) with toileting hygiene and lower body dressing; and was dependent (helper did all the effort) with shower/ bathe self. The MDS indicated Resident 62 required partial/ moderate assistance to roll left and right and walk 10 feet; substantial/ maximal assistance to sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, walk 50 feet with two turns, and walk 150 feet; and was dependent for toilet transfer and tub/ shower transfer. During a review of Resident 62's Oder Summary Report, dated 11/5/2024, the report indicated an order, dated 10/8/2024, trazodone 50 mg at bedtime for depression. During a review of Resident 62's MAR for October 2024, the record indicated Resident 62 started receiving trazadone 50 mg at bedtime on 10/8/2024. (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 12/4/2024 at 12:03 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 62's medical records (both physical and electronic) were reviewed, the records indicated there was no informed consent for trazodone 50 mg at bedtime, ordered on 10/8/2024. LVN 2 stated she was not able to locate the informed consent for Resident 62's trazodone 50 mg at bedtime, ordered on 10/8/2024. During a concurrent interview and record review on 12/4/2024 at 12:10 p.m. with Registered Nurse (RN) 1, Resident 62's medical records were reviewed, the record indicated no informed consent for trazodone 50 mg at bedtime, ordered on 10/8/2024. RN 1 stated the informed consent was not found in the medical record meant it was not done, and the purpose of the informed consent was to inform resident about the side effects of medication. RN 1 stated the psychotropic medications (medications affected the mind, emotions, and behavior) increased the risk of the intoxication in residents. RN 1 stated residents were at risk of experiencing side effects of the medication without the informed consent. RN 1 stated the informed consent needed to be completed when the medication order was obtained. RN 1 stated the licensed nurse could not administer medication without an informed consent, and the licensed nurse needed to ensure there was informed consent before administrating the medication. RN 1 stated it was not acceptable to administer trazodone without an informed consent in Resident 62's medical record. During a review of facility's P&P titled Informed consent, dated 12/2018, the P&P indicated The signed consent form is to be obtained and kept in the patient's record as: For every patient receiving antipsychotic medications, the facility must maintain a written record of the patient's decision to consent to such medications.

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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. 49900 Based on observation, interview, and record review the facility failed to ensure the inside gasket of the kitchen's ice machine was free of yellow and white build up components. This deficient practice placed all the residents who consumes ice in the facility, at risk for foodborne illnesses (diseases caused by consuming food or drinks that are contaminated with harmful bacteria, viruses, parasites, or chemicals). Findings: During a concurrent observation and interview on 12/2/2024 at 10:31 a.m. with the Dietary Supervisor (DS), in facility kitchen, the inside gasket of the ice machine (a rubber lining that creates a tight seal around the door of an ice machine) was observed with yellow and white buildup. The DS stated the yellow buildups should not be inside the ice machine, and nothing yellow should be inside the ice machine. The DS stated the yellow buildups could be mold. The DS stated ice are considered as food, and the yellow buildups could potentially contaminate the ice and cause food poisoning when ingested by the residents. The DS stated maintenance department are responsible for cleaning the internal of the ice machine. During a concurrent observation and interview on 12/2/2024 at 10:40 a.m. with the Maintenance Manager (MM), in facility kitchen, the MM observed the inside gasket of the ice machine had yellow and white residue built up. The MM stated there were dirty calcium buildups inside the ice machine and shouldn't have been there. During a review of the facility's policy and procedure (P&P) titled, Sanitation and infection control, dated 2018, the P&P indicated, ice should be produced, stored, and dispensed in a manner to avoid contamination. The P&P indicated the inside gaskets or seals should be wiped down weekly by Department of Food and Nutrition Services to remove any potential mold/calcium buildup.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure left over food, for four out of four residents (Residents 69, 66, 73 and 63), were stored, in accordance with the facility's policy and procedure (P&P) titled, Foods brought by family/ visitors. These deficient practices placed Residents 69, 66, 73 and 63 at risk for food-borne illnesses (food poisoning, with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and could lead to other serious medical complications and hospitalization . Findings: 1. During a review of Resident 69's Admission Record, dated 12/5/2024, the admission record indicated Resident 69 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a heart disorder which caused the heart to not pump the blood efficiently), hypertension (HTN, high blood pressure), and chronic kidney disease (CKD, kidneys were damaged and could not filter blood the way they should). During a review of Resident 69's History and Physical (H&P), dated 10/5/2024, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool), dated 9/13/2024, the MDS indicated Resident 69's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 66 had no impairments on extremities and used a walker or wheelchair for mobility. The MDS indicated Resident 66 required supervision with toileting hygiene, upper body dressing, and personal hygiene; partial/moderate assistance (helper did less than half the effort) with lower body dressing and putting on/taking off footwear; and substantial/maximal assistance (helper did more than half the effort) with shower and bathing self. The MDS indicated Resident 69 required supervision to perform sit to lying, lying to sitting on side of bed, and walk 50 feet with two turns; partial/ moderate assistance to sit to stand, chair bed-to-chair transfer, toilet transfer, and walk 150 feet; and substantial/ maximal assistance with tub/ shower transfer. During a concurrent observation and interview on 12/2/2024 at 9:43 a.m. with Resident 69, in Resident 69's room, a used hot sauce without label of resident's name, the item, and the use by date, was observed on Resident 69's bedside table. Resident 69 stated he used his hot sauce every day, and it was brought in by his wife (date not known). During a concurrent observation and interview on 12/2/2024 at 3:48 p.m. with Certified Nursing Assistant (CNA 3), in Resident 69's room, CNA 3 confirmed the bottle of used hot sauce had no label of resident's name, the item, and the use by date, that was on Resident 69's bedside table. 2. During a review of Resident 66's Admission Record, the admission record indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), end stage renal disease (ESRD, irreversible kidney failure), Heart Failure, and HTN. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 66's H&P, dated 7/2/2024, the H&P indicated Resident 66 had the capacity to understand and make decisions. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition was intact. The MDS indicated Resident 66 had impairments on lower extremities and used wheelchair for mobility. The MDS indicated Resident 66 required partial/moderate assistance with upper body dressing and personal hygiene; substantial/maximal assistance with toileting hygiene and lower body dressing; and was dependent (helper did all the effort) with shower/ bathe self. The MDS indicated Resident 66 required partial/ moderate assistance to roll left and right; substantial/ maximal assistance to sit to lying, lying to sitting on side of bed, and chair bed-to-chair transfer; and was dependent for toilet transfer and tub/ shower transfer. During a concurrent observation and interview on 12/2/2024 at 10:55 a.m. with Resident 66, in Resident 66's room, outside food from Popeyes (an American multinational chain of fried chicken restaurants) was observed on Resident 66's bedside table without a label of resident's name, the item, and the use by date. Resident 66 stated she brought the food from outside of the facility yesterday. During an observation and interview on 12/3/2024 at 8:50 a.m. with Resident 66, in Resident 66's room, a box of dessert and SaraLee (frozen baked goods and desserts manufacture and supplier) classic pound cake was observed on Resident 66's bedside table without label of resident's name, the items, and the use by date. Resident 66 stated the food was brought in by her family. During a concurrent of observation and interview on 12/3/2024 at 2:30 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 66's room, LVN 3 observed the box of dessert and SaraLee classic pound cake without label of resident's name, the items, and the use by date on Resident 66's bedside table. LVN 3 stated she was not sure if outside food should have been labeled. 3. During an observation on 12/2/2024 at 10:45 a.m., in Resident 73's room, a bottle of used hot sauce without label of resident's name, the item, and the use by date was observed on Resident 73's bedside table. During a review of Resident 73's Admission Record, the admission record indicated Resident 73 was admitted to the facility on [DATE] with diagnoses of DM, dysphagia (difficulty swallowing), heart failure, and HTN. During a review of Resident 73's H&P, dated 11/17/2023, the H&P indicated Resident 73 had the capacity to understand and make decisions. During a review of Resident 73's MDS dated [DATE], the MDS indicated Resident 73's cognition was intact. The MDS indicated Resident 73 had no impairments on extremities and used wheelchair or walker for mobility. The MDS indicated Resident 73 required supervision with personal hygiene; partial/moderate assistance with upper body dressing and toileting hygiene; and substantial/maximal assistance with shower/ bathe self, putting on/taking off footwear, and lower body dressing. During a concurrent of observation and interview on 12/2/2024 at 11:22 a.m. with Resident 73, in Resident 73's room, a bottle of used hot sauce without label of resident's name, the item, and the use by date, was observed on Resident 73's bedside table. Resident 73 stated the hot sauce was brought in by family. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent of observation and interview on 12/2/2024 at 3:45 p.m. with CNA 3, in Resident 73's room, CNA 3observed a bottle of used hot sauce without label of resident's name, the item, and the use by date on Resident 73's bedside table. CNA 3 stated she did not know if outside food needed to be labeled. During an interview on 12/3/2024 at 2:38 p.m., the Director of Staff Development (DSD), stated food left at bedside should have been labeled with date, time, and resident's name. The DSD state the facility had a refrigerator for residents to store residents' food. The DSD stated, food without date could be spoiled, and resident could get sick if they were eaten. The DSD stated nurses, CNA, or anyone who observed food at resident's bedside are responsible to label the food. During an interview on 12/3/2024 at 2:49 p.m., the Dietary Supervisor (DS) stated any leftover food at resident's bedside needed to be labeled with name and date. The DS stated, even the hot sauce should have been labeled with the resident's name and dated. The DS stated the food at the resident's bedside should be discarded, especially, if it was there for a long time. The DS stated staff should follow guideline to keep food at bedside or else resident could get sick. 48131 4. During a review of Resident 63's Admission Record, the admission record indicated Resident 63 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including ESRD, dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type 2 DM and HTN. During a review of Resident 63's H&P, dated 9/26/2024, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 was cognitively intact. The MDS indicated Resident 63 required partial assistance (helper does less than half the effort) with eating, oral hygiene and personal hygiene and was dependent (helper does all the effort) for toileting hygiene and bathing. The MDS indicated Resident 63 required a wheelchair for mobility (the ability of a resident to move around independently or with assistance). During an observation on 12/3/2024 at 8:11 a.m., in Resident 63's room, a brown paper bag sitting on Resident 63's nightstand was observed. The brown paper bag contained a left over, half eaten sandwich. During a concurrent observation and interview on 12/3/2024 at 8:18 a.m., with Licensed Vocational Nurse (LVN 1) in Resident 63's room, LVN 1 acknowledged the brown paper bag on Resident 63's nightstand. LVN 1 stated the sandwich came from Resident 63's lunch for her hemodialysis appointment the day before. LVN 1 stated the sandwich should not have been at the bedside because it was not refrigerated. LVN 1 stated Resident 63 may have gotten sick if she had eaten the sandwich. During an interview on 12/4/2024 at 2:34 p.m. with the Director of Nursing (DON), the DON stated that any leftover food should be thrown away and not left at the bedside. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Foods brought by family/ visitors, dated 3/2022, the P&P indicated, food brought by family/visitors that are left with the resident to consume later, should be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. The P&P indicated; perishable foods should be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the 'use by' date.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure the garbage storage area was maintained in a sanitary condition, by failing to ensure: 1. There were no trash bags and cardboard boxes on the ground. 2. The outside trash dumpster lid was closed. These deficient practices had the potential to result in pests' inside the facility and pest-related diseases (like [NAME] virus [spread by mosquitoes], lyme disease [a bacterial infection spread by the bite of an infected blacklegged tick], and rabies [a preventable viral disease of mammals usually transmitted through the bite of an infected animal]). Findings: During a concurrent observation and interview on 12/2/2024 at 11:35 a.m. with the Dietary Supervisor (DS), at the facility outdoor garbage storage area, the area had trash bags and cardboard boxes on the ground. The DS stated she had no comments on the garbage area because the maintenance should be the one responsible for it. During a concurrent observation and interview on 12/2/2024 at 10:40 a.m. with the Maintenance Manager (MM), at the facility outdoor garbage storage area, the MM observed trash bags and cardboard boxes on the ground. The dumpster had overflow of trash and the lid was not closed. The MM stated it was not acceptable to have trash on the ground and dumpster lid not closed. The MM stated it could cause disease and potential to cause infection. During a review of the facility's policy and procedure (P&P) titled, Sanitation and infection control, dated 2018, the P&P indicated the lids of outside trash dumpsters should be kept closed to prevent pests, animals, or debris from falling in.require a protective cover to prevent pests, animals, or debris from falling in.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to conduct a rehabilitation screening and/or provide rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) and restorative nursing services (RNS, nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible) for one of 21 sampled residents (Resident 45). This deficient practice prevented the facility Case Manager (CM) from advocating for Resident 45 to receive rehabilitative therapy services and led to a delay in the provision of RNS to Resident 45. This created the potential for a decline in Resident 45's mobility and ability to perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). Findings: During a review of Resident 45's Admission Record, the Admission Record indicated the facility admitted Resident 45 on 3/19/2024, and most recently readmitted Resident 45 on 4/16/2024. Resident 45's admitting diagnoses included a cerebral infarction (stroke, loss of blood flow to a part of the brain) and an amputation (removal) of the left leg below the knee. During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 10/22/2024, the MDS indicated Resident 45 had mild cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 45 required supervision to total dependence on staff for activities of daily living (ADLS, activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 45's discontinued physician orders, dated 4/17/2024, the orders indicated Resident 45 was to receive skilled physical, occupational, and speech therapy evaluations. During a review of Resident 45's active physician orders, dated 7/23/2024, the orders indicated Resident 45 was to receive passive range of motion (PROM, a type of RNS where an outside force [such as a therapist or machine] causes movement of a joint) exercises five times a week, as tolerated. During an interview on 12/2/2024 at 2:36 p.m., with Resident 45, Resident 45 stated she was not receiving any physical, occupational, or speech therapy services. During a concurrent interview and record review, on 12/5/2024 10:07 a.m., with the Director of Rehabilitation Services (DOR), Resident 45's rehabilitation screenings were reviewed. The DOR stated the rehabilitation screenings indicated Resident 45 was not evaluated or screened for skilled therapy services, as ordered on 4/17/2024, upon readmission to the facility on [DATE]. Resident 45's Interdisciplinary (IDT, group of different disciplines working together towards a common goal of a resident) assessment dated [DATE] was reviewed, and the DOR stated the assessment indicated there were no therapy staff in attendance, and stated the assessment did not indicate Resident 45 was assessed for, or that a plan of care was developed for, restorative nursing services including PROM exercises, or skilled therapy services. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/2024 at 10:31 a.m., with the Case Manager (CM), the CM stated Resident 45 was not authorized to received skilled therapy services prior to readmission to the facility. The CM stated that if the physician ordered for therapy evaluations upon readmission, the resident should still be screened for skilled therapy services. The CM stated that if the evaluation determined the resident could benefit from skilled therapy services, she could advocate for the resident and attempt to get authorization for skilled therapy services. During a concurrent interview and record review, on 12/5/2024 at 11:06 a.m., with the DOR, Resident 45's physician orders and documentation of Resident 45's PROM exercises were reviewed. The DOR stated Resident 45's orders and documentation for the resident's PROM exercises indicated Resident 45 did not receive PROM exercises until 7/23/2024, following her readmission on 4/16/2024. The DOR stated assessment for, and provision of, RNS did not need to be authorized prior to Resident 45's admission to the facility. The DOR stated the RNS should have been started upon Resident 45's readmission to the facility. The DOR stated delaying the provision of the RNS could contribute to a decline in Resident 45's mobility and/or ability to perform ADLs. The DOR stated the facility's failure to conduct the therapy screening, as ordered by the physician, also prevented the CM from advocating for Resident 45 to receive skilled therapy services. The DOR stated Resident 45 was receiving therapy services prior to the resident's hospitalization and readmission and stated Resident 45's discharge assessment indicated the resident likely would have continued to benefit from therapy services upon readmission. During a review of the facility's policy and procedure (P&P) titled Rehabilitation Services, undated, the P&P indicated patient assessment and evaluation for benefits of rehabilitations services were supposed to be performed on all residents referred to rehabilitation services by an ordering physician. The P&P indicated staff were supposed to develop treatment plans for all residents determined to be candidates for beneficial outcome from rehabilitation services. During a review of the facility's P&P titled Standards for Restorative Nursing Program, dated 9/2019, the P&P indicated restorative nursing services were provided to ensure maintenance of the resident's optimum level of function. The P&P indicated residents who had been discharged from therapy and would benefit from restorative nursing services were supposed to be started on a restorative nursing program by a licensed therapist.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to implement infection control practices for three out of three sampled residents (Resident 38, 62, 84) by failing to: 1. Change the nasal cannula (NC, a plastic medical device to provide supplemental oxygen therapy to resident who had lower oxygen levels; device went directly into the nostrils) tubing every seven days. 2. Ensure Resident 38 and 84's indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) tubing did not touch the floor. 3. Ensure Resident 84's indwelling urinary catheter tubing and drainage bag was free of sediments (gritty particles that settle at the bottom of a liquid). These deficient practices placed Resident 62, Resident 38, and Resident 84 at risk for infection which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death), and increased Resident 84's risk of an undiagnosed urinary tract infection (UTI- an infection in the bladder/urinary tract) or the presence of kidney disease. Findings: 1. During an observation on 12/2/2024 at 10:55 a.m., in Resident 66's room, Resident 66 was observed receiving oxygen via NC. The NC tubing was dated 11/25/2024. During an observation on 12/2/2024 at 1:59 p.m., in Resident 66's room, Resident 66 was observed receiving oxygen via NC. The NC tubing was dated 11/25/2024. During an observation on 12/3/2024 at 8:50 a.m., in Resident 66's room, Resident 66 was observed receiving oxygen via NC dated 11/25/2024. During a review of Resident 66's Admission Record, dated 12/5/2024, the admission record indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 66's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), end stage renal disease (ESRD -irreversible kidney failure), heart failure (HF- a heart disorder which caused the heart to not pump the blood efficiently), and hypertension (HTN- high blood pressure). During a review of Resident 66's History and Physical (H&P), dated 7/2/2024, the H&P indicated Resident 66 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), dated 11/21/2024, the MDS indicated Resident 66's cognitive skills for daily decision making (ability to think, remember, and reason) was intact. The MDS indicated Resident 66 required partial/moderate assistance (helper did less than half the effort) with upper body dressing and personal hygiene, substantial/maximal assistance (helper did more than half the effort) with toileting hygiene and lower body dressing and was dependent (helper did all the effort) with showering/bathing. The MDS indicated Resident 66 was dependent for toilet transfer and tub/ shower transfer. The MDS indicated Resident 66 had impairments on the lower extremities and used a wheelchair for mobility. During a review of Resident 66's Oder Summary Report, dated 11/5/2024, the report indicated an order, dated 7/1/2024, to change the resident's oxygen tubing every Sunday. During a concurrent of observation and interview on 12/3/2024 at 2:30 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 66's room, Resident 66 was observed receiving oxygen via NC. The NC tubing was dated 11/25/2024. LVN 3 stated the NC tubing should be changed every seven days to prevent infection because the microorganism (an organism that could be seen only through a microscope including bacteria and fungi) could enter the residents respiratory tract through the NC. LVN 3 stated Resident 66 might develop a respiratory infection if the NC was not changed every seven days. LVN 3 stated the charge nurse was the one responsible for changing the NC. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen administration, undated, the P&P indicated, Label and date nasal cannula tubing and change every 7 days by LN (Licensed nurse) and or RT (Respiratory therapy). 49900 2. During an observation on 12/2/2024 at 2:33 p.m., in Resident 38's room, Resident 38's indwelling urinary catheter tubing and drainage bag was observed touching the floor. During an observation on 12/3/2024 at 9:01 a.m., in Resident 38's room, Resident 38's indwelling urinary catheter tubing and drainage bag was observed touching the floor. During a review of Resident 38's Admission Record, the admission record indicated Resident 38 was admitted to the facility on [DATE]. Resident 38's diagnoses included UTI and kidney failure (loss of kidney function). During a review of Resident 38's H&P dated 9/14/2024, the H&P indicated Resident 38 did not have the capacity to make decisions for herself. During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 38 was dependent on staff for toileting hygiene, shower/bathing and putting on and taking off footwear. The MDS indicated Resident 38 required maximal assistance (helper does more than half the effort) for eating, oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. During a review of Resident 38's Order Summary Report dated 11/12/2024, the order summary report indicated Resident 38 had an order for a urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 38's care plan for the use of a urinary catheter dated 11/12/2024, the care plan indicated the goal was that resident will show no signs of urinary tract infection. The staff's interventions were to place the catheter bag and tubing below the level of the urinary bladder and away from the entrance room door, change the catheter drainage bag every 2 weeks on the 10th and 24th of each month, and change the catheter bag as needed when bag is soiled or catheter is dislodged. 45009 3. During an observation on 12/2/2024 at 3:02 p.m., in Resident 84's room, Resident 84's urinary catheter drainage bag was observed touching the floor. The drainage bag air vents (help prevent air from building up in the bag, which causes issues with urine flow) and urinary catheter drip chamber (prevents microorganisms from moving up the inlet tube and allows the user to visually check the flow of urine) were covered with yellow urine and encrusted (buildup of mineral crystals on the surface or inside of a medical device) sediments. During an observation on 12/3/2024 at 9:27 a.m., in Resident 84's room, Resident 84's urinary catheter tubing and drainage bag was observed touching the floor. The urinary drainage bag air vents were covered with yellow urine sediments and the foley's drip chamber was observed with encrusted sediments. During an observation on 12/4/2024 2:22 p.m., in Resident 84's room, Resident 84's urinary drainage bag air vents were observed covered with yellow urine sediments and the drip chamber was observed with encrusted sediments. During an observation on 12/5/2024 at 11:34 a.m., in Resident 84's room, Resident 84's urinary drainage bag air vents were covered with yellow urine sediments and the drip chamber was observed with encrusted sediments. During a review of Resident 84's Admission Record, the admission record indicated Resident 84 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 84's diagnoses included kidney failure and diabetes mellitus (body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). During a review of Resident 84's H&P dated 10/7/2024, the H&P indicated Resident 84 did not have the capacity to understand and make decisions. During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 84 was dependent on staff for oral hygiene, toileting hygiene, shower/bathing, dressing, putting on and taking off footwear and personal hygiene. During a review of Resident 84's Order Summary Report dated 11/12/2024, the order summary report indicated Resident 84 had an order for a urinary catheter to gravity for drainage. The order summary report indicated Resident 84 had an order to change the urinary catheter drainage bag every 2 weeks on the 10th and 24th of each month. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 84's care plan for the use of an indwelling urinary catheter dated 11/12/2024, the care plan indicated the goal was that Resident 84 will show no signs of urinary tract infection. The staff's interventions were to place the catheter bag and tubing below the level of the urinary bladder and away from entrance room door, change the catheter drainage bag every 2 weeks on the 10th and 24th of each month, and change catheter bag as needed when bag is soiled or catheter dislodged. During a concurrent observation and interview on 12/5/2024 at 11:22 a.m. with Certified Nursing Assistant (CNA 4), Resident 1's urinary drainage bag was observed encrusted with sediments in the air vents and drip chamber. CNA 4 stated she emptied out Resident 84's drainage bag that day (12/5/2024) and did not notice the sediments in the urine. CNA 4 stated she did not notice that the drainage bag was dirty or encrusted with sediments. CNA 4 stated she was responsible for checking the color and smell of the urine and if there were sediments in the urine she had to report it to the charge nurse. CNA 4 stated she had to report the findings to the charge nurse for infection prevention. CNA 4 stated the urinary catheter tubing and drainage bag must not touch the floor for infection control purposes. During a concurrent observation and interview on 12/5/2024 at 11:45 a.m. with LVN 5, Resident 84's urinary drainage bag was observed with encrusted sediments in the air vents and drip chamber. LVN 5 stated she was not aware that Resident 84 had sediments in the tubing and that the drainage bag was dirty because it had encrusted sediments. LVN 5 stated she did not know when the last time Resident 84's urinary drainage bag was changed. LVN 5 stated it was important for residents not to have a dirty urinary bag to prevent infections. During a concurrent observation and interview on 12/5/2024 at 12:15 p.m. with the Infection Preventionist Nurse (IPN), Resident 1's urinary drainage bag was observed with encrusted sediments in the air vents and drip chamber. The IPN stated Resident 84's urinary drainage bag should have been changed because it had the potential to cause a urine infection. The IPN stated the urinary drainage bag must be changed because the sediments caused the urine flow to slow down and it was taking longer for the urine to drain down the tubing. The IPN stated if urine was not draining as it should, it would cause a backflow of urine and possibly cause a urine infection. The IPN stated the whole team should have noticed the state the urinary draining bag was in and any licensed nurse should have change it. The IPN stated the urinary tubing and drainage bags should never touch the floor to prevent infections. During an interview on 12/5/2024 at 1:01 p.m. with Registered Nurse (RN 1), RN 1 stated the urinary catheter tubing and drainage bags should never touch the floor to prevent an infection and for hygiene. RN 1 stated sediments in the urine was not normal and must be reported to a charge nurse. RN 1 stated encrusted sediments could potentially cause urinary retention, pain, create a risk for urine backflow, and possibly cause a urine infection. During a review of the facility's Policy and Procedure (P&P) titled Foley/Indwelling Catheter, undated, the P&P stated residents with a foley (indwelling) catheter would be monitored for complications due to foley catheter usage.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48131 Based on observation, interview, and record review, the facility failed to ensure effective, ongoing pest control program was maintained in the facility. This deficient practice resulted in unresolved infestation of german cockroaches (a small, fast-moving, nocturnal cockroach that is a common household pest in the United States) and had the potential to affect the health and living conditions of the 91 residents residing in the facility. Findings: During an observation on 12/2/2024 at 8:45 a.m. in the Admission's Office (surveyor's work area), which was located directly next to the kitchen, the area was cluttered with three desks, a couch, a refrigerator, microwave, christmas decorations and cardboard boxes, stored on the floor filled with paper documents. The cardboard box was observed on the floor against the wall, next to the refrigerator. The cardboard box had water damage at the base of the box. On the wall adjacent to the kitchen was a square hole, which had an uncovered electrical outlet with exposed wires coming from the hole. During an observation on 12/2/2024 at 9:15 a.m., in the Admission Office, two live adult german cockroaches were observed crawling on the floor from under a desk. The cockroaches scattered and hid amongst the boxes and clutters stored on the floor. During a concurrent observation and interview on 12/2/2024 at 9:25 a.m. with the Administrator (ADM), the pictures and video of the german cockroaches found in the Admission office were reviewed. The ADM stated the facility had a problem with cockroaches and these pests were hard to control because the facility was an old building. The ADM stated it was recommended that the walls of the facility be torn down to get rid of the pest problem. The ADM stated tearing down walls would be difficult because there would be nowhere to place the residents. The ADM stated the facility also had a problem eradicating the cockroaches because of a carwash located next door. The ADM stated the cockroaches were coming from the carwash. The ADM stated the owner of the carwash refused to do anything about their pest problem. The ADM stated the carwash also caused water to drain onto the facility property causing excess moisture and dampness which is also a breeding ground for cockroaches. The ADM stated he would have maintenance come into the Admissions office at the end of the day to do a thorough cleaning and have the area exterminated by the pest-control company. During an observation on 12/2/2024 at 12:47 p.m., in the Admissions office, a live adult german cockroach was observed running along the wall on the base board toward the exposed outlet in the wall. During an observation on 12/2/2024 at 1:00 p.m. in the Admissions Office, observed two roach baits (a food-based product that contains an insecticide that attracts and kills cockroaches) had been placed in the office by the maintenance department. One live adult german cockroach was observed in the roach bait. During an observation on 12/3/2024 at 10:20 a.m., in the Admissions Office, one nymph (baby) german cockroach was observed crawling on the work stand. (continued on next page)

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Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/4/2024 at 7:56 a.m., in the Admissions office, one adult german cockroach was observed running across the floor and under the sofa. During an interview on 12/4/2024 at 2:53 p.m. with the ADM, the ADM stated the current pest-control process was not fixing the problem. The ADM stated the facility needed better pest-control provided to do a better job or eliminating the pest in the facility. The ADM stated he had reached out to a new pest-control company that could do a better job of eliminating the pest problem. The ADM stated pests such as cockroaches, carry germs and viruses and could cause cross contamination. The ADM stated he was working on the problem and would consider tearing down the walls if needed to, to eliminate the pest problem. During an interview on 12/5/2024 at 1:15 p.m., with the Maintenance Manager (MM), the MM stated he was responsible for pest control and would have the pest control company exterminate at least once or twice a month. The MM stated staff had never reported roaches in the office. The MM stated on 12/2/2024, pest control came out and exterminated the admissions office. The MM stated he also had the electrical outlet in the wall patched to prevent roaches from coming through the hole in the wall. The MM stated the room needed to be cleaned out and the boxes of paper thrown away or stored in something other than cardboard boxes on the floor. The MM stated he planned to get plastic storage containers to replace the cardboard boxes and have the plastic containers placed on a pallet (a flat, portable platform used for storing, handling, and transporting goods) to prevent the containers from sitting directly on the floor. During a review of the facility's policy and procedure (P&P) titled, Pest Control, dated April 2018, the P&P indicated, it is the policy of the facility to maintain an ongoing pest control program to ensure the building premises and its grounds are kept free of insects, rodents, and other pests. The P&P indicated the facility employees and staff would report any signs of rodent or insects and the Maintenance Supervisor would take immediate action to remove the pests.