STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to label the personal belongings of one of one sampled resident (Resident 120). This failure placed Resident 120 at risk of not maintaining possession of her belongings due to staff being unaware of who the item belonged to. Findings: During a review of Resident 120's Admission Record, the Admission Record indicated Resident 120 was admitted on [DATE]. Resident 120's admitting diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and dementia (a progressive state of decline in mental abilities). During a review of Resident 120's Minimum Data Set (MDS, a resident assessment tool), dated 11/21/2024, The MDS indicated Resident 120 had had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily functioning and independence). The MDS indicated Resident 120 required partial to moderate assistance from staff for mobility while in and out of bed. The MDS indicated it was somewhat important to Resident 120 to take care of her personal belongings or things. During an interview on 3/10/2025 at 4:22 PM, with Resident 120's Family Member (FM) 2, FM 2 stated she brought a blanket to the facility for Resident 120 because Resident 120 would get cold, and the blankets in the facility were not sufficient to keep her warm. FM 2 stated the blanket was laundered by the facility but was not returned to Resident 120. During a review of Resident 120's inventory list, dated 11/17/2024, the inventory list indicated Resident 120 had a blanket brought in upon admission. During a review of Resident 120's inventory list, dated 11/18/2024, indicated Resident 120's belongings were inventoried at discharge. The inventory list did not indicate Resident 120 was discharged with the blanket. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

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Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 3/12/2025 at 3:44 PM, with the Social Services Director (SSD), Resident 120's inventory lists dated 11/17/2024 and 11/18/2024 were reviewed. The SSD stated the inventory lists indicated Resident 120 was admitted with a blanket but was not discharged with the blanket. The SSD stated that the facility was responsible for ensuring that residents' belongings were maintained and kept safe. The SSD stated that all belongings on the inventory list were supposed to be labelled to ensure that they can be returned to the correct resident if list or misplaced. The SSD stated that based on the description of the blanket, she knew where the blanket was and stated it was in outdoor storage at the facility. The SSD stated the facility had washed the blanket, but it was not returned to Resident 120. During an interview on 3/12/2025 at 3:53 PM, with the SSD, the SSD retrieved Resident 120's blanket from the outdoor storage. The SSD stated the blanket was not labeled and should be labeled with Resident 120's name or other identifiers. The SSD stated that because it was not labeled, it could cause laundry staff to be unsure of who the blanket belonged to and therefore placed in storage and not returned to Resident 120. During a review of the facility's policy and procedure (P&P) titled Homelike Environment, undated, the P&P indicated it was the facility's policy to ensure residents were provided with a comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P indicated staff were to provide person-centered care that emphasized the residents comfort and personal needs and preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure needs and preferences were accommodated for two of 26 sampled residents (Resident 65 and Resident 40) when: 1. Staff failed to ensure the call light was within reach for Resident 40. 2. Staff failed to ensure the call light was within functional reach of Resident 65, and ensure staff assisted Resident 65 to put on her bifocal glasses. These deficient practices created the potential for a delay or an inability for Resident 40 and Resident 65 to obtain necessary care and services as needed. These deficient practices also created the potential to negatively impact Resident 65's quality of life due to her inability to see clearly without her glasses. Findings: 1. During a review of Resident 40's Admission Record (a document that contains a summary of basic information about the resident), the Admission Record indicated Resident 40 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (stroke, caused by a blockage or loss of blood flow to a part of the brain), hemiplegia (total paralysis [loss of the ability to move and feel in all or part of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one or both sides of the body) affecting right dominant side, paraplegia (loss of movement and/or sensation, to some degree, of the legs) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 40's History and Physical (H&P), dated 12/22/2024, the H&P indicated Resident 40 could make needs known but could not make medical decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 40's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 40 was dependent (helper does all the effort) for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 40's care plan titled The resident has a communication problem, initiated on 9/21/2023 and revised on 12/31/2024, the care plan indicated Resident 40's communication problem was related to expressive aphasia (a disorder that makes it difficult to speak), respiratory impairment (conditions that affect the lungs and airway making it difficult to breath), stroke, and weak or absent voice. The care plan interventions indicated to anticipate and meet the needs of the resident and provide a safe environment by ensuring the call light was within reach. (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 3/10/2025 at 12:12 PM, with Resident 40, observed Resident 40 lying in bed with his right hand folded across his chest. Resident 40's call light device was observed resting on the right side of his bed below his waist area. Resident 40 stated he did not call the nurses for assistance because he could not reach the call light placed on his right side. Resident 40 stated he could not use his right hand, but he would have been able to use his call light if the nurses had placed it closer to his left hand. During an interview on 3/12/2025 at 4:32 PM, with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 40 could not reach his call light on his right side because he uses his left hand. LVN 2 stated it was important to have Resident 40's call light within reach to be able to attend to his needs or if he is in distress and needed help immediately. During an interview on 3/13/2025 at 12:12 PM, with the Director of Nursing (DON), the DON stated the call light should always be accessible and within the resident's reach. The DON stated Resident 40 could have an accident like a fall or respiratory distress and would not be able to call out for assistance. 47286 2. During a review of Resident 65's Admission Record, the Admission Record indicated Resident 65 was admitted on [DATE]. Resident 65's admitting diagnoses included major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 65's H&P, dated 9/25/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65 had severely impaired cognition (a significant decline in cognitive abilities that interferes with daily functioning and independence). The MDS indicated Resident 65 required partial to moderate assistance from staff to eat and required substantial to maximal assistance from staff for all other activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). a. During a concurrent observation and interview on 3/11/2025 at 11:06 AM, at Resident 65's bedside, Resident 65 was observed with a pad call light clipped to her chest. When asked to demonstrate pressing the call light, Resident 65 was unable to reach the call light and press it. Resident 65 was unable to move her fingers and her hands were stiff. Resident 65 stated her hands were weak and stated she usually asked her roommate to call for help for her. During interview on 3/11/2025 at 11:11 AM, with Certified Nursing Assistant (CNA) 9, CNA 9 stated placement of the pad call light was resident-specific and stated the call light should be placed in a position that allows the resident to call for help. CNA 9 stated the call lights should be accessible because if a resident could not call for help, they might not receive the assistance the need. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/11/2025 at 11:14 AM, with CNA 9, CNA 9 asked Resident 65 to press the call light while it was clipped to her chest. Resident 65 could not press the call light. CNA 9 moved the pad call light to a lower position, on Resident 65's abdomen, and Resident 65 able to press the call light with her elbow. During an interview on 3/11/2025 at 11:17 AM, with CNA 9, CNA 9 stated Resident 65 originally had the call light clipped to her chest. CNA 9 stated this location was not functional to ensure Resident 65 could use the call light. CNA 9 stated staff should assess appropriateness of call light placement and ensure it was resident-specific to meet the resident's needs. CNA 9 stated Resident 65 was verbal, and usually yelled for assistance. CNA 9 stated that yelling was not an appropriate method to call for help and stated Resident 65 should be able to use her call light. b. During a review of Resident 65's optometry progress note, dated 11/5/2024, the progress note indicated Resident 65 required bifocal glasses (glasses that provide two different lens powers, correcting vision at both long and short distances) for improvement of vision and quality of life. The progress note indicated a new prescription was ordered for Resident 65's bifocal glasses. During a review of Resident 65's progress note, dated 2/3/2025, the progress note indicated Resident 65's new glasses were provided to her by the Social Services Director. During an interview on 3/11/2025 at 10:44 AM, with Resident 65, Resident 65 stated an eye doctor prescribed glasses because she had glaucoma (a group of eye diseases that damage the optic nerve, potentially leading to vision loss and blindness). Resident 65 stated the glasses were brought to her, but she did not wear them because she could not put them on. Resident 65 stated she could not move her hands, so she asked nursing staff to help her out them on, but the nursing staff said they were busy and did not come back. Resident 65 stated she had the glasses in the bedside dresser. During an interview on 3/11/2024 at 3:24 PM, with Certified Nursing Assistant (CNA) 7, CNA 7 stated she did not know Resident 65 required glasses. CNA 7 stated it was important for residents requiring glasses to have access to them so they can participate in ADLs and leisure activities like watching television. CNA 7 stated should assist residents to put on and take off their glasses if the resident could not do it on their own. During a concurrent observation and interview on 3/11/2025 at 3:27 PM, with CNA 7, at Resident 65's bedside, CNA 7 stated Resident 65 had a rose-gold colored pair of glasses in her bedside dresser. The glasses were wrapped in a protective foam cover inside of their case, and did not appear to have been used. CNA 7 stated she provided care to Resident 65 for the last month and never observed Resident 65 wearing the glasses. CNA 7 put the glasses on for Resident 65, and Resident 65 stated she could see better and wanted to wear the glasses all the time. During an interview on 3/11/2025 at 3:35 PM, with the Director of Nursing (DON), the DON stated staff should assist the resident to put on their glasses if the resident does not have the mobility to put them on themselves. The DON stated any nursing staff could assist the resident. The DON stated it was important for the residents to have access to visual aids to prevent accidents, and to allow the resident to participate in daily activities of living. (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 3/12/2025 at 8:31 AM, at Resident 65's bedside, Resident 65 was observed lying in bed with the television on. Resident 65 was not wearing any glasses, and a pad call light was clipped to her chest. Resident 65 stated she could not see well without her glasses and stated she wanted to wear them but could not put them on. When asked if she had asked staff to assist her in putting her glasses on, Resident 65 stated she was unable to push the call light because it was placed in a position where she was too weak to reach it and press hard enough to activate it. During a concurrent observation and interview on 3/12/2025 at 8:39 AM, at Resident 65's bedside, with CNA 1, CNA 1 asked Resident 65 to press her call light. Resident 65 was unable to activate the call light while clipped to her chest. CNA 1 stated the current placement of the call light was not effective if the resident could not press it. CNA 1 stated that the call light needed to be repositioned to allow the resident to reach it and press it with enough strength to activate it. CNA 1 clipped the call light lower on Resident 65's abdomen and Resident 65 was able to press the call light. During a review of the facility's policy and procedure (P&P) titled Accommodation of Needs, revised 3/2021, the P&P indicated facility environment and staff behaviors were to be directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P indicated staff were to accommodate the resident's individual needs, including maintaining glasses and other adaptive devices for residents and promoting their communication and dignity. During a review of the facility's P&P titled Answering the Call Light, revised 9/2022, the P&P indicated staff were to ensure the call light was accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) assessments for four of 26 sampled residents (Residents 65, 84, 23, and 109) were completed and documented accurately. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Residents 65, 84, 23, and 109's health status. This deficient practice also created the potential for Residents 65, 84, 23, and 109 to not receive the care and interventions needed to reach their highest practicable physical and psychosocial well-being. Findings: 1. During a review of Resident 65's Admission Record, the Admission Record indicated Resident 65 was admitted on [DATE]. Resident 65's admitting diagnoses included major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 65's History and Physical (H&P), dated 9/25/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65 had severely impaired cognition. The MDS indicated Resident 65 required partial to moderate assistance from staff to eat and required substantial to maximal assistance from staff for all other activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS did not indicate Resident 65 required glasses, and indicated Resident 65's vision was adequate. During a review of Resident 65's optometry (pertaining to the eyes) progress note, dated 11/5/2024, the progress note indicated Resident 65 required bifocal glasses (glasses that provide two different lens powers, correcting vision at both long and short distances) for improvement of vision and quality of life. The progress note indicated a new prescription was ordered for Resident 65's bifocal glasses. During a review of Resident 65's progress note, dated 2/3/2025, the progress note indicated Resident 65's new glasses were provided to her by the Social Services Director (SSD). During an interview on 3/11/2025 at 10:44 AM, with Resident 65, Resident 65 stated she was seen by an eye doctor and the eye doctor prescribed glasses because she had glaucoma (a group of eye diseases that damage the optic nerve, potentially leading to vision loss and blindness). During a concurrent interview and record review on 3/11/2025 at 3:25 PM, with the Director of Nursing (DON), Resident 65's MDS dated [DATE] was reviewed. The DON stated the MDS did not indicate Resident 65 required glasses. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/2024 at 3:44 PM, with Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated she assessed Resident 65's vision for the MDS dated [DATE]. When asked how the assessment was completed, MDSN 1 stated Resident 65 waved to her (MDSN 1) while MDSN 1 was walking in the hallway outside of Resident 65's room. MDSN 1 stated this meant Resident 65 could see adequately. MDSN 1 stated she did not assess Resident 65's ability to see things at a close distance, including her ability to read written material. MDSN 1 stated Resident 65 was not wearing glasses at the time of her assessment dated [DATE]. During a concurrent interview and record review, on 3/13/2024 at 11:44 AM, with MDSN 1, Resident 65's optometry progress note dated 11/5/2024, and MDS dated [DATE], were reviewed. MDSN 1 stated the optometry progress note indicated Resident 65 required bifocal glasses, and stated the MDS did not indicate Resident 65 required glasses. MDSN 1 stated the Resident Assessment Instrument (RAI) manual (a manual that helps nursing staff gather definitive information on a resident's strengths and needs) indicated Resident 65's vision adequacy should have been assessed by asking Resident 65 to read printed material. MDSN 1 stated she did not do this when assessing Resident 65's vision. MDSN 1 stated Resident 65's MDS was not completed accurately. MDSN 1 stated this places Resident 65 at risk of not receiving the care and assistance needed to ensure her physical and psychosocial well-being. During an interview on 3/13/2025 at 2:07 PM, with the Assistant Director of Nursing (ADON), the ADON stated MDS assessments should be conducted using the instructions provided in the RAI manual and stated MDSN 1 had access to the RAI Manual in the electronic medical record (EMR). The ADON stated it was not appropriate to assume Resident 65's vision was adequate based on her ability to wave to someone in the hallway. The ADON stated it was important to perform accurate assessments to identify changes in vision, including changes due to complications from other diagnoses. The ADON stated accurate assessments also ensured nursing staff could identify and care plan resident-specific interventions to address the resident's needs. The ADON stated absence of interventions to address Resident 65's impaired vision could negatively impact Resident 65's quality of life and could place Resident 65 at risk for injury. During an interview on 3/13/2025 at 2:45 PM, with the MDS Nurse Consultant (MDSC), the MDSC stated her role was to train and re-educate MDS staff (including MDSN 1), to ensure MDS assessments were completed accurately and in accordance with the RAI manual. The MDSC stated the RAI manual indicated use of corrective lenses should be assessed through record review and interviews with the resident and direct care staff. The MDSC stated this would ensure the identification of need for visual aids, if indicated, and ensure the assessment for vision adequacy could be conducted accurately. The MDSC stated the RAI manual indicated vision adequacy was assessed by bringing printed reading material to the resident, providing the resident with any required visual aids (including glasses), and asking the resident to read. The MDSC stated it was not appropriate to rely on the resident's ability to see or wave at people in the hallway. 2. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 84's admitting diagnoses included lack of coordination, abnormal posture, generalized muscle weakness, and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84 had severely impaired cognition. The MDS indicated Resident 84 required substantial to maximal assistance from staff for mobility while in bed, and was dependent on staff for toileting hygiene, bathing, and dressing her lower body. The MDS indicated Resident 84 did not have any impairments to her upper extremities (shoulders, elbows, wrists, and hands) or lower extremities (hips, knees, ankles, and feet) that interfered with her daily function or placed her at risk for injury. During a review of Resident 84's active physician orders, dated 12/20/2024, the orders indicated staff provided passive range of motion exercises (PROM, exercises that use external force like gravity, leverage, or hands to move a joint where the resident does not assist) to Resident 84 four times a week, as tolerated. During an interview on 3/12/2025 at 1:25 PM, with the Director of Rehabilitation (DOR), the DOR stated Resident 84 was discharged from physical therapy services on 12/19/2024 and could not perform any active range of motion (AROM, exercises that involve moving joints through their normal range of motion using the patient's own muscle strength) in her upper or lower extremities. The DOR stated these limitations in mobility affected Resident 84's ability to perform ADLs and placed Resident 84 at risk for injury. During a concurrent interview and record review, on 3/12/2025 at 1:40 PM, with the DOR, Resident 84's MDS dated [DATE] was reviewed. The DOR stated the MDS was not accurate and should have indicated Resident 84 had impairments to her upper and lower extremities on both sides of her body. During and interview on 3/12/2025 at 1:46 PM, with MDSN 1, MDSN 1 stated she did not assess for impairments to Resident 84's upper and lower extremities in accordance with the RAI manual. MDSN 1 stated the MDS assessment for extremity impairments should be assessed and documented accurately to ensure staff knew how to safely care for the resident. During a concurrent interview and record review, on 3/12/2025 at 1:56 PM, with MDSN 1, Resident 84's MDS dated [DATE] was reviewed. MDSN stated the MDS indicated Resident 84 did not have any impairments to her upper and lower extremities. MDSN 1 stated Resident 84 could not move any of her extremities on her own and could not carry out any daily functions. MDSN 1 stated she did not conduct or document her assessment of Resident 84 accurately. During an observation on 3/13/2025 at 2:58 PM, with the MDSC, at Resident 84's bedside, observed MDSC assess for impairments to Resident 84's upper and lower extremities. Resident 84 was unable to follow any of the MDSC's commands and was not observed moving any of her extremities. During an interview on 3/13/2025 at 3:01 PM, with the MDSC, the MDSC stated her assessment indicated Resident 84 had impairments to all extremities due to her inability to follow commands and complete tasks. The MDSC stated Resident 84 had functional limitations that interfered with her daily functioning, and stated her MDS should indicate impairments to all upper and lower extremities. 48343 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN, high blood pressure), and muscle weakness (loss of muscle strength). During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 109 was dependent (helper does all the effort) from staff for ADLs. During a concurrent observation and interview, on 3/11/2025 at 9:18 AM, with Resident 109, in Resident 109's room, Resident 109 was observed sitting up in bed, eating his breakfast. Resident 109 stated it was hard to chew his food because he did not have his natural teeth. Resident 109 stated his dentures were broken. During a concurrent observation and interview, on 3/12/2025 at 10:18 AM, in Resident 109's room, with MDSN 2, Resident 109 was observed lying in bed. MDSN 2 stated Resident 109 did not have his upper and bottom teeth. MDSN 2 stated Resident 109 did not have his natural teeth and the MDS assessment should be coded correctly to reflect Resident 109's dental status. During a concurrent interview and record review on 3/12/2025 at 2:04 PM, with MDSN 2, Resident 109's MDS, dated [DATE] was reviewed. MDSN 2 stated Resident 109's MDS oral/dental status assessment was coded incorrectly as it did not reflect the resident's actual oral and/or dental status. MDSN 2 stated because Resident 109 did not have his natural teeth, the MDS should have been coded. MDSN 2 stated accuracy of the MDS assessment was important for, quality measures tools that help quality and measure healthcare process, outcome, and resident perceptions, and care plan for the resident. MDSN 2 stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. 47858 4. During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included fracture (broken bone) of the left and right femur (thigh bone), morbid obesity (a severe form of obesity characterized by an excessive amount of body fat that significantly impacts health and well-being), contracture of muscle multiple sites (a permanent or prolonged shortening of muscles, tendons, or other soft tissues that results in limited range of motion and stiffness), functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), neuromuscular dysfunction of bladder (poor bladder control), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of uneasiness). During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 23 had an impairment on both sides of her lower extremities. The MDS indicated Resident 23 required substantial or maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for rolling to the left and right side of the bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's Physical Therapy Discharge Summary, dated 12/29/2022, the discharge summary indicated Resident 23 was assessed as total dependence with attempts to initiate for bed mobility. During a review of Resident 23's Certified Nursing Assistant (CNA) Task Flowsheet, dated 12/2024, the flowsheet indicated Resident 23 was assessed as dependent for the task of rolling to the left and the right side of the bed on the 7 a.m. to 3 p.m. shift on 21 days out of the 31 days in the month of December. The flowsheet indicated Resident 23 was assessed as dependent for the task of toileting hygiene on the 7 a.m. to 3 p.m. shift on 24 days out of the 31 days in the month of December. During a concurrent interview and record review, on 3/11/2025 at 4:00 PM, with Minimum Data Set Nurse MDSN 1, Resident 23's MDS Section GG (an assessment that evaluates the need for assistance with self-care and mobility activities, functional limitations in range of motion, and current and prior device use), dated 12/29/2024, was reviewed. MDSN 1 stated Resident 23's MDS Section GG indicated Resident 23 required substantial maximal assistance (helper does more than half of the effort) when rolling left and right in bed. MDSN 1 stated the normal process to code Section GG accurately was to gather data by conducting interviews from CNA staff, reviewing the CNA documentation, and the Rehabilitation Department documentation. MDS 1 stated she did not physically observe and assess Resident 23 reposition herself in bed to the left and the right side. During a concurrent interview and record review on 3/12/2025 at 1:46 PM, with MDSN 1, Resident 23's Physical Therapy Discharge Summary, dated 12/29/2022, and Resident 23's CNA Task Flowsheet, dated 12/2024, were reviewed. MDSN 1 stated most of the CNA documentation indicated Resident 23 was dependent on staff for rolling left and right in bed and for toileting hygiene. MDSN 1 stated Resident 23's Physical Therapy Discharge Summary, dated 12/29/2022, indicated Resident 23 was assessed as total dependence with attempts to initiate for bed mobility. MDS 1 stated there was a lack of documentation of the interviews she conducted with the CNAs to obtain the usual performance of Resident 23. MDSN 1 stated Resident 23's Section GG MDS assessment for rolling left and right in bed, dated 12/29/2024, did not accurately reflect the data and the documentation authored by the CNAs and the Rehabilitation Department. MDSN 1 stated it was important to ensure the MDS accurately reflected the true abilities and assessments of the residents so that care could be rendered appropriately. During an interview on 3/13/2025 at 12:36 PM with the ADON, the ADON stated the best practice for the MDSN was to observe the resident [performing] the action when coding the MDS assessment. The ADON stated the best source of information to accurately code MDS was from the Rehabilitation Department and CNA documentation. The ADON stated the MDS nurse could overrule the charting by conducting interviews with CNAs and the Rehabilitation Department and by documenting the interviews conducted. During a review of the facility's policy and procedure (P&P) titled Comprehensive Assessments, dated 10/2023, the P&P indicated comprehensive MDS assessments were conducted to assist in developing person-centered care plans. The P&P indicated the comprehensive assessment process included direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. The P&P indicated staff were to conduct accurate assessments of each resident's functional capacity using the RAI manual. During a review of the facility's P&P titled MDS Assessment Coordinator, undated, the P&P indicated each individual who completes the MDS assessment must certify the accuracy of the assessment.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR- a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level II Evaluation was completed for one of six sampled resident (Resident 86). This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Residents 86. Findings: During a review of Resident 86's Admission Record, dated 3/13/2025, the admission record indicated Resident 86 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated Resident 86's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), delusional disorder (a mental illness characterized by having false or unrealistic beliefs), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 86's History and Physical (H&P), dated 11/8/2024, the H&P indicated Resident 86 had the capacity to understand and make decisions. During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 86's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 86 required supervision (helper provides verbal cues and or touching assistance) for eating and substantial assistance (helper does more than half the effort) for toileting and bathing. During a review of Resident 86's Level I PASRR Screening, dated 5/4/2025, the Level I PSARR Screening indicated Resident 86 required a Level II PASRR evaluation due to suspected mental illness. The Level 1 PASRR Screening indicated a Level II mental health evaluation would be conducted to determine if the resident could benefit from specialized mental health services. The Level 1 PASRR Screening indicated the facility would be provided recommendations for specialized services once the mental health evaluation was complete. During an interview on 3/12/2025 at 11:50 a.m., with the Social Services Director (SSD), the SSD stated she was not responsible for completing the PASRR and did not know the process of following up on a Level II PASRR. The SSD stated the MDS Nurses (MDSNs) would have more information regarding Level II PASRRs. During an interview on 3/12/2025 at 11:53 a.m., with MDSN 1, MDSN 1 stated she did not know the PASRR process or what took place once a resident was recommended a Level II PASRR. MDSN 1 stated she would have to inquire who in the facility was responsible for following up on residents that required a Level II PASRR evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 2:34 p.m. with MDSN 1, MDSN 1 indicated the facility did not have a process for following up on Level II PASRR evaluations. MDSN 1 stated the facility would implement a process moving forward. MDSN 1 stated because Resident 86's PASRR was not followed up, the resident did not benefit from any mental health services. During an interview on 3/12/2025 at 3:34 p.m., with the Director of Nursing (DON), the DON stated the SSD should have followed up on Resident 86's PASRRs to ensure Level I and Level II PASRRs were indicated for the resident. The DON stated the facility did not have a policy and procedure (P&P) pertaining to PASRRs. The DON stated not following up on Resident 86's PASRR could delay treatment and qualifications regarding mental health. The DON stated because the facility did not have a PASRR P&P, the SSD did not know it was her responsibility to follow up with the PASRRs.

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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 observation, interview, and record review, the facility failed to ensure care plans were developed and/or implemented for 7 of 26 sampled residents (Residents 66, 21, 65, 62, 72, 109, and 12) when: 1. Resident 66's call light was not within reach on 3/11/2025 and fall mats (cushioned floor pads designed to help prevent injury should a person fall) were not placed at the bedside on 3/11/2025, 3/12/2025, and 3/13/2025. 2. Resident 21 and Resident 66 did not have care plans for their use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). 3. Resident 65 did not have a care plan developed for her use of corrective lenses (glasses). 4. Resident 62 did not have care plans for his use of Levetiracetam (a drug used to help control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and Valproic Acid (a drug used to treat seizures). 5. Resident 72 did not have a care plan for his use of Eliquis (a blood thinner drug used to treat blood clots [clumps of blood that changed from a liquid to a gel]). 6. Resident 109 did not have a care plan addressing his missing teeth. 7. Resident 12 did not have an active plan of care for his self-releasing, nonrestraint seat belt that was used to ensure he did not fall from his wheelchair. These deficient practices placed Residents 66, 21, 65, 62, 72, 109, and 12 at risk for physical and psychosocial harm due to lack of provision of the required resident-specific interventions to meet the residents' needs. Findings: 1. During a review of Resident 66's Admission Record, the admission record indicated Resident 66 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 66's admitting diagnoses included generalized muscle weakness, reduced mobility, and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 66 had moderately impaired cognition (a condition where a person experiences noticeable declines in cognitive functions, such as memory, attention, and problem-solving, but these impairments are not severe enough to interfere significantly with daily life). The MDS indicated Resident 66 required substantial to maximal assistance from staff to roll left and right in bed and was fully dependent on staff to transition from sitting to lying, and lying to sitting positions, and chair/bed-to-chair transfers. (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 66's care plan titled The resident is at risk for unavoidable falls, created 7/6/2024, the care plan indicated goals of care were Resident 66 being free from falls and associated injury. Care plan interventions indicated staff were to ensure Resident 66's call light was within reach. During a review of Resident 66's care plan titled [Resident 66] has had an actual fall .with serious injury, created 7/6/2024, the care plan indicated goals of care were Resident 66 not having any additional fall incidents. Care plan interventions indicated staff were to ensure Resident 66 had fall mats on both sides of her bed. During a review of Resident 66's Post-Fall Review assessment, dated 1/7/2025, the assessment indicated Resident 66 had an unwitnessed fall on 1/7/2025. The assessment indicated Resident 66's care plan was reviewed after the fall, and Resident 66 was to have floor mats to both sides of her bed and be encouraged to request for assistance. During a review of Resident 66's Quarterly Risk Data Collection Tool assessment, dated 1/17/2025, the assessment indicated Resident 66 was at risk for falls and had fallen one to two times in the last six months. During an observation on 3/11/2025 at 11:48 AM, at Resident 66's bedside, Resident 66 was observed lying in a left-facing position, with a blanket and sheet draped over her right arm. Resident 66's call light was placed on her bedside table, on her right side. When asked to demonstrate reaching the call light, Resident 66 was unable to reach it. During a concurrent observation and interview on 3/11/2025 at 1:13 PM, at Resident 66's bedside, with Resident 66, the resident stated she fell while in the facility. No fall mats were observed at Resident 66's bedside. During an observation on 3/12/2025 at 8:29 AM, at Resident 66's bedside, no fall mats were observed. During a concurrent observation and interview on 3/12/2025 at 11:53 AM, at Resident 66's bedside, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 66 did not have fall mats to either side of her bed. CNA 1 stated the purpose of the fall mats was to lessen or prevent injury from a fall. CNA 1 stated the fall mats were softer than the floor, and stated that without the mat, there was increased potential for injury. During a concurrent observation and interview, on 3/12/2025 at 11:56 AM, at Resident 66's bedside, with CNA 2, CNA 2 stated she had provided care to Resident 66 for the last month. CNA 2 stated that in the last month, she did not observe fall mats at Resident 66's bedside. During a concurrent interview and record review, on 3/12/2025 at 12:07 PM, with Licensed Vocational Nurse (LVN) 1, Resident 66's care plan titled [Resident 66] has had an actual fall .with serious injury, dated 7/6/2024, was reviewed. LVN 1 stated the care plan indicated Resident 66 required fall mats to both [NAME] of her bed. LVN 1 stated Resident 66 was high risk for falls and the fall mats would minimize potential for injury if Resident 66 fell . (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 observation on 3/13/2025 at 9:31 AM, at Resident 66's bedside, no fall mats were observed. During an interview on 3/13/2025 at 9:38 AM, with LVN 1, LVN 1 stated it was important for a resident's call light to be within reach. LVN 1 stated that if the call light was not within reach, the resident's needs might not be met, or they might attempt to get up unassisted and could fall and sustain injuries. 2. During a review of Resident 66's Admission Record, the admission record indicated Resident 66 had an admitting diagnosis of type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 66's active physician order, dated 2/3/2025, the order indicated insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) twice a day for DM. During a review of Resident 21's Admission Record, the record indicated Resident 21 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 21's admitting diagnoses included DM with diabetic retinopathy (a complication of diabetes that damages the blood vessels in the retina, the light-sensitive tissue at the back of the eye) to the left eye. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 had severely impaired cognition (a significant decline in cognitive abilities that interferes with daily functioning and independence) and was dependent on staff for mobility while in bed. During a review of Resident 21's active physician orders, dated 12/20/2024 and 3/5/2025, the orders indicated Resident 21 was to receive two types of insulin, twice a day, for DM. During an interview on 3/12/2025 at 3:09 PM, with Registered Nurse (RN) 3, RN 3 stated use of insulin required a care plan to ensure staff were aware of the interventions required for insulin administration. RN 3 stated interventions included monitoring the resident's blood sugar, oral intake of food, if applicable, monitoring hemoglobin A1c (a blood test that measures the average blood sugar level over the past 2-3 months) levels, and rotating insulin injection sites. RN 3 stated care plan goals would ensure staff monitored for effectiveness of the insulin, as well as adverse effects of the insulin, including excessively high or low blood sugar levels. During an interview on 3/13/2025 at 11:56 AM, with RN 1, RN 1 stated Resident 21 did not have a care plan for his use of insulin. During an interview on 3/13/2025 at 12:00 PM, with RN 1, RN 1 stated Resident 66 did not have a care plan for her use of insulin. 3. During a review of Resident 65's Admission Record, the Admission Record indicated Resident 65 was admitted on [DATE]. Resident 65's admitting diagnoses included major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). (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 65's History and Physical (H&P), dated 9/25/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65 had severely impaired cognition. The MDS indicated Resident 65 required partial to moderate assistance from staff to eat and required substantial to maximal assistance from staff for all other activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 65's optometry progress note, dated 11/5/2024, the progress note indicated Resident 65 required bifocal glasses (glasses that provide two different lens powers, correcting vision at both long and short distances) for improvement of vision and quality of life. The progress note indicated a new prescription was ordered for Resident 65's bifocal glasses. During a review of Resident 65's progress note, dated 2/3/2025, the progress note indicated Resident 65's new glasses were provided by the Social Services Director and indicated Resident 65 was happy. During an interview on 3/11/2025 at 10:44 AM, with Resident 65, Resident 65 stated she was seen by an eye doctor and the eye doctor prescribed glasses because she had glaucoma (a group of eye diseases that damage the optic nerve, potentially leading to vision loss and blindness). Resident 65 stated she had the glasses but could not put them on due to pain and limited mobility in her hands. Resident 65 stated the glasses were in her bedside dresser, but staff did not assist her to put them on. During an interview on 3/11/2024 at 3:24 PM, with CNA 7, CNA 7 stated she did not know Resident 65 required glasses. CNA 7 stated it was important for residents requiring glasses to have access to them so they can participate in ADLs and leisure activities like watching television. During a concurrent observation and interview on 3/11/2025 at 3:27 PM, with CNA 7, at Resident 65's bedside, CNA 7 stated Resident 65 had a rose-gold colored pair of glasses in her bedside dresser. The glasses were wrapped in a protective foam cover inside of their case, and did not appear to have been used. CNA 7 stated she provided care to Resident 65 for the last month and never observed Resident 65 wearing the glasses. During an interview on 3/11/2025 at 3:25 PM, with the Director of Nursing (DON), the DON stated use of corrective lenses/glasses should be care planned to ensure staff know why the resident required glasses, and to ensure staff knew if the resident required assistance with putting them on and taking them off. The DON stated Resident 65 did not have a care plan for her use of glasses. The DON stated that without a care plan, staff would not know Resident 65 required glasses, which placed Resident 65 at risk for accidents, and could also interfere with her ability to participate in and enjoy activities. 48343 4. During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included convulsions (muscles contract uncontrollably during seizure), dementia (a progressive state of decline in mental abilities), major depression, dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). (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 62's MDS, dated [DATE], the MDS indicated Resident 62's cognitive (the ability to think and process information) skills for daily decision making severely impaired. The MDS indicated Resident 62 required moderate (helper does less than half the effort) assistance from staff for ADLs. During a review of Resident 62's Order Summary Report, dated 1/24/2025, the order summary report indicated Resident 62's physician prescribed Levetiracetam 750 milligram ([mg]- metric unit of measurement, used for medication dosage and/or amount), oral tablet, Resident 62 would receive one (1) tablet every 12 hours for seizures. The Order Summary Report indicated Resident 62's physician prescribed Valproic Acid 250 mg/milliliter ([ml]- metric unit of measurement, used for medication dosage and/or amount), oral solution, Resident 62 would receive 15 ml every 12 hours for seizures. During a concurrent interview and record review, on 3/12/2025 at 9:00 AM, with Registered Nurse (RN) 1, Resident 62's Medication Administration Record (MAR), dated 1/24/2025 to 3/12/2025 was reviewed. RN 1 stated Resident 62's MAR indicated the resident received Levetiracetam 750 mg, 1 tablet every 12 hours for seizures, and Valproic Acid 15 ml every 12 hours for seizures from 1/24/2025 through 3/12/2025. RN 1 stated Resident 62's seizure medication should have a care plan to guide the nurses to monitor for seizure any side effects of the seizure medications. During a concurrent interview and record review on 3/12/2025 at 9:20 AM, with RN 1, Resident 62's active care plans, dated 1/24/2025 through 3/12/2025 were reviewed. RN 1 stated the care plans did not indicate Resident 62's use of Levetiracetam and Valproic Acid was addressed and care planned. RN 1 stated Resident 62 was receiving scheduled seizure medications which should have been care planned to ensure Resident 62 was monitored for seizures and the nursing staff could communicate to Resident 62's physician the efficacy of the Levetiracetam and Valproic Acid. RN 1 stated the care plan would guide the nurses to monitor for side effects and be aware of the black box warning (a label on a drug that alerts the healthcare providers to a serious risk of injury or death by administering the drug). RN 1 stated without the appropriate care plans in place, Resident 62 was at risk of not receiving the necessary care and services. 5. During a review of Resident 72's Admission Record, the Admission Record indicated Resident 72 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depression disorder, anxiety (a feeling of fear), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72's cognitive skills for daily decision making was intact. The MDS indicated Resident 72 was dependent (helper does all the effort) from staff for ADLs. During a concurrent interview and record review on 3/12/2025 at 9:30 AM, with RN 1, Resident 72's Order Summary Report, dated 2/27/2025, was reviewed. RN 1 stated order summary report indicated Resident 72 received Eliquis 2.5 mg, 1 tablet every 12 hours for blood clots prophylaxis (preventative treatment). RN 1 stated Eliquis was a blood thinner medication that can cause bleeding, abnormal bruising and should have a care plan to ensure Resident 72 was being monitored for any side effects. (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 concurrent interview and record review on 3/12/2025 at 9:40 AM, with RN 1, Resident 72's active care plans were reviewed. RN 1 stated care plans did not indicate Resident 72's use of Eliquis was care planned. RN 1 stated a care plan was important to ensure staff were aware of the interventions required for the use of Eliquis and Resident 72 being monitored for effectiveness of the Eliquis. 6. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses which included DM, congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN, high blood pressure), and muscle weakness. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognitive skills for daily decision making was intact. The MDS indicated Resident 109 was dependent from staff for ADLs. The MDS indicated Resident 109 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 3/12/2025 at 1:18 PM, in Resident 109's room, with MDSN 2, Resident 109 was observed lying in bed. MDSN 2 stated Resident 109 did not have his upper and bottom teeth. MDSN 2 stated Resident 109 did not have his natural teeth and should have care planning to reflect Resident 109's oral and dental status. During a concurrent interview and record review on 3/12/2025 at 2:04 PM, with Minimum Data Set Nurse (MDSN) 2, Resident 109's electronic medical record (EMR) was reviewed. MDSN 2 stated she was not able to locate a care plan for Resident 109's dental status. MDSN 2 stated there should have been a care plan initiated upon Resident 109's admission to the facility to ensure staff were aware of the interventions required for oral care and monitoring for an increased risk of oral health problem. MDSN 2 stated if there was no care plan, the facility staff would not be able to provide quality of care to residents. 47858 7. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included muscle wasting and atrophy, muscle weakness, and dementia. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 12 required partial or moderate assistance (helper does less than half the effort) when eating and performing oral hygiene. The MDS indicated Resident 12 required substantial or maximal assistance (helper does more than half of the effort) when performing toileting hygiene, and showering. The MDS indicated Resident 12 required substantial or maximal assistance when sitting to standing. During an observation on 3/10/2025 at 10:42 AM, in Resident 12's room, Resident 12 observed seated on a wheelchair with the wheelchair seat belt fastened. During a concurrent observation and interview on 3/11/2025 at 10:26 AM, with CNA 4, observed Resident 12's wheelchair seat belt fastened. CNA 4 stated Resident 12 used the seat belt for safety. (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 all of Resident 12's Care Plans, dated 2024 to 2025, there was no active care plan in place for Resident 12's wheelchair seat belt. During an interview on 3/12/2025 at 3:38 PM with RN 3, RN 3 stated that a care plan was needed for Resident 12's seat belt, especially if the staff were utilizing the seat belt for safety. RN 3 stated there was the potential for an accident to occur if the seat belt was not regularly monitored. RN 3 stated a restraint (devices or methods used to limit a patient's movement, primarily to prevent harm to themselves or others) assessment should be regularly performed to ensure Resident 12 was able to unfasten the seat belt. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated a comprehensive, person-centered care plan, was to include includes measurable objectives and timeframes and describe the services that staff were to furnish to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to maintain good grooming and personal hygiene for two of six sampled residents (Residents 49 and 62) by failing to keep Resident 49's fingernails, and Resident 62's toenails clean and neat. This failure had the potential to result in a negative impact on Residents 49 and 62's quality of life and self-esteem and had the potential for the development of infection. Findings: 1. During a concurrent observation and interview on 3/10/2025 at 11:18 AM, with Resident 49, in Resident 49's room, observed Resident 49's fingernails were long with a brown substance underneath the nails. Resident 49 stated, No one cuts or cleans my nails. Resident 49 stated his fingernails looked long and that he would like to have his fingernails cut and cleaned. During a review of Resident 49's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN- high blood pressure). During a review of Resident 49's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 49' cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 49 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 49's care plan with a focus of Resident has an ADLs self-care deficit related to confusion, date initiated 10/24/2024, the care plan interventions indicated the facility would clean Resident 49's fingernails daily and trim as necessary. During a concurrent observation and interview on 3/10/2025 at 11:27 AM, with Certified Nursing Assistant (CNA 3), in Resident 49's room, Resident 49 was observed with long fingernails and a brown substance underneath the nails. CNA 3 stated Resident 49's fingernails were long and dirty. CNA 3 stated CNAs were responsible for cleaning the residents' fingernails daily and trimming as needed. CNA 3 stated it was important to keep Resident 49's fingernails clean and trimmed to prevent the growth of bacteria (infection). CNA 3 stated long, dirty fingernails had the potential for the resident to scratch his skin and if Resident 49 scratched himself hard enough, it could create an open wound and increased risk for infection. CNA 3 stated having dirty fingernails was not sanitary because the resident will use his hands to hold utensils when eating and any bacteria could transfer into the body. 2. During an observation on 3/10/2025 at 1:19 PM, in Resident 62's room, observed Resident 62 with long toenails and a black substance underneath and around his toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 62's Face Sheet, the Face Sheet indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, major depression, dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62's cognitive skills for daily living was severely impaired. The MDS indicated Resident 62 required moderate assistance from staff for ADLs. During a review of Resident 62's care plan with a focus of Resident has an ADLs self-care deficit related to dementia, date initiated 9/5/2024, the care plan interventions indicated the facility would clean Resident 62's nails daily and trim as necessary. During a concurrent observation and interview on 3/11/2025 at 1:20 PM, with CNA 3, in Resident 62's room, observed Resident 62 with long toenails and a black substance underneath and around the toenails. CNA 3 stated Resident 62's toenails were dirty and required cleaning and trimming. CNA 3 stated nail care was one of the CNAs duties, where they looked over the residents' nails and if the nails were long or dirty, the CNAs would clip, trim, and clean the nails. CNA 3 stated residents' toenails should be cleaned daily and trimmed as needed. CNA 3 stated it was important to keep residents' toenails clean and trim to prevent infection, cuts, and skin injury. During an interview on 3/13/2025 at 11:25 AM, with the Director of Staff Development (DSD), the DSD stated nail care should be performed daily and if the resident required assistance with cleaning or trimming their nails, the CNAs should assist. The DSD stated nails care was important because the residents' nails were a source of infection and having dirty nails could affect how residents' see themselves. The DSD stated the residents' hygiene was very important and residents' nails should have been addressed. The DSD stated dirty nails increased the risk for infection. The DSD stated residents should be provided with care and services necessary to maintain good personal hygiene. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated the facility will clean the nails, and keep nails trimmed to prevent infections. The P&P indicated nail care included daily cleaning and regular trimming. During a review of the facility's P&P titled Activities of Daily Livings (ADL), Supporting, revised 3/2018, the P&P indicated residents who are unable to carry out ADLs independently would receive the services necessary to maintain good grooming and personal hygiene.

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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 mattress designed to distribute the individual's body weight over a broad surface area and help prevent skin breakdown) was set according to the resident's weight for one of six sampled residents (Resident 282). This deficient practice had the potential to cause the development, worsening or reinjury of pressure sores (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) to Resident 282. Findings: During an observation on 3/10/2025 at 11:42 a.m., in Resident 282's room, observed Resident 282 lying on a low air loss mattress (LALM - a mattress designed to distribute the individual's body weight over a broad surface area and help prevent skin breakdown). Resident 282's LALM was set to [PHONE NUMBER] pounds (lbs., measure of weight). A weight of 293 lbs. and a date of 1/21/2025 was posted on the LALM control panel. During a review of Resident 282's Admission Record, dated 2/27/2024, the admission record indicated Resident 282 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), anemia (a condition where the body does not have enough healthy red blood cells), cirrhosis of the liver (scarring of the liver caused by long-term damage), and morbid (severe) obesity (excessive body fat). During a review of Resident 282's History and Physical (H&P), dated 3/4/2025, the H&P indicated Resident 282 did not have the capacity to understand and make decisions. During a review of Resident 282's Minimum Data Set (MDS - a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 282's cognition (ability to think, remember, and reason) for daily decision making was severely impaired. The MDS indicated Resident 282 was dependent (helper does all the effort) for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 282's Braden Scale (measures the risk for development of a pressure sore) dated 3/4/2025, the Braden Scale indicated Resident 282 was bedbound (confined to bed), had very limited mobility (ability to move) and was at a high risk of developing pressure sores. During a concurrent observation and interview on 3/11/2025 at 4:26 p.m., with Licensed Vocational Nurse (LVN 2), Resident 282's LALM settings were observed. LVN 2 stated Resident 282's LALM should be adjusted according to his weight. LVN 2 stated the LALM was set to [PHONE NUMBER] lbs. which was too high for Resident 282. LVN 2 stated the higher the setting, the harder the bed would be. LVN 2 stated the hard bed would not be good for Resident 282's skin and would cause further skin breakdown. (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 concurrent observation and interview on 3/13/2025 at 12:18 p.m., with Treatment Nurse (TN 1), Resident 282's LALM settings were observed. TN 1 stated he observed Resident 282's bed was set too high when he started the morning shift on 3/12/2025. TN 1 stated he set the LALM mattress to the correct setting according Resident 282's weight of 293 lbs. TN 1 stated because Resident 282's LALM was set too high, it was not protecting the resident's skin or promoting healing. TN 1 stated Resident 282 was lying on a hard surface due to the high settings which increased the pressure and could have caused redness and dead tissue to his skin. TN 1 stated all licensed nurses were responsible for checking the LALM setting every day and every shift. During a review of the facility's policy and procedure (P&P) titled Support Surface Guideline, revised February 2024, the P&P indicated residents at risk for developing pressure ulcers should be placed on a redistribution support surface such as alternating air or air-loss device when lying in bed and follow any air support surface mattress manufacture guidelines. During a review of the facility's document titled, Drive Med Air Plus 10 Alternating Pressure and Low Air Loss Mattress, undated, the document indicated to adjust the pressure based on the patient's weight and comfort level.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure the Director of Rehabilitation (DOR), or the assigned Licensed Vocational Nurse (LVN) were made aware of the development of a resident's right-hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) for one out of two sampled residents (Resident 95). This failure had the potential to result in the worsening of Resident 95's right hand contracture. Findings: During a review of Resident 95's Admission Record, the Admission Record indicated Resident 95 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 95's diagnoses included cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), aphasia (a disorder that makes it difficult to speak), muscle weakness, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), anxiety (a feeling of uneasiness) and delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking). During a review of Resident 95's Minimum Data Set ([MDS], a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 95's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 95 had an impairment on one side of his upper and lower extremities. The MDS indicated Resident 9 was dependent on staff (helper does all the effort) activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and bed mobility. During a review of Resident 95's Occupational Discharge Summary, dated 9/9/2023, indicated Resident 95's right upper extremities were within functional limits (a person's ability to perform tasks is sufficient for daily living, even if it's not within the normal range). During a review of all the Certified Nursing Assistant (CNA) Stop and Watch Forms (forms completed by the CNA or the RNA [restorative nurse aide] to document the notification to the LVN or the RN of a resident change of condition), dated 2/1/2025 to 3/11/2025, there was no Stop and Watch Form completed addressing Resident 95's contracture. During a review of Resident 95's Occupational Therapy Evaluation, dated 3/12/2025, the evaluation indicated Resident 95 had a contracture to the right hand. The evaluation indicated the right upper extremity (arm) range of motion of the wrist, hand, index finger, middle finger, ring finger, and little finger were impaired. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/2025 at 4:24 p.m. with the Director of Rehabilitation (DOR), the DOR stated he was not made aware of Resident 96's decline in range of motion or change of condition. The DOR stated changes of condition or decline in mobility were discussed in the daily meetings with the Rehabilitation Department and the restorative nurse aides (RNA). During a concurrent interview and record review on 3/12/2025 at 7:43 a.m. with Occupational Therapist (OT) 1, Resident 95's Joint Mobility Assessment (a medical evaluation that determines the range of motion (ROM) and flexibility of joints was conducted). OT 1 stated Resident 95 developed a right-hand contracture. OT 1 stated the normal practice was that a change of condition was reported to the LVN or the DOR. OT 1 stated if the Rehabilitation Department was made aware of the development of Resident 95's right hand contracture, then she would have expected an order for hand splinting to be inputted right away. During an interview on 3/12/2025 at 8:06 a.m. with RNA 1, RNA 1 stated she was familiar with Resident 95 and usually provided Resident 95 with passive range of motion exercises (joint movement achieved when an external force, like a therapist or device, moves a body part, without the person actively engaging their muscles to perform the movement). RNA 1 stated the normal process to report a change of condition or a decline in mobility was to document the change on a Stop and Watch form and notify the LVN or DOR. RNA 1 stated she noticed the development of Resident 95's contracture approximately two weeks ago. RNA 1 stated she did not complete the Stop and Watch form and because she recalled making the Rehabilitation Department aware. RNA 1 stated she should have completed a Stop and Watch form to document that she made the LVN aware. RNA 1 stated if the LVN or DOR was not made aware of the change, then there was a potential for continued decline in Resident 95's range of motion because orders for hand splinting would not be obtained. During a review of the facility's Policy and Procedure (P&P) titled, Acute Condition Changes, revised 3/2018, the P&P indicated the direct care staff, including nursing assistants would be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the Nurse. During a review of the facility's RNA Job Description (undated), the Job Description indicated the RNA was to report any changes in residents' condition immediately to the supervisor.

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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** 47858 Based on observation, interview, and record review, the facility failed to ensure the following for two of four sampled residents (Resident 23 and Resident 66). 1. Certified Nursing Assistant (CNA) 4 used a two person assist when performing perineal care ([peri care] the washing of the genitals and anal area) and repositioning for Resident 23. 2. The call light was within reach and fall mats were provided for Resident 66. This failure resulted in Resident 23 falling from the bed, sustaining a bilateral (pertaining to both sides) femur fractures (broken thighbone, a serious injury, often requiring surgery and extensive rehabilitation, and is typically caused by high-impact trauma like car accidents or falls) which required surgical intervention at a general acute care hospital (GACH). This failure also resulted in Resident 23 undergoing a right and left right femur open reduction internal fixation surgery (a surgical procedure used to treat severe fractures or dislocations by realigning the broken bones and stabilizing them with internal hardware, such as screws, plates, or rods) and required the transfusion of three units of packed red blood cells (a medical procedure where concentrated red blood cells (RBCs) are infused into a patient's bloodstream). This failure also placed Resident 66 at risk for falls and subsequent fall-related injuries. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 23's diagnoses included fracture of the left and right femur, morbid obesity (a severe form of obesity characterized by an excessive amount of body fat that significantly impacts health and well-being), contracture of muscle multiple sites (a permanent or prolonged shortening of muscles, tendons, or other soft tissues that results in limited range of motion and stiffness), functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), neuromuscular dysfunction of the bladder (poor bladder control), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of uneasiness). During a review of Resident 23's Minimum Data Set ([MDS], a resident assessment tool), dated 12/29/2024, the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 23 had an impairment on both sides of her lower extremities (legs). The MDS indicated Resident 23 was dependent on staff (helper does all the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting hygiene (ability to maintain perineal hygiene), showering or bathing, upper and lower body dressing, and performing personal hygiene. The MDS indicated Resident 23 required substantial or maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for rolling to the left and right side of the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 23's Physical Therapy Discharge Summary, dated 12/29/2022, the discharge summary indicated Resident 23 was assessed as total dependence with attempts to initiate for bed mobility. During a review of Resident 23's Fall Risk Assessment, dated 12/27/2024, the Risk Assessment indicated Resident 23 was at risk for falls. During a review of Resident 23's Certified Nursing Assistant (CNA) Task Flowsheet, dated December 2024, the flowsheet indicated Resident 23 was assessed as dependent for the task of rolling to the left and right side of the bed, on the 7 a.m. to 3 p.m., shift, for 21 out of the 31 days in the month of December 2024. The flowsheet indicated Resident 23 was assessed as dependent for the task of toileting hygiene, on the 7 a.m. to 3 p.m. shift, for 24 out of the 31 days in the month of December 2024. During a review of Resident 23's Change of Condition Note, dated 12/31/2024, timed at 9:30 a.m., the Change of Condition Note indicated on 12/31/2024 at 9:30 a.m., while CNA 4 was changing Resident 23, CNA 4 turned Resident 23 to the right side Resident 23 reached and grabbed on to the call light slid off the bed and landed on her back. During a review of Resident 23's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/31/2024 (untimed), the SBAR indicated on 12/31/2024 at 9:30 a.m., Resident 23 fell . The SBAR indicated Registered Nurse (RN) 1 assessed Resident 23 on the floor. The SBAR indicated Resident 23's Physician ordered a STAT (without delay) right hip and right femur x-rays (imaging that creates pictures of the inside of your body) , and for Resident 23 to be transferred to a GACH. During a review of Resident 23's Physician Progress Note, dated 12/31/2024, timed at 12:42 p.m., the note indicated Resident 23 had a right anterior (the front or front surface of a structure or body part) thigh deformity (not having the normal or natural shape or form) with concern for a fracture. The note indicated Resident 23 complained of left hip and right leg pain. During a review of Resident 23's Radiology (a medical specialty that uses imaging technology to diagnose and treat diseases) Results Report, dated 12/31/2024, timed at 12:53 p.m., the Radiology Results Report indicated the following: 1. Left hip x-ray indicated Resident 23 sustained a displaced (when the broken bone snaps into two or more pieces and the ends are no longer aligned) acute fracture to the proximal (near the center of the body) femur. 2. Left femur x-ray indicated Resident 23 sustained a displaced acute subtrochanteric (a break in the femur that occurs below the lesser trochanter, a bony prominence located at the top of the femur) fracture. 3. Right femur x-ray indicated the presence of a fracture to the mid shaft femur. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the GACH Internal Medicine History and Physical Note, dated 12/31/2024, timed at 9:27 p. m., the note indicated Resident 23's blood pressure was 53/39 millimeters of mercury ([MM HG]- unit of measurement that describes the amount of force blood uses to get through the vessels of the body [normal range of 120-129 [top number] and 80-84 [bottom number]). The note indicated Resident 23's oxygen saturation (the percentage of oxygen in a person's blood) was 88 percent (%) (normal range 93-100%) on room air. The note indicated Resident 23's x-ray of the bilateral femurs and bilateral hips indicated Resident 23 sustained the following: 1. A comminuted (a fracture where a bone is broken into multiple pieces or fragments) medial angulated fracture (a fracture that results when one piece of the bone points in an inward direction) of the right femur mid shaft (a break in the middle portion of the femur) with 3.5 centimeter (cm- a unit of measurement) overlap of fracture fragments. 2. A comminuted, mildly medically displaced fracture of the left femoral proximal shaft (the upper, long part of the femur bone) with extension into the lesser trochanter (a small, bony prominence located on the inner side of the femur). During a review of the GACH Operating Room Note, dated 1/2/2025, timed at 9:29 a.m., the note indicated Resident 23 underwent a right and left femur open reduction internal fixation surgery (a surgical procedure used to treat severe fractures or dislocations by realigning the broken bones and stabilizing them with internal hardware, such as screws, plates, or rods). During a review of the facility's Post Fall Review, dated 1/9/2025, timed at 10:30 a.m., the review indicated on 12/31/2024, Resident 23 suffered an assisted fall and slid off the bed while being changed and turned. During a review of the GACH Principal Discharge Diagnosis with Brief Summary Note, dated 1/16/2025, timed at 12:50 p.m., the note indicated Resident 23 was admitted the GACH on 12/31/2024 for hypovolemic shock (a life-threatening condition that occurs when there is a significant loss of blood or fluids in the body, leading to inadequate blood circulation and oxygen delivery to organs) due to blood loss and bilateral thigh hematomas (a localized collection of blood outside of blood vessels that forms due to injury or trauma) secondary to bilateral femoral fractures while receiving anticoagulation (blood thinning) medication. The GACH Note indicated Resident 23 received three units of blood. During a concurrent observation and interview on 3/10/2025 at 10:10 a.m. with Resident 23, in Resident 23's room, Resident 23 was lying on her back in bed. Resident 23's eyebrows were furrowed as the resident stated, I just wish I could be repositioned more often. During an interview on 3/11/2025 at 12:19 p.m. with Resident 23's family member ([FM] 1), FM 1 stated on 12/31/2024, Resident 23 fell and sustained a fracture to both of her femurs and right hip while CNA 4 cleaned Resident 23 in bed. During an interview on 3/11/2025 at 12:20 p.m. with Resident 23, in Resident 23's room, Resident 23 stated on 12/31/2024, while being changed she suggested CNA 4 grab another nurse for help because she felt CNA 4 could not change her alone. Resident 23 stated CNA 4 replied no and proceeded to clean Resident 23. Resident 23 stated CNA 4 rolled her to her side and she (Resident 23) fell off the bed to the ground. Resident 23 stated after the fall, she suffered excruciating pain all over Resident 23 stated she did not recall reaching for a call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/11/2025 at 2:40 p.m., with Registered Nurse (RN) 2, RN 2 stated on 12/31/2024 at 9:30 a.m., CNA 4 informed her that Resident 23 fell . RN 2 stated she (RN 2) observed Resident 23 on the floor to the right side of the bed. RN 2 stated Resident 23 was able to hold onto to the grab bars (a small railing place on the side of the bed) on her bed during repositioning and peri care. RN 2 stated Resident 23 had poor core strength (a group of muscles that include the abdominal muscles, back muscles and the muscles around the pelvis) when assisting with repositioning or turning in bed. RN 2 stated Resident 23 had broken her leg after seeing a large deformity to the resident's right leg. RN 1 stated CNA 4 reported that while cleaning Resident 23, CNA 4 repositioned the resident away from her (CNA 4's) body. RN 1 stated CNA 4 stated that Resident 23 tried to grab the call light to break her fall as the resident slipped off the air mattress. RN 1 stated CNA 4 should have had a second nurse assist with repositioning and cleaning Resident 23 to maintain safety and to prevent falls. During an interview on 3/11/2025 at 3:20 p.m., with CNA 4, CNA 4 stated on 12/31/2024 she was the assigned CNA for Resident 23 for the 7 a.m. to 3 p.m. shift. CNA 4 stated on 12/31/2024, at approximately 9:00 a.m., she provided peri care for Resident 23. and positioned the resident on her right side in preparation for Resident 23's wound treatment. CNA 4 stated the wound nurse was at the door and she (CNA 4) did not intend on leaving Resident 23 on her right side for a long time. CNA 4 stated Resident 23 attempted to grab an area of the bed to hold on to. CNA 4 stated Resident 23's legs fell first off, the bed, and the rest of the resident's body followed. CNA 4 stated she did not ask another nurse for help because she did not usually need help with Resident 23's repositioning or peri care. CNA 4 stated the normal process to determine each resident's level of performance and the number of staff needed to perform the task was to refer to the Kardex (a type of platform (paper or electronic) that nurses use to quickly reference key patient information for care planning). CNA 4 stated no one there was no information provided about Resident 23's bed mobility in the Kardex. CNA 4 stated there was only information about the number of staff needed to perform a transfer from the bed to chair for Resident 23. CNA 4 stated Resident 23's fall may have been prevented if she asked another nurse for help before providing peri care and repositioning the resident alone. During a concurrent interview and record review on 3/11/2025 at 4:00 p.m. with Minimum Data Set Nurse (MDSN) 1, Resident 23's MDS Section GG (an assessment that evaluates the need for assistance with self-care and mobility activities, functional limitations in range of motion, and current and prior device use), dated 12/29/2024, was reviewed. MDSN 1 stated the MDS indicated Resident 23 was dependent on staff for toileting hygiene. MDSN 1 stated Resident 23's MDS Section GG indicated Resident 23 required substantial, maximal assistance when rolling left and right in bed. During an interview on 3/11/2025 at 4:15 p.m. with the Director of Rehabilitation (DOR), the DOR stated it was best practice to have a second staff member assist in changing or repositioning a resident that was identified as maximal assist or dependent for repositioning or toileting hygiene. The DOR stated that CNA 4 could have probably done better. The DOR stated Resident 23 was hurt because of the fall. During an interview on 3/12/2025 at 8:06 a.m. with Restorative Nurse Aide (RNA) 1, RNA 1 stated she was familiar with Resident 23's bed mobility before the resident's fall (on 12/31/2024). RNA 1 stated it was necessary to have a nurse on each side of Resident 23's bed for repositioning or cleaning to ensure the resident's safety and to prevent a fall. (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 3/12/2025 at 1:38 p.m. with Occupational Therapist (OT) 1, Resident 23's CNA Task Flowsheet, dated 12/2024, was reviewed. OT 1 stated the CNA Task Flowsheet indicated Resident 23 was dependent for the task of rolling to the left and right in bed. OT 1 stated the CNA Task Flowsheet indicated dependent meant two or more nurses were needed for repositioning. During an interview on 3/13/2025 at 9:29 a.m. with CNA 8, CNA 8 stated Resident 23 used an air mattress which caused residents to be unstable in bed because of the slippery texture of the mattress. CNA 8 stated Resident 23 required the assistance of two CNAs during care and repositioning to ensure safety. During a concurrent interview and record review on 3/13/2025 at 10:13 a.m. with CNA 5, Resident 23's CNA Task Flowsheet, dated 12/2024, was reviewed. CNA 5 stated the CNA Task Flowsheet indicated Resident 23 was dependent for bed mobility and toileting hygiene [which meant Resident 23 required two-person assistance for safely repositioning Resident 23]. CNA 5 stated Resident 23's trunk and core strength was unstable before the fall on 12/31/2024. CNA 5 stated she was always very cautious with Resident 23, especially because the resident utilized an air mattress that contributed to Resident 23's bed instability. CNA 5 stated the texture of all air mattresses were very slippery which was why she (CNA 5) always made sure she had another nurse to assist her whenever she repositioned or provided peri care to Resident 23. CNA 5 stated she always exercised caution with Resident 23 even if Resident 23 was able to grab the grab bars on her bed. CNA 5 stated the use of two nurses to reposition and provide peri care for Resident 23 was best practice to ensure Resident 23's safety, and to prevent bodily injury from a fall. During a concurrent interview and record review on 3/13/2025 at 10:26 a.m. with the (DOR), Resident 23's Physical Therapy Discharge Summary, dated 12/29/2022, was reviewed. The DOR stated he was not made aware of any improvements or decline in mobility for Resident 23 after she had been discharged from physical therapy in 2022. The DOR stated Resident 23 was assessed as total dependence with attempts to initiate for bed mobility. The DOR stated Resident 23's fall was preventable if a second nurse had assisted Resident 23 reposition in bed. During a concurrent interview and record review on 3/13/2025 on 11:31 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 23's Weekly Nursing Progress Notes, dated 12/23/2024 and 12/30/2024, were reviewed. The Weekly Nursing Progress Notes indicated Resident 23 was dependent on staff for bed mobility and toileting hygiene. LVN 3 stated she authored the Weekly Nursing Progress Notes for Resident 23 and was familiar with Resident 23's physical capabilities and necessary level of care. LVN 3 stated Resident 23 required the assistance of two staff for safe handling. LVN 3 stated Resident 23 had poor strength and relied on staff when she was repositioned and cleaned. During a concurrent interview and record review on 3/13/2025 at 2:20 p.m., with MDSN 1, Resident 23's Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Care Plan, initiated 1/4/2023 and revised 1/21/2025, was reviewed. The care plan indicated Resident 23 was totally dependent on staff for toilet use and required two staff participation to use the toilet. The care plan did not indicate how many staff members were needed for Resident 23's bed mobility and repositioning. MDSN 1 stated it was important to ensure the number of staff needed to the complete the task was included in the ADL Care Plan to ensure that care was rendered properly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	47286 2. During a review of Resident 66's Admission Record, the Admission Record indicated Resident 66 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 66's admitting diagnoses included generalized muscle weakness, reduced mobility, and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had moderately impaired cognition. The MDS indicated Resident 66 required substantial to maximal assistance from staff to roll left and right in bed and was fully dependent on staff to transition from sitting to lying, and lying to sitting positions, and chair/bed-to-chair transfers. During a review of Resident 66's care plan titled The resident is at risk for unavoidable falls, created 7/6/2024, the care plan indicated goals of care were Resident 66 being free from falls and associated injury. Care plan interventions indicated staff were to ensure Resident 66's call light was within reach. During a review of Resident 66's care plan titled [Resident 66] has had an actual fall .with serious injury, created 7/6/2024, the care plan indicated goals of care were Resident 66 not having any additional fall incidents. Care plan interventions indicated staff were to ensure Resident 66 had fall mats on both sides of her bed. During a review of Resident 66's Post-Fall Review assessment, dated 1/7/2025, the assessment indicated Resident 66 had an unwitnessed fall on 1/7/2025. The assessment indicated Resident 66's care plan was reviewed after the fall on 1/7/2025. The care plan indicated Resident 66 was to have floor mats to both sides of her bed and be encouraged to request for assistance. During a review of Resident 66's Quarterly Risk Data Collection Tool assessment, dated 1/17/2025, the assessment indicated Resident 66 was at risk for falls and had fallen one to two times in the last six months. During an observation on 3/11/2025 at 11:48 AM, at Resident 66's bedside, Resident 66 was observed lying in a left-facing position, with a blanket and sheet draped over her right arm. Resident 66's call light was placed on her bedside table, on her right side. When asked to demonstrate reaching for the call light, Resident 66 was unable to reach. During a concurrent observation and interview on 3/11/2025 at 1:13 PM, with Resident 66, at Resident 66's bedside, no fall mats were observed at Resident 66's bedside. Resident 66 stated she had a fall. During an observation on 3/12/2025 at 8:29 AM, at Resident 66's bedside, no fall mats were observed. During a concurrent observation and interview on 3/12/2025 at 11:53 AM, at Resident 66's bedside, with CNA 1, no fall mats were observed. CNA 1 stated Resident 66 did not have fall mats to either side of her bed. CNA 1 stated the purpose of the fall mats was to lessen or prevent injury from a fall. CNA 1 stated the fall mats were softer than the floor, and stated that without the mat, there was increased potential for injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview, on 3/12/2025 at 11:56 AM, at Resident 66's bedside, with CNA 2, CNA 2 stated she provided care to Resident 66 for the last month. CNA 2 stated that in the last month, she did not observe fall mats at Resident 66's bedside. During a concurrent interview and record review, on 3/12/2025 at 12:07 PM, with LVN 1, Resident 66's care plan titled [Resident 66] has had an actual fall .with serious injury, dated 7/6/2024, was reviewed. LVN 1 stated the care plan indicated Resident 66 required fall mats to both [NAME] of her bed. LVN 1 stated Resident 66 was high risk for falls and the fall mats would minimize potential for injury if Resident 66 fell . During an observation on 3/13/2025 at 9:31 AM, at Resident 66's bedside, no fall mats were observed. During an interview on 3/13/2025 at 9:38 AM, with LVN 1, LVN 1 stated it was important for a resident's call light to be within reach. LVN 1 stated that if the call light was not within reach, the resident's needs might not be met, or they might attempt to get up unassisted and could fall and sustain injuries. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated the facility would strive to make the environment as free from accident hazards as possible. The P&P indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated a comprehensive, person-centered care plan, was to include includes measurable objectives and timeframes and describe the services that staff were to furnish to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During a review of the facility's P&P titled, Falls and Fall Risk Managing, revised 2/7/2024, the P&P indicated the facility nursing staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling based on previous evaluations and current data. The P&P indicated that air surface support mattress (i.e. Low air loss mattress /Pressure redistribution optimization mattress) was identified as an environmental risk factor that contributes to the risk of falls. The P&P indicated cognitive impairments, lower extremity weakness, poor grip strength, functional impairments, incontinence, heart failure, anemia, neurological disorders, and balance and gait disorders contributed to the risk of falls. The P&P indicated staff were to implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for at risk residents and those with a history of falls.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to assess the midline (a long thin, flexible tube inserted into a large vein used to administer medication) insertion site at least every shift and change the dressing every seven (7) days for two of six sampled residents (Residents 330 and 72). This deficient practice had the potential for Residents 330 and 72's Midline insertion site to develop an infection. Findings: 1. During an observation on 3/10/2025 at 11:11 AM, in Resident 330's room, observed a midline to Resident 330's left upper arm. The midline dressing was dated 2/27/2025. During a review of Resident 330's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 330 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included sepsis (a life-threatening infection), peritonitis (infection of an abdominal organ), and hypertension ([HTN]- high blood pressure). During a review of Resident 330's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 330's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 330 was dependent (helper does all the effort) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 330's Order Summary Report dated 3/6/2025, the Order Summary Report indicated Resident 330's physician prescribed Meropenem (drug used to treat infection) one (1) gram ([gm] - metric unit of measurement, used for medication dosage and/or amount) intravenously ([IV] - into or within the vein) two times a day for seven days for peritonitis. During a concurrent interview and record review on 3/11/2025 at 3:30 PM, with Registered Nurse (RN 1), Resident 330's Medication Administration Record ([MAR] - a daily documentation record used by licensed nurse to document medications/treatment given to a resident) from 3/6/2025 to 3/11/2025 was reviewed. RN 1 stated Resident 330's midline site was not assessed every shift and the dressing was not changed every 7 days per the facility policy. RN 1 stated it was important to monitor the midline site for redness, swelling, pain as signs of infection, document in the MAR, and change the dressing. 2. During a review of Resident 72's Face Sheet, the Face Sheet indicated Resident 72 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included sepsis, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and HTN. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72's cognitive skills for daily decision making was intact. The MDS indicated Resident 72 was totally dependent from staff for ADLs. During a review of Resident 72's MAR, dated 2/28/2025, the MAR indicated Resident 72 was to receive Ertapenem (drug used to treat infection) 1 gm, IV, one time a day for sepsis for 7 days. During a concurrent observation and interview on 3/11/2025 at 4:00 pm, with RN 1, in Resident 72's room, observed a midline to Resident 72's right upper arm. RN 1 stated Resident 72' midline dressing was soiled, dislocated, and dated 2/24/2025. RN 1 stated RNs were responsible for assessing the residents' midline site daily, changing the dressing every 7 days, and as needed for soiled or dislocated dressing to prevent infection. During a review of the facility's policy and procedure (P&P) titled Central Venous Catheter Care and Dressing Changes, revised 3/2022, the P&P indicated the facility will perform site care and dressing change every 7 days, if it becomes damp, loosed or visibly soiled. The P&P indicated to record assessments, dressing changes, and any observed complications in the resident's medical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure interventions were provided for one of three sampled residents (Resident 65) when: 1. Resident 65's call light was not placed within reach to allow Resident 65 to call for assistance. 2. Staff failed to reposition Resident 65 at least every two hours. These failures placed Resident 65 at risk for avoidable undue pain due to staying in the same position for a prolonged period. These failures also created the potential for a delay or an inability for Resident 65 to request help from staff for repositioning, also interfering with Resident 65's ability to report her pain to staff, and request interventions to address the cause of her pain and treat it. Findings: During a review of Resident 65's Admission Record, the Admission Record indicated Resident 65 was admitted on [DATE]. Resident 65's admitting diagnoses included generalized muscle weakness, abnormalities of gait (walking pattern) and mobility, right shoulder pain, dorsalgia (physical discomfort occurring anywhere on the spine or back, ranging from mild to disabling), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 65's History and Physical (H&P), dated 9/25/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 65 had severely impaired cognition (a significant decline in cognitive abilities that interferes with daily functioning and independence). The MDS indicated Resident 65 required substantial to maximal assistance from staff to roll to a left or right facing position from her back, and to transition from a sitting to lying position or lying to sitting position, while in bed. During a review of Resident 65's care plan titled Resident is risk for pain . initiated 5/18/2021 and revised 2/28/2025, the care plan indicated a goal that Resident 65 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The interventions indicated staff were to monitor for probable causes of pain and remove/limit the cause where possible and respond immediately to any complaints of pain. During a review of Resident 65's care plan titled Impaired physical mobility related to muscle weakness (generalized), abnormalities of gait and mobility, pain in right shoulder, created 7/18/2024, the care plan indicated Resident 65 was totally dependent on staff for repositioning and turning in bed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/11/2025 at 10:10 AM, at Resident 65's bedside, Resident 65 was observed lying in bed in a left-facing position, with a pad call light clipped to her chest. Resident 65 stated the physical therapist told her she needed to be turned every two hours to prevent pain. Resident 65 stated she was sometimes kept in the same position for four to five hours, and she kept track of how long she was in the same position because she could see the clock on the wall. An analog clock was observed on the wall facing Resident 65's bed and the time on the clock was correct. Resident 65 stated that when she is kept in the same position for longer than two hours, the pain in her back was unbearable, and stated being kept in the same position made her feel sad because she could not move on her own and she was dependent on staff for help. During a concurrent observation and interview on 3/11/2025 at 11:06 AM, at Resident 65's bedside, Resident 65 was observed with a pad call light clipped to her chest. When asked to demonstrate pressing the call light, Resident 65 was unable to reach the call light and press it. Resident 65 was unable to move her fingers and her hands were stiff. Resident 65 stated her hands were weak and stated she usually asked her roommate to call for help for her. Resident 65's roommate was not in the room at the time of the interview. During interview on 03/11/2025 at 11:11 AM, with Certified Nursing Assistant (CNA) 9, CNA 9 stated placement of the pad call light was resident-specific and stated the call light should be placed in a position that allows the resident to call for help. CNA 9 stated the call lights should be accessible because if a resident could not call for help, they might not receive the assistance the need. During an observation on 3/11/2025 at 11:14 AM, with CNA 9, observed CNA 9 ask Resident 65 to press the call light while it was clipped to her chest. Resident 65 could not press the call light. CNA 9 moved the pad call light to a lower position, on Resident 65's abdomen, and Resident 65 able to press the call light with her elbow. During an interview on 3/11/2025 at 11:17 AM, with CNA 9, CNA 9 stated Resident 65 originally had the call light clipped to her chest. CNA 9 stated this location was not functional to ensure Resident 65 could use the call light. CNA 9 stated staff should assess appropriateness of call light placement and ensure it was resident-specific to meet the resident's needs. CNA 9 stated Resident 65 was verbal, and usually yelled for assistance. CNA 9 stated that yelling was not an appropriate method to call for help and stated Resident 65 should be able to use her call light. During an observation on 3/11/2025 at 12:13 PM, at Resident 65's bedside, Resident 65 was observed in the same left-facing position. During a concurrent observation and interview on 3/11/25 at 1:33 PM, at Resident 65's bedside, Resident 65 was observed in the same left-facing position. Resident 65 stated she had pain from being in the same position for too long. During a concurrent observation and interview on 3/12/2025 at 8:31 AM, at Resident 65's bedside, Resident 65 was observed lying on her back with her pad call light clipped to her chest. Resident 65 stated she was last turned at 5:00 AM, and she was unable to press the call light to request to be repositioned. Resident 65 stated she felt a pain score of seven (0= no pain, 10 being the worst pain) in her back, and she was grimacing during the interview. Resident 65 stated she felt pain from being in the same position for too long. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Briarcrest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5648 East Gotham Street Bell Gardens, CA 90201	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 3/12/2025 at 8:39 AM, at Resident 65's bedside, with CNA 1, CNA 1 asked Resident 65 to press her call light. Resident 65 was unable to activate the call light while clipped to her chest. CNA 1 stated the current placement of the call light was not effective if Resident 65 could not press it. CNA 1 stated the call light needed to be repositioned to allow the resident to reach it and press it with enough strength to activate it. CNA 1 clipped the call light lower on Resident 65's abdomen and Resident 65 was able to press the call light. During an interview on 3/13/2025 at 9:35 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident could not reposition herself and was fully dependent on staff for repositioning. LVN 1 stated that keeping Resident 65 in the same position for a prolonged period could cause her to experience pain. LVN 1 stated staff should reposition the resident at least every two hours, or more frequently, to prevent pain. LVN 1 stated residents should have their call light within reach to be able to report pain and/or request to be repositioned. During a review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, undated, the P&P indicated pain management was a multidisciplinary process and included assessing the potential for pain, addressing the underlying causes of pain, and implementing approaches to pain management. The P&P indicated non-pharmacological interventions for main management included repositioning. During a review of the facility's policy and procedure (P&P) titled Accommodation of Needs, revised 3/2021, the P&P indicated facility environment and staff behaviors were to be directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. During a review of the facility's P&P titled Answering the Call Light, revised 9/2022, the P&P indicated staff were to ensure the call light was accessible to the resident when in bed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47286 Based on interview and record review, the facility failed to ensure Minimum Data Set Nurse (MDSN) 1 demonstrated the competencies required of her job position and failed to evaluate MDSN 1's ability to accurately perform MDS assessments on an annual basis. This failure placed all facility residents at risk of receiving inaccurate Minimum Data Set (MDS, a resident assessment tool) assessments, which could negatively impact the care the residents received because their care plans were based on data contained in the MDS. Cross-reference F-tag F641. Findings: During an interview on 3/13/2025 at 2:07 PM, with the Assistant Director of Nursing (ADON), the ADON stated the purpose of the MDS was to accurately identify and document the resident's condition. The ADON stated MDS assessments allowed staff to identify changes in a resident's condition and care areas that needed follow up and/or intervention. The ADON stated the MDS also guided the plan of care, including interventions that staff provided to the resident. The ADON stated that to conduct the MDS assessment accurately, the MDSN should be utilizing the Resident Assessment Instruction (RAI) manual. The ADON stated MDSN 1 had access to an electronic copy of the RAI manual in all residents' electronic medical records, and there were no circumstances where the RAI manual should not be followed. During an interview on 3/13/2025 at 2:45 PM, the MDS Nurse Consultant (MDSC), the MDSC stated her role was to train and re-educate MDS staff (including MDSN 1), to ensure MDS assessments were completed accurately and in accordance with the RAI manual. The MDSC stated MDSNs were required to follow the instructions provided in the RAI manual when conducting and documenting MDS assessments. The MDSC stated she trained MDSN 1 a few years ago, but there were no routine performance evaluations of MDSN 1 since that time. MDSC stated she picked random resident MDS assessments to audit monthly, but it was not an observation of MDSN 1 performing the assessments directly. The MDSC stated the importance of an accurate MDS was to provide an accurate assessment of the resident and ensure they received resident-centered care that addressed their needs. During an interview on 3/13/2025 at 3:49 PM, with the Administrator (ADM), the ADM stated there was no current annual evaluation in place to evaluate MDSN 1's ability to accurately conduct or document MDS assessments. During a review of MDSN 1's employee record titled MDS Nurse, dated 7/1/2022, the record indicated the essential duties and responsibilities of MDSN 1. The record indicated MDSN 1 was responsible for restoring and/or maintaining the resident's health and well-being by conducting resident assessments. The record indicated MDSN 1 was responsible for ensuring residents' present/potential health and wellness problems were identified, and indicated the charting was to be documented accurately. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled Performance Evaluations, revised 9/2020, the P&P indicated the job performance of each employee was to be reviewed and evaluated at least annually.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure the following for one of one sampled residents (Resident 15): 1. Adequate documentation indicating Resident 15's physician (MD) 1 was made aware of Resident 15's newly prescribed antipsychotic (a class of medications used to treat mental health conditions medication) after being readmitted from the general acute care hospital (GACH). 2. Carry out MD 1's order for a psychiatrist consult (focusing on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders, including substance use disorders) when Resident 15 displayed physically aggressive behaviors on 3/8/2025. These failures had the potential to result in a delay of necessary behavioral health treatment and services to maintain the highest practicable physical, mental and psychosocial well-being for Resident 15. Findings: During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included dementia (a progressive state of decline in mental abilities), anxiety (a feeling of uneasiness), depressive disorder (a mental health condition characterized by persistent low mood, loss of interest, and other symptoms that can significantly impact daily life), and agitation (a state of restlessness, unease, and distress). During a review of Resident 15's Minimum Data Set ([MDS], a resident assessment tool), dated 2/8/2025, the MDS indicated Resident 15's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 15 exhibited delusions, (misconception or beliefs that are firmly held, contrary to reality) and exhibited verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others). The MDS indicated Resident 15 was dependent on staff (helper does all the effort) for toileting hygiene, bathing, and lower body dressing. The MDS indicated Resident 15 required partial or moderate assistance (helper does less than half of the effort) when performing oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 15 required substantial or maximal (helper does more than half of the effort) assistance for bed mobility. During a review of Resident 15's situation, background, assessment, recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/19/2024, the SBAR indicated on 9/19/2024, Resident 15 was physically aggressive towards staff while staff tried to change her clothing. During a review of Resident 15's SBAR, dated 2/7/2025, the SBAR indicated on 2/7/2025, Resident 15 exhibited increased confusion and was physically aggressive. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's Admission Summary Note, dated 2/11/2025, the note indicated Resident 15 was admitted from the general acute care hospital (GACH). The note indicated all medications were verified and approved by MD 1. There was no documentation to indicate which medications were started or discontinued from the GACH. During a review of Resident 15's SBAR, dated 3/8/2025, the SBAR indicated on 3/8/2025, Resident 15 exhibited poor safety awareness and scratched staff during activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. The SBAR indicated MD 1 ordered a psychiatric consult for Resident 15 on 3/8/2025. During an observation on 3/10/2025 at 11:00 a.m., in Resident 15's room, Resident 15 was observed lying in bed yelling, You're a demon!. Resident 15 hit Certified Nursing Assistant (CNA) 5 with her teddy bear and proceeded to yell, Get out, get out, you're one of them!. During a concurrent observation and interview on 3/12/2025 at 8:03 a.m. with CNA 10, CNA 10's arm was observed. A two-centimeter (cm- a unit of measurement) scar was on her right arm. CNA 10 stated Resident 15 scratched her and it caused the scar. CNA 10 stated Resident 15 always hits me. 1. During a concurrent interview and record review on 3/12/2024 at 10:28 a.m. with Registered Nurse (RN) 1, Resident 15's GACH Discharge Medication List, dated 2/11/2025, and Admission Summary Note, dated 2/11/2025, was reviewed. The GACH Discharge Medication List indicated Resident 15 was to start taking Seroquel (an antipsychotic medication) 50 milligram (mg- a unit of measurement) oral tablet once a day at bedtime. RN 1 stated the normal process for admitting a resident was to verify new and old medications to continue at the facility with the physician and document. RN 1 stated if there were newly prescribed medications, the physician had to be made aware and would decide whether the medications would be continued at the facility. RN 1 stated a rational for the discontinuation of any newly prescribed medications should be documented. RN 1 stated the Admission Summary Note did not indicate MD 1 was made aware of Resident 15's new prescription of Seroquel 50 mg oral tablet once a day at bedtime. During an interview on 3/12/2025 at 1:30 p.m. with MD 1, MD 1 stated if she was made aware Resident 15 had a newly prescribed psychotropic medication from the GACH, then she would have automatically resorted to inputting a psychiatric consult. MD 1 stated it was her practice to ensure all psychotropic medications were appropriately evaluated and prescribed for a proper psychiatric diagnosis. MD 1 stated she exercised great caution with the prescribing of psychotropic medications. MD 1 stated there was a potential for Resident 15 to not improve if there was no psychiatric consult in place. MD 1 stated she reviewed Resident 15's Physician Orders and did not see an order after Resident 15's readmission to the facility. During a concurrent interview and record review on 3/12/2025 at 3:17 p.m. with RN 3, Resident 15's GACH Discharge Medication List, dated 2/11/2025, and Admission Summary Note, dated 2/11/2025, were reviewed. RN 3 stated she authored the Admission Summary Note and stated the normal process when admitting the resident was to verify the medications with the physician and fax the medication list to the physician. RN 3 stated it was not in her practice to explicitly list each newly prescribed medication that was started or discontinued. RN 3 stated that it was important for the physician to know of any new medications that were prescribed to a resident in the hospital. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 3/12/2025 at 3:38 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 15's SBAR, dated 3/8/2025, and Resident 15's Physician Order's, dated 2/2025 to 3/2025, were reviewed. Resident 15's Physician Orders indicated there was no order for a psychiatric consult placed on 3/8/2025. LVN 1 stated the normal process for obtaining a psychiatric consult was to place the order in the electronic medical record (EMR), call or text the psychiatrist, and notify the social services director. LVN 1 stated she authored the SBAR and received the order on 3/8/2025, but did not place an order for a psychiatric consult in the EMR. LVN 1 stated she did not start the process of obtaining a psychiatric consult because she believed the order was already placed in the past. LVN 1 stated if the order was not placed for a psychiatric consult, then there was potential for Resident 15 to continue exhibiting behaviors, which could lead to Resident 15 being sent out the GACH for a psychiatric evaluation. During a review of the facility's Policy and Procedure (P&P) titled, Reconciliation of Medications on Admission, revised 7/2017, the P&P indicated medication reconciliation helped to ensure that medications, routes and dosages had been accurately communicated to the Attending Physician and care team. The P&P indicated that the licensed nurse was to use an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders (sources). The P&P indicated the licensed nurse was to review the list carefully to determine if there are discrepancies/conflicts. For example: a. The dosage on the discharge summary does not match the dosage from the resident's previous MAR; b. There is a potential medication interaction between a medication from the admitting orders and a supplement from the resident's medication history; or c. There is a medication listed on the discharge summary for which there is no diagnosis or condition to support the use of the medication. The P&P indicated to document findings and actions. During a review of the facility's P&P titled, Telephone Orders (undated), the P&P indicated verbal telephone orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. During a review of the facility's P&P titled, Behavioral Health Services (undated), the P&P indicated residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.

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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 to failed ensure infection control measures were implemented for five of 26 sampled residents (Residents 84, 6, 40, 101, and 104) when: 1. Signage for enhanced barrier precautions (EBP, precautions utilized to prevent the spread of multi-drug-resistant organisms [MDROs, microorganisms, primarily bacteria, that have developed resistance to multiple classes of antibiotics] to residents) was not posted outside of Resident 84's room or Resident 6's room. 2. Resident 101's oxygen tubing (flexible clear tubing used to connect to an oxygen source), nebulizer (a medical device that turns liquid medicine into a mist that can be easily inhaled) and respiratory (related to breathing) setup bag (a plastic bag with drawstring closure used to store and transport respiratory equipment) were not changed according to the facility's policy and procedure (P&P). 3. Resident 104's oxygen humidifier (a medical device used to add moisture to supplemental oxygen) was not changed according to doctor's orders. 4. Resident 40's suction tubing (a flexible, clear tubing that connects to a suction device used to remove fluid from the airway) and suction filter (protects from fluid back up in the suction tubing) were on the floor. These deficient practices placed all facility residents and staff at risk for infection from the potential spread of MDROs. These deficient practices placed Residents 101, 104, and 40 at risk for respiratory infections from contaminated respiratory equipment. Findings: 1a. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 84's admitting diagnoses included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 84's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 84 had severely impaired cognition (ability to think and reason). The MDS indicated Resident 84 required substantial to maximal assistance from staff for mobility while in bed. The MDS indicated Resident 84 had a gastrostomy and received more than 51 percent (%) of her calories from feeding administered through the feeding tube. During a review of Resident 84's active physician order, dated 7/10/2024, the order indicated Resident 84 required enhanced barrier precautions (EBP, precautions utilized to prevent the spread of multi-drug-resistant organisms [MDROs] to residents) due to dependency of [gastrostomy] tube. (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 titled Enhanced Barrier Precautions due to dependency of [gastrostomy] tube, dated 7/10/2024, the care plan indicated the goal of care was to prevent spread of infection and other MDROs. Staff interventions indicated a blue dot was to be placed next to the resident's name outside of the room to indicate the requirement for exercising EBP. During an observation on 3/10/2025 at 9:36 AM, at Resident 84's bedside, observed Resident 84 lying in bed receiving feeding through her gastrostomy. During an observation on 3/10/2025 at 9:41 AM, outside of Resident 84's room, no EBP signage, or indicators of the need for staff to exercise EBP, were observed. There was no personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) observed outside of Resident 84's room. b. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 6's admitting diagnoses included transient ischemic attack (TIA, a temporary interruption of blood flow to the brain that causes sudden neurological symptoms that typically resolve within 24 hours) and cerebral infarction (stroke, loss of blood flow to a part of the brain). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was cognitively intact. The MDS indicated Resident 6 required substantial to maximal assistance from staff for toileting hygiene. During a review of Resident 6's active physician order, dated 3/10/2025, the order indicated Resident 6 required EBP due to the use of an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During an observation on 3/10/2025 at 2:53 PM, at Resident 6's bedside, observed Resident 6 lying in bed, with an indwelling urinary catheter drainage bag hanging from the side of the bed. During an observation on 3/10/2025 at 3:03 PM, outside of Resident 6's room, observed no EBP signage, or indicators of the need for staff to exercise EBP. There was no PPE observed. During an interview on 3/12/2025 at 10:48 AM, with the Infection Preventionist Nurse (IPN), the IPN stated the purpose of EBP was to prevent spread of MDROs and infection. The IPN stated that absence of signage or indicators alerting staff of the need to exercise EBP created the potential for the spread of infection because staff would not know they needed to don (wear) PPE during high-risk patient care activities. During a concurrent interview and record review on 3/12/2025 at 10:52 AM, with the Infection Preventionist Nurse (IPN), the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, dated 4/2024, was reviewed. The IPN stated the P&P indicated EBP were indicated for residents with indwelling medical devices, including gastrostomy tubes and urinary catheters. The IPN stated the P&P indicated signs were supposed to be posted in the door or on the wall outside of the resident rooms indicating EBP and use of PPE was required. 48131 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a review of Resident 101's Admission Record, dated 3/14/2025, the admission record indicated Resident 101 was admitted on [DATE]. The admission record indicated the following diagnoses which included, chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and asthma (a condition in which the airways narrow and swell and may produce extra mucus). During a review of Resident 101's Progress Note, dated 2/14/2025, the progress note indicated Resident 101 was alert and oriented to person, place and time and forgetful of the date. During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 101 required supervision (helper provides verbal cues and/or touching/steadying to complete activity) with eating, oral hygiene and toileting and moderate assistance (helper does less than half the effort) for bathing. During an observation on 3/10/2025 at 10:25 AM, in Resident 101's room, observed Resident 101's oxygen tubing, nebulizer and respiratory set up bag was dated 2/14/2024. 3. During a review of Resident 104's Admission Record, dated 3/17/2025, the Admission Record indicated Resident 40 was admitted on [DATE]. The admission record indicated the following diagnoses which included tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), respiratory failure with hypoxia (lack of sufficient oxygen in the blood, tissues and cells). During a review of Resident 104's Progress Note, dated 2/14/2025, the progress note indicated Resident 104 was alert and oriented to person, place, time and event and could make needs known. During a review of Resident 104's MDS, dated [DATE], the MDS indicated Resident 104's cognition was intact. The MDS indicated Resident 104 required supervision for eating and was dependent (helper does all the effort) for toileting and bathing. During a review of Resident 104's Order Summary Report dated 3/17/2025, the order summary report indicated Resident 104 had an active order on 5/4/2024 to change the humidifier every Monday on night shift and as needed. During an observation on 3/10/2025 at 11:15 AM, in Resident 104's room, observed Resident 104's oxygen humidifier dated 2/28/2024. 4. During a review of Resident 40's Admission Record, dated 3/14/2025, the admission record indicated Resident 40 was initially admitted on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included tracheostomy status, acute respiratory failure (a serious condition that makes it difficult to breathe on your own), dependence on respirator (ventilator, a machine that helps you breathe), and cerebral infarction. During a review of Resident 40's History and Physical (H&P), dated 12/22/2024, the H&P indicated Resident 40 could make needs known but could not make medical decisions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Briarcrest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5648 East Gotham Street Bell Gardens, 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's was intact. The MDS indicated Resident 40 was dependent on staff for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 40's Order Summary Report dated 3/13/2025, the order summary report indicated Resident 40 had an active order on 2/26/2025 to change the resident's suction filters as needed. During an observation on 3/10/2025 at 12:12 PM, in Resident 40's room, observed Resident 40's suction tubing and suction filter lying on the floor. During an interview on 3/12/2025 at 4:27 PM, with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the respiratory therapy department, and the nursing staff were responsible for changing out respiratory equipment and making sure the equipment was up to date. LVN 2 stated Resident 40's suction tubing and filter should not be on the floor. LVN 2 stated respiratory equipment should be changed if found on the floor because the floor is dirty and can cause contamination and infection in the mouth and lungs. During an interview on 3/13/2025 at 12:25 PM, with the Treatment Nurse (TN) 1, TN 1 stated the humidifier should have been changed for Resident 104. TN 1 stated if the water in the humidifier was not fresh, it could grow bacteria and lead to infection. During a concurrent observation and interview on 3/13/2025 at 2:49 PM, with Respiratory Therapist (RT) 1, Resident 104's nebulizer, oxygen tubing and setup bag were observed with a date of 2/14/2025. RT 1 stated Resident 104's equipment should be changed every week. RT 1 stated 2/14/2025 was too long to keep respiratory equipment. RT 1 stated the respiratory equipment should have been changed to prevent Resident 104 from an infection. During an interview on 3/13/2025 at 3:01 PM, with RT 1, RT 1 stated Resident 104's humidifier should have been changed once a week. RT 1 stated Resident 104's humidifier needed to be changed to prevent the water from becoming contaminated which could have led to a lung infection. During an interview on 3/13/2025 at 3:38 PM, with the Director of Nursing (DON), the DON stated respiratory equipment should be changed every week and as needed due to infection control. The DON stated it was important to make sure the respiratory equipment was changed weekly because the residents are prone to infection. During a review of the facility's policy and procedure (P&P) titled Administering Medications through a Small Volume (Handheld Nebulizer), revised 10/2010, the P&P indicated the purpose of the policy was to safely and aseptically administer aerosolized particles of mediation into the resident's airway. The P&P indicated staff were to change the equipment and tubing every seven days. During a review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, the P&P indicated the purpose of the policy was to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The P&P indicated staff were to change the oxygen cannula and oxygen tubing every seven days or as needed.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation and interview, the facility failed to ensure a resident window screen was the correct size and without gaping, and the toilet seat was not broken for one of six sampled residents (Resident 133). These deficient practices had the potential to place Resident 133 at risk for injury, entry of insects into the room, and negatively impact Resident 133's well-being. Findings: During a concurrent observation and interview on 3/10/2025 at 1:19 PM, with Resident 133, in Resident 133's room, observed two gaps around the window screen. Resident 133 stated flies and mosquitos were entering his room through the gaps of the screen. Resident 133's bathroom seat was not anchored in place and was broken. Resident 133 stated he felt scared while using the bathroom because the seat was moving around and he could fall. During a review of Resident 133 Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 133 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension ([HTN]- high blood pressure), and muscle weakness (loss of muscle strength). During a review of Resident 133's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 133's cognitive (the ability to think and process information) skills for daily living was intact. The MDS indicated Resident 133 required supervision or touching (helper seat and clean up; resident completes activity) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 3/10/2025 at 1:36 PM, with Maintenance Manager (MM 1), in Resident 133's room, the window was observed with a gap to the left and right side of the screen. MM 1 stated the window screen was not the correct size. MM 1 stated there was a seven inch gap to the left and right side of the window screen. MM 1 stated the ill-fitting window screen was dangerous and had the potential for a pest infestation. MM 1 stated he was not aware of this issue. MM 1 stated the window screen needed to be changed. During a concurrent observation and interview on 3/10/2025 at 1:45 PM, with MM 1, in Resident 133's bathroom, the toilet seat was observed. MM 1 stated the toilet seat was not locked into place and was broken. MM 1 stated the broken seat was a safety issue and had the potential to place Resident 133 at risk for fall and injury. MM 1 stated it was his responsibility to keep the resident's rooms and equipment in a safe manner. (continued on next page)

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F 0921 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 Maintenance Services, revised 12/2009, the P&P indicated the facility would always maintain the buildings and equipment in a safe and operable manner. The P&P indicated maintenance department would maintain the building in good repair and free from hazards. During a review of the facility P&P titled Maintenance Manager Job Description, undated, the P&P indicated maintenance manager would perform regular inspections of resident rooms for safety.