STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Park Convalescent Hospital	2312 West 8th Street Los Angeles, CA 90057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced residents' dignity and respect for two of 12 sampled residents (Resident 87 and 93), by standing over the residents while assisting them during a meal. These deficient practices had the potential to affect residents' sense of self-worth, self-esteem, and psychosocial wellbeing. Findings: a. A review of Resident 87's Admission Record (Face Sheet) indicated the facility admitted the resident on 8/6/2020, and readmitted on [DATE], with diagnoses including Alzheimer's disease (a brain disorders the slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high manic episodes to low depression episodes), and essential hypertension (a condition in which the blood vessels have persistently raised pressure). A review of Resident 87's History and Physical (H&P) dated 6/5/2023 indicated the resident did not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 5/6/2024, indicated Resident 87 had severely impaired cognition (problems with a person's ability to think, learn, remember, and make decisions). The MDS also indicated the resident required maximal assistance on bed mobility, transfer, locomotion on and off the unit, dressing, toileting and personal hygiene and supervision with eating. During a concurrent observation and interview, on 6/17/2024 at 12:20 PM with Licensed Vocational Nurse (LVN) 3, Resident 87 was observed in the Geri chair eating lunch. The Activity Assistant (AA) 2 was standing over Resident 87 while assisting the resident with feeding. AA 2 stated that she was required to sit at the resident's eye level during the feeding. LVN 3 stated AA 2 was required to feed the resident in sitting position to promote Resident 87's dignity. During an interview on 6/20/2024 at 1:45 PM, the Director of Nursing (DON) stated facility staff were required to feed the residents with attention to dignity. The DON stated staff were required to sit while assisting residents with meals. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44309 b. A review of Resident 93's Admission Record indicated the facility readmitted the Resident on 4/15/2024, with diagnoses including dementia (loss of memory, thinking and reasoning), need for assistance with personal care, and adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). A review of Resident 93's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was severely impaired and was dependent to staff for toileting hygiene, lower body dressing, personal hygiene, and oral hygiene. The MDS further indicated Resident 93 required substantial/maximal assistance for eating. A review of Resident 93's Nutritional assessment dated [DATE], indicated the resident was dependent to staff for eating. According to the History and Physical dated 5/9/2024, Resident 93 did not have the capacity to understand and make medical decisions. During a concurrent observation and interview on 6/17/2024 at 12:14 PM, inside Resident 93's room, Certified Nursing Assistant (CNA) 5 was standing over Resident 93 while feeding her. CNA 5 stated, I normally feed the resident while standing, because I have better control over the resident. During a concurrent observation and interview on 6/17/2024 at 12:16 PM, with LVN 3, LVN 3 observed CNA 5 standing over Resident 93 while assisting her with her lunch. LVN 3 stated staff were required to assist residents with feeding in a sitting position so they can maintain their dignity. During an interview on 6/20/2024 at 1:40 PM, the DON stated it was important for the CNAs to be sitting down when feeding the residents because this provided dignity and respect for the residents. A review of facility's policy and procedure titled, Assistance with Meals, undated, indicated residents who cannot feed themselves would be fed with attention to safety, comfort, and dignity, for example, not standing over residents while assisting them with meals.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on interview and record review, the facility failed to ensure a copy of the resident's advance directive (a written instruction, recognized under State law, relating to the provision of health care when the individual is unable to make decisions for themselves) was in the resident's medical chart and the Advance Directive Acknowledgement form was completed thoroughly for two of seven sampled residents (Residents 92 and Resident 140). These deficient practices had the potential for the facility to not honor the residents' medical decisions regarding end-of-life treatment. Findings: A review of Resident 92's Admission Record (Face Sheet) indicated the facility admitted the resident on 2/2/2024, with diagnoses including abnormalities in gait and mobility (a change to your walking pattern), osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), and fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory, and mood issues). A review of Resident 92's Advance Directive Acknowledgement form dated 2/2/2024, indicated the resident executed an advance directive. A review of Resident 92's History and Physical (H&P) dated 2/4/2024, indicated the resident had fluctuating (changing) capacity to understand and make decisions. According to a review of the Physician's Orders for Life-Sustaining Treatment (POLST - a written medical order from a physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness) dated 2/6/2024, the resident had an advance directive. During a concurrent interview and record review on 6/18/2024 at 10:10 AM, the Director of Social Services (DSS) stated there should have been a copy of the Advanced Directive (AD) in the chart. The DSS stated the importance of having an AD was to clarify that the decisions were made before hand when the resident had full capacity to make decisions. That way, the decisions reflected in the AD would be their own wishes. During an interview on 6/18/2024 at 10:40 AM, the Director of Nursing (DON) stated there should have been a copy of the AD in the chart. The DON stated the purpose of the AD was the resident's rights regarding care and treatment. The DON stated if the AD was not in the chart, the resident could be affected because the facility was not following the resident's wishes and the facility must protect the residents. A review of the Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 6/29/2024, indicated Resident 92 had moderate cognitive impairment (cannot navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated Resident 92 required supervision or touching assistance and substantial / maximal assistance with oral / toileting / personal hygiene, showering, transfers, and walking 10 feet. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44309 b. A review of Resident 140's Admission Record indicated the facility admitted the resident on 4/27/2024, with diagnoses including hypotension (blood pressure is lower than normal), fall, and need for assistance with personal care. A review of Resident 140's MDS dated [DATE], indicated the resident's cognitive skills (ability to think, remember, reason, express thoughts, and make decisions) for daily decision making was mildly impaired (some difficulty in new situations only). The MDS indicated Resident 140 was dependent to staff for toileting hygiene, upper and lower body dressing, personal hygiene, eating, showering/bathing, and oral hygiene. A review of Resident 140's History and Physical dated 5/8/2024, indicated the resident had the capacity to understand and make decisions. During a concurrent interview and record review on 6/20/2024 at 10:15 AM, with the Social Services Director (SSD), Resident 140's medical chart was reviewed. The SSD stated that she was in charge of completing the Advance Directive Acknowledgment form upon the resident's admission to the facility. The SSD further stated that Advance Directive Acknowledgment form for Resident 140 was not completed upon admission and the potential outcome was inability to provide education and inform the residents about their right to accept or refuse medical treatments. During an interview on 6/20/2024 at 1:42 PM, the Director of Nursing (DON) stated the Advance Directive Acknowledgment form was required to be completed upon admission, staff were required to complete all sections of the form, and make sure the form was signed by the resident or resident's responsible party. The DON stated Advance Directive Acknowledgment Form for Resident 140 was not completed. A review of the facility's policy and procedure (P&P) titled, Advance Directive, dated 7/1/2023, indicated upon admission the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his legal representative, about the existence of any written advanced directives. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. If the resident indicated that he or she has not established advanced directive, the facility staff will offer assistance in establishing advanced directive. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to report the following incidents to the State Survey Agency (SSA, the Bureau of Health Facility Licensing) within the appropriate timeframe for two of six sampled residents (Resident 13 and Resident 195) as evidenced by: -For Resident 13, the facility failed to report an injury of unknown origin (an injury that the source was not observed by any person or could not be explained by the resident). -For Resident 195, the facility failed to report a fall with injury. These deficient practices resulted in a delay of an onsite inspection by the California Department of Public Health (CDPH) to ensure Resident 13's injury of unknown origin and Resident 195's fall with injury were investigated. Findings: a. A review of Resident 13's Admission Record (face sheet) indicated the facility readmitted on [DATE], with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), need for assistance with personal care, and history of falling. A review of Resident 13's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/16/2024, indicated the resident's cognitive skills (ability to think, remember, and make decisions) for daily decision making was moderately impaired. The MDS indicated Resident 13 required substantial/maximal assistance for lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 13 required partial/moderate assistance for oral hygiene, toileting hygiene, showering/bathing, upper body dressing, and personal hygiene. A review of the Physician's History and Physical (H&P) dated 4/9/2024, indicated Resident 13 did not have the capacity to understand and make decisions. A review of Resident 13's Situation Background Assessment and Recommendation Form (SBAR-documentation of a complete assessment in response to a change in condition) dated 3/12/2024, indicated Resident 13 was observed with a bump on her left forehead, discoloration on her left hand, and an abrasion (a superficial rub or wearing off of the skin) to her left knee. A review of Resident 13's Interdisciplinary Post Event Note (IDT, a team of health care professions, which include the facility's Medical Director, Director of Nursing, social worker, Registered Nurse, and other staff as needed who work together to establish plans of care for residents) dated 3/13/2024, indicated On 3/12/2024 at around 7:20 AM, the nurse on duty noted a bump on the left side of Resident 13's forehead, discoloration on her left hand, and an abrasion on her left knee. Resident 13 stated that she did not fall. Upon further investigation, Resident 13 did not recall any incidents. However, Resident 13 stated that she forgot to ask for help, and she did not use the call light prior to the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/19/2024 at 2:32 PM, with Registered Nurse Supervisor (RN) 2, Resident 13's SBAR communication forms and IDT notes were reviewed. RN 2 stated that on 3/12/2024, a staff member observed a bump on Resident 13's forehead, discoloration on her left hand, and an abrasion on her left knee. RN 2 stated she initiated the IDT post event note on 3/13/2024, and the notes indicated Resident 13 stated that she did not fall. RN 2 stated this incident was considered an incident of unknown origin because it was not witness by any staff member. RN 2 stated all incidents of unknown origins were required to be reported to CDPH for further investigation. RN 2 stated this incident was not reported to CDPH and was not investigated. During an interview on 6/19/2024 at 3:09 PM, the Director of Nursing (DON) stated on 3/12/2024, staff observed a bump on Resident 13's forehead, discoloration on her left hand, and an abrasion on her left knee. The DON stated, I did not report this incident to CDPH because the facility's consultant (a person who provides expert advice professionally) told me that the incident was not reportable. The DON stated, When I interviewed Resident 13, the resident stated that she fell when she was trying to go to bathroom. Resident 13 was confused and based on her physician H&P, she does not have the capacity to understand and make decisions. The DON stated, I should have reported this incident to CDPH for further investigation. The DON stated the facility was required to report all injuries of unknown origin to CDPH for proper investigation. The DON further stated the potential outcome of not reporting an injury of unknown origin to CDPH and other appropriate agencies is a delay in the investigation. 43851 b. A review of Resident 195's Admission Record indicated the facility admitted the resident on 5/1/2024 with diagnoses that included surgical aftercare following surgery on the digestive system, Type II diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), acute respiratory failure (a condition in which your blood does not have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), dysphagia (difficulty swallowing), need for assistance with personal care, abnormalities of gait and mobility, hypertension (high blood pressure), and hyperlipidemia (high levels of cholesterol in the blood). A review of Resident 195's Fall Risk assessment dated [DATE], indicated the resident was not a high risk for a potential fall, the resident had a score of 8 (a score above 10 represented a high risk for potential fall). A review of Resident 195's MDS dated [DATE], indicated the resident had moderately impaired cognition and required setup or clean up assistance with eating and oral hygiene. The MDS indicated Resident 195 required supervision or touching assistance for personal hygiene. The MDS indicated Resident 195 required partial/moderate assistance for upper body dressing, required substantial/maximal assistance for toileting hygiene, showering/bathing self, and lower body dressing. The MDS further indicated Resident 195 was dependent on help for putting on/taking off footwear. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 195's Change of Condition (COC) documentation dated 5/27/2024 at 7 PM, indicated the resident's family member was at bedside for a visit and notified staff that the resident claimed they had a fall during self-transfer, from the toilet seat to wheelchair, and indicated the resident was having pain on the left hip. The COC indicated Resident 195 was administered Norco (a pain medication) 5/325 milligrams (mg) which was effective. The COC indicated Resident 195 was assessed to have no body discoloration and was able to move all extremities without discomfort. The COC indicated Resident 195's physician was notified with no new orders. The COC indicated to continue monitoring Resident 195 for pain. A review of Resident 195's COC documentation dated 5/28/2024 at 7:30 AM, indicated the resident was verbalizing pain on their left hip. The COC indicated Resident 195 was able to move their extremity with purpose. The COC indicated Resident 195 did not have swelling, redness, or discoloration noted. The COC indicated Resident 195 was provided with Norco for pain as needed. According to a review of the Physician's Order dated 5/28/2024 at 7:48 AM, Resident 195 was to have a STAT x-ray of the left hip. A review of Resident 195's Radiology Report of the left hip dated 5/28/2024, indicated no acute osseous findings (there were no abnormal findings in the bone). A review of Physician's Order dated 6/7/2024 at 3:30 PM, indicated Resident 195 was to have a STAT x-ray of the bilateral (both sides) hips, pelvis, thigh, and leg due to pain. A review of Resident 195's Health Status Progress Note dated 6/7/2024 at 3:30 PM, indicated the resident had a STAT x-ray of the bilateral hips, thigh, and legs due to pain. The progress note indicated Resident 195 did not have a fall, but the resident was complaining of pain when they tried to walk or make movements. The progress notes further indicated Resident 125's physician and responsible party were made aware. According to a review of Resident 195's Radiology Report of the bilateral hips and left femur (thighbone) dated 6/7/2024 at 6:23 PM, the resident had a left ischial ring fracture (broken pelvic bone). A review of Resident 195's Change of Condition (COC) documentation dated 6/7/2024 at 8:50 PM, indicated the resident was complaining of left hip and thigh pain. The COC indicated Resident 195 was noted to have skin discoloration on their left thigh. The COC indicated Resident 195 did not fall. The COC indicated Resident 195's physician was notified, and orders were received for a STAT x-ray of the resident's bilateral hips, femur, and legs. The COC indicated the results of the x-ray were received and indicated a left ischial ring fracture. During an interview on 6/18/2024 at 2:00 PM, Resident 195 stated they had a fall last month in the nighttime. Resident 195 stated that they went to the bathroom and fell because they did not ask anyone for help. Resident 195 stated they developed bruising to their left leg a few days after the fall. Resident 195 stated when they fell and did the first x-ray, they were told that there was nothing broken. Resident 195 stated they were having some pain to the left leg, so they did another x-ray. Resident 195 stated staff told her to call for help before getting up/going to the bathroom, so they do that now. Resident 195 stated they call staff using the call light. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/2024 at 3:13 PM, Registered Nurse (RN) 3 stated Resident 195 was complaining of pain to their left leg since the morning shift. RN 3 stated the resident did not have a fall. RN 3 stated Resident 195's physician was notified and ordered a stat x-ray of the left and right leg. RN 3 stated Resident 3's left leg had a fracture. RN 3 stated that the day she received the x-ray results of the fracture to Resident 195's leg, she asked the resident if they fell but the resident stated they did not fall. RN 3 stated staff continued to monitor Resident 195. RN 3 stated she informed the Director of Nursing (DON) about the fracture but did not report to the Department of Public Health (DPH) or to the ombudsman (a representative who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences). RN 3 stated falls with major injury should reported and an injury of unknown origin should be reported to DPH and the ombudsman. RN 3 stated if there was a major injury, DPH and ombudsman should be notified within 2 hours, if there was a minor injury it should be reported within 24 hours. RN 3 stated she did not report. RN 3 stated Resident 195's fracture should have been reported so it can be investigated timely. RN 3 stated there was a potential for the injury to not be investigated timely if it was not reported to DPH and ombudsman. During an interview on 6/20/2024 at 1:42 PM, the DON stated Resident 195's left ischial fracture injury was not reported to the department of public health or ombudsman. The DON stated an injury of unknown origin, unusual occurrences, and fall with major injury should be reported to the department and ombudsman within 2 hours. The DON stated the injury might not be investigated if not reported. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, revised 3/2024, indicated all other instances of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) will be reported by the facility Administrator, or his/her designee, to the following agencies immediately or as soon as practicable, but not later than two hours after the incident occurred: The local state ombudsman, law enforcement officials, and the state licensing/certification agency responsible for surveying/licensing the facility. A review of the facility's undated policy and procedure titled, Unusual Occurrence Reporting, indicated unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations with-in 25 hours of such incident or as otherwise required by federal and state regulations.

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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. 43851 Based on interview and record review, the facility failed to develop a comprehensive care plan for hospice (a specialized type of care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life) one of six sampled residents (Resident 123). This deficient practice had the potential for Resident 123 to not be provided with necessary and personalized care. Findings: A review of Resident 123's Admission Record indicated the facility readmitted the resident on 5/31/2024 with diagnoses that included malignant neoplasm of the stomach (cancer [a disease in which abnormal cells divide uncontrollably and destroy body tissue] of the stomach), encounter for palliative care (specialized medical care for people living with a serious illness, such as cancer or heart failure [occurs when the heart muscle doesn't pump blood as well as it should]), severe protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and sepsis (a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly). A review of the Physician's Order dated 5/31/2024, indicated Resident 123 was admitted to Hospice 1 under the care of Medical Doctor (MD) 1. A review Resident 123's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/7/2024, indicated the resident had moderately impaired cognition (problems with a person's ability to think, remember, and make decisions). The MDS indicated Resident 123 required supervision or touching assistance for eating, required substantial/maximal assistance for oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, and personal hygiene. The MDS further indicated Resident 123 was dependent on help for lower body dressing and putting on/taking off footwear. A review of Resident 123's care plan indicated the resident did not have a care plan for hospice. During a concurrent interview and record review on 6/18/2024 at 1:10 PM, Registered Nurse (RN) 2 stated, Resident 123 was being seen by hospice. RN 2 stated Resident 123 did not have a care plan for hospice and stated the resident should have a care plan specifically for hospice care. During a concurrent interview and record review, on 6/20/2024 at 1:42 PM, Resident 123's physician's order for hospice and care plan were reviewed with the Director of Nursing (DON). The DON confirmed Resident 123 had hospice orders, but did not have a care plan for hospice. The DON stated Resident 123 should have a care plan for hospice as the care plan indicated the resident's care interventions. The DON stated there was a potential for Resident 123 to not receive the necessary care needed and not receive personalized care if there was no care plan for hospice. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Care Plans, Comprehensive Person-Centered, indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: include measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; describe any specialized services to be provided as a result of PASSAR recommendations; include the resident's states goals upon admission and desired outcomes. The policy indicated the comprehensive, person-centered care plan will: include include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; incorporate identified problem areas; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect the resident's expressed wishes regarding care and treatment goals; reflect treatment goals, timetables, and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing decline in the resident's functional status and/or functional levels; enhance the optimal functioning of the resident by focusing on the rehabilitative program; and reflect currently recognized standards of practice for problem areas and conditions.

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Grand Park Convalescent Hospital	2312 West 8th Street Los Angeles, CA 90057

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48661 Based on observation, interview, and record review, the facility failed to address the resident's pain level before, during, and after Restorative Nursing Assistant application (RNA - a Certified Nursing Assistant [CNA] who helped patient's regain physical and cognitive ability after an injury or illness) for three of four sampled residents (Resident 52, Resident 92, and Resident 129). This deficient practice had the potential for residents to experience pain when not properly assessed. Findings: a. A review of Resident 52's Admission Record indicated the facility initially admitted the resident on 10/31/2018 and readmitted the resident on 4/27/2024, with diagnoses including polyarthritis (a condition that causes inflammation, pain, and stiffness in five or more joints at the same time), neuralgia (severe, sharp, and often shock-like pain that follows the path of a nerve) and need for assistance with personal care. A review of the Physician's Order dated 7/13/2023, indicated for Resident 52 to receive RNA for ambulation with front-wheeled walker (FWW) once a day five times a week as tolerated. A review of the Physician's Order dated 7/13/2023, indicated RNA to monitor pain rate before, during, and after RNA application for Resident 52. According to a review of Resident 52's Care Plan initiated 7/13/2023 and reviewed April 2024, the RNA for ambulation with FWW once a day five times a week did not indicate to monitor the resident's pain before, during, and after RNA services. A review of Resident 52's Minimum Data Set (MDS - a standardized resident assessment and care planning tool) dated 4/30/2024, indicated the resident had moderate cognitive impairment, and required substantial / and assistance on facility staff with showering, lower body dressing, putting on / taking off footwear, sit to stand, and transfers. The MDS indicated Resident 52 required partial / moderate assistance on facility staff with toileting / personal hygiene, walking 10 feet, and required setup or clean-up assistance on facility staff with eating. A review of Resident 52's History and Physical (H&P) dated 5/21/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 52's Restorative Nursing dated 6/1/2024 to 6/30/2024, indicated there was no documentation noted to monitor the resident's pain rate before, during, and after RNA application from 6/1/2024 to 6/18/2024. b. A review of Resident 92's Admission Record indicated the facility initially admitted the resident on 3/22/2023 and readmitted the resident on 2/2/2024, with diagnoses including abnormalities in gait and mobility (a change to your walking pattern), osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), and fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory, and mood issues). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 92's Care Plan initiated 7/10/2023 and reviewed March 2024, indicated RNA for ambulation with FWW five times a day once a day as tolerated. The Care Plan did not indicate to monitor the resident's pain before, during, and after RNA services. A review of Resident 92's H&P dated 2/4/2024, indicated the resident had fluctuating capacity to understand and make decisions. A review of the Physician's Order dated 5/11/2024, indicated for Resident 92 to receive RNA for ambulation with FWW five times a week as tolerated, every day shift. According to a review of the Physician's Order dated 5/11/2024, the RNA was to monitor pain level before, during, and after RNA application for Resident 92. A review of Resident 92's Restorative Nursing dated 6/1/2024 to 6/30/2024, indicated there was no documentation noted to monitor the resident's pain rate before, during, and after RNA application from 6/1/2024 to 6/18/2024. A review of Resident 92's MDS dated [DATE], indicated Resident 92 had moderate cognitive impairment. The MDS indicated Resident 92 required supervision or touching assistance on facility staff with eating and rolling to the left and right side, and substantial / maximal assistance with oral / toileting / personal hygiene, showering, transfers, and walking 10 feet. During an interview on 6/19/2024 at 9:25 AM, Resident 92 stated during RNA services the resident could walk further than some other days. Resident 92 stated if there was pain, the nurse was notified, pain medication was given, and RNA services was done for that day. Resident 92 stated there was left leg pain sometimes and that was why the wheelchair was utilized. c. A review of Resident 129's Admission Record indicated the facility originally admitted the resident on 12/11/2023 and readmitted the resident on 1/30/2024, with diagnoses including abnormalities with gait and mobility, need for assistance with personal care, and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities). A review of Resident 129's H&P dated 1/31/2024, indicated the resident did not have the capacity to understand and make decisions. A review of the Physician's Order dated 3/26/2024, indicated for Resident 129 to receive RNA for ambulation with FWW five times a week once a day as tolerated, every day shift. According to a review of the Physician's Order dated 3/26/2024, the RNA was to monitor pain level before, during, and after RNA application for Resident 129. A review of Resident 129's MDS dated [DATE], indicated the resident had severe cognitive impairment (problems with a person's ability to think, remember and make decisions). The MDS indicated Resident 129 required partial / moderate assistance on facility staff with eating, upper body dressing, rolling to the left and right side, sit to lying and transfers. The MDS indicated Resident 129 required substantial / maximal assistance on facility staff with oral / personal hygiene, lower body dressing, walking 10 feet, and was dependent on facility staff with showering and toileting hygiene. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 129's Care Plan initiated 3/26/2024 and reviewed June 2024, indicated RNA for ambulation with FWW five times a day QD as tolerated. The Care Plan did not indicate to monitor the resident's pain before, during, and after RNA services. A review of Resident 129's Restorative Nursing dated 6/1/2024 to 6/30/2024, indicated there was no documentation noted to monitor the resident's pain rate before, during, and after RNA application from 6/1/2024 to 6/18/2024. During an interview on 6/19/2024 at 9:11 AM, Restorative Nursing Assistant (RNA) 1 stated documentation of pain was only charted when the resident was in pain. RNA 1 stated if the resident was not in pain, no documentation was required even though there was an order and space to document for pain was displayed. During an interview on 6/19/2024 at 9:38 AM, the Registered Nurse (RN) 2 / Quality Assurance (QA) stated the RNA should have documented the resident's pain level. The RN 2/QA stated if the RNA do not document the resident's pain, the residents would be uncomfortable, and the facility would not know if the residents actually were in pain. During an interview on 6/19/2024 at 10 AM, the Director of Nursing (DON) stated the RNA should have documented in the monitor for pain order. The DON stated the licensed nurse educate the RNA on proper documentation and the facility did not notice the RNA not document the pain level. The DON stated if the RNA did not document the pain level in resident's before, during, and after RNA services there could be a big problem because the patient would be suffering. A review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, dated July 2023, indicated residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives were individualized and resident-centered and were outlined in the president's plan of care. A review of the P&P titled, Charting and Documentation, dated July 2023, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The P&P indicated documentation of procedures and treatments would include care-specific details, including: the assessment data and/or any unusual findings obtained during the procedure/treatment and how the resident tolerated the procedure / treatment.

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F 0689 Level of Harm - Minimal harm or potential for 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** 48661 Based on observation, interview, and record review, the facility failed to ensure safety measures were assessed and implemented for one of six sampled residents (Resident 134) by failing to initiate a smoking risk assessment when the facility was aware the resident was a smoker. This deficient practice had the potential for Resident 134 to be at risk for injury or burns without a proper assessment. Findings: A review of Resident 134's Admission Record indicated the facility admitted the resident on 5/16/2024, with diagnoses including abnormalities of gait and mobility (a change to your walking pattern), hypertension (high blood pressure) and diabetes mellitus (chronic metabolic disease that occurs when the body did not produce enough insulin or cannot use insulin properly). A review of Resident 134's Admission Nursing Risks assessment dated [DATE], indicated the resident did not smoke, which did not prompt the document to allow safety measures to be reviewed and implemented. A review of Resident 134's History and Physical (H&P) dated 5/17/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 134's Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 5/19/2024, indicated the resident's cognition was intact and required substantial / maximal assistance on facility staff with lower body dressing, putting on / taking off footwear, sit to lying, lying to sitting, and transfers. The MDS indicated Resident 134 required partial / moderate assistance on facility staff with oral / toileting / personal hygiene, showering, and setup or clean-up assistance on facility staff with eating. A review of Resident 134's Social Services Admission Evaluation dated 5/20/2024, indicated the resident was a smoker and must be supervised. During an observation on 6/18/2024 at 8:15 AM in the smoking patio, Resident 134 was smoking with an activities assistant supervising nearby. The activities assistant asked the resident if he would wear a fire-resistant apron and the resident refused. The activities assistant provided Resident 134 with a cigarette and proceeded to light the cigarette for the resident. An individualized ash tray was placed in front of Resident 134. During an interview on 6/19/2024 at 9:49 AM, the Registered Nurse (RN) 2 / Quality Assurance (QA) stated the nurses were supposed to initiate the smoking risk assessment. The RN 2 / QA stated once the Social Worker was made aware Resident 134 was a smoker a risk assessment should have been done. The RN 2 / QA stated if a smoking risk assessment was not done then the patient could be at risk for injury or burns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/2024 at 1 PM, the Director of Nursing (DON) stated during the admission process Resident 134 declined being a smoker. The DON stated the smoking risk assessment should have been done and the facility made a mistake because the assessment was not done. The DON stated if a smoking risk assessment was not done the resident could be at risk for burns if the resident was not properly assessed. A review of the facility's policy and procedure (P&P) titled, Smoking Policy - Residents, dated 7/1/2023, indicated the resident would be evaluated on admission to determine if he or she was a smoker or non-smoker. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. The P&P indicated a resident's ability to smoke safely would be re-evaluated quarterly, upon a significant change, and as determined by the staff.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure residents were provided care and nutrition consistent with their weight loss assessment and the Registered Dietitian's (RD) recommendations for one of four sampled residents (Residents 133). This deficient practice had the potential to result in the resident's weight loss. Findings: A review of Resident 133's Admission Record indicated the facility admitted the resident on 2/7/2024 and readmitted him on 4/7/2024 with diagnoses including end stage of renal disease (final, permanent stage of chronic kidney disease, where kidney function declined to the point that the kidneys can no longer function on their own), dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) and depression (an illness characterized by persistent sadness and a loss of interest in activities, accompanied by an inability to carry out daily activities). A review of Resident 133's History and Physical, dated 4/8/2024, indicated the resident had the capacity to understand and make decisions. A review of a nutritional assessment dated [DATE] indicated Resident 133 had gradual weight loss of 3.8 % for the last 30 days, which was not seen as beneficial because the resident's body mass index (BMI) was slightly underweight. The nutritional assessment interventions indicated to provide snacks three times a day between meals. According to a review of Resident 133's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 5/12/2024, the resident had intact cognition (able to understand, remember and making decisions), was totally dependent on staff with all activities of oral and toileting hygiene, and shower transfer, and required moderate assistance with eating. Further, the MDS indicated the resident lost 5% of his body weight within the last month and was on a therapeutic diet. A review of Resident 133's Order Summary Report dated 6/18/2024 indicated the order from 4/22/2024 for fluid restriction no added salt, renal diet regular texture, regular consistency. A review of Resident 133's care plan revised on 4/22/2024 indicated the resident had a potential nutritional problem and the interventions included snacks three times a day. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 7 on 6/17/2024 at 11:02 AM, Resident 133 was observed in his room eating lunch early because his dialysis was scheduled for 12:30 PM that day. There was a brown bag with a sandwich and CNA 7 stated the resident was receiving snacks to go for dialysis. Resident 133 stated he always received snacks before dialysis. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Quality Assurance Nurse (QAN) on 6/18/2024 at 3 PM, the QAN reviewed Resident 133's chart and stated there was no order for snacks three times a day in Resident 133's chart, and no indication in the MAR to monitor the resident was receiving snacks three times a day. The QAN stated that after recommendations were received from the RD, nurses were required to call the medical doctor to receive an order, make sure it was in the MAR, and to monitor that the resident was receiving snacks. During an interview and record review with Licensed Vocational Nurse (LVN) 3 on 6/18/2024 at 3:05 PM, LVN 3 stated there was no order for snacks three times a day and she did not know if the resident was receiving snacks. On 6/19/2024 at 3 PM, during a concurrent interview and record review with the Dietary Supervisor (DS), the DS stated he was receiving diet communication slips from the nurses, which indicated special diets or snacks. The DS stated Resident 133's Diet Communication slip, dated 4/22/2024, indicated to add snacks three times a day to Resident 133's renal diet. The DS stated he did not know if the diet communication had to be in the resident's order or MAR. During a concurrent interview and record review with the Registered Dietician (RD) on 6/19/2024 at 2:55 PM, the RD stated she recommended to provide snacks three times a day for Resident 133 after she did a nutritional assessment of Resident 133 on 4/22/2024. The RD stated it was important to ensure the resident was receiving nutrition as ordered to maintain his body weight. During an interview on 6/20/2024 at 1:20 PM, the Director of Nursing (DON) stated nurses were required to call the medical doctor about the RD assessment and recommendations and carry-out the medical doctor order in the MAR including to monitor that the intervention provided for resident was effective. The DON stated the missing order may increase the risks for the resident's weight loss. A review of the facility's policy and procedure (P&P) titled, Nutrition (Impaired) /Unplanned Weight Loss-Clinical Protocol, revised on 7/2023, indicated the physician and staff would monitor nutritional status an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43851 Based on observation, interview, and record review, the facility failed to ensure a new tube feeding (a way to provide nutrition when you cannot eat or drink safely by mouth, delivered through a gastric tube [G-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach]) set was used when starting a new tube feeding bottle for one of six sampled residents (Resident 124). This deficient practice had the potential for Resident 124 to experience infection control issues and experience tube feeding intolerance symptoms such as nausea, vomiting, and abdominal discomfort. Findings: A review of Resident 124's Admission Record indicated the facility admitted the resident on 1/17/2024 with diagnoses that included Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), aftercare following surgery on the digestive system, gastrostomy (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach), dysphagia (difficulty swallowing), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of the Physician's Order dated 1/17/2024, indicated to change the resident's tube feeding syringe and spike the tube feeding tubing set every night shift. A review of Resident 124's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/21/2024 indicated the resident had severely impaired cognition (problems with a person's ability to think, remember, and make decisions) and required partial/moderate assistance with eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 124 required substantial/maximal assistance with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 124 had a feeding tube and received a mechanically altered diet (foods that are easy to swallow because they are blended, chopped, grinded, or mashed so that they are easy to chew and swallow) and therapeutic diet (a specialized diet designed to address special medical conditions and improve health). A review of Physician's Order dated 5/3/2024, indicated the resident was to receive Jevity 1.5 (a type of tube feeding that provides calories and fiber nutrition) at 65 milliliters (ml) per hour for 12 hours every morning and at bedtime by G-tube. The physician's order further indicated to start the tube feeding at 6 PM and turn off the tube feeding at 6 AM; or until volume dose was delivered. During a concurrent observation and interview on 6/17/2024 at 9:30 AM, Resident 124 was observed lying in their bed. Resident 124 was observed with tube feeding tubing dated 6/15/2024 at 2:10 AM and the tube feeding bottle dated 6/16/2024 at 6 PM. Licensed Vocational Nurse (LVN) 5 confirmed Resident 124's tube feeding tubing was dated 6/15/2024 at 2:10 AM and the tube feeding bottle was dated 6/16/2024 at 6 PM. LVN 5 stated the tube feeding tubing should have been disposed of and a new tubing set should have been used when starting a new tube feeding bottle. LVN 5 stated there was a potential for infection control issues when tube feeding tubing was reused. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/2024 at 1:42 PM, the Director of Nursing (DON) stated tube feeding tubing should be changed every 24 hours at the same time as the tube feeding bottle. The DON stated a new set of tube feeding tubing should be used every time a new tube feeding bottle was used. The DON stated there was a potential for infection control issues if Resident 124's tube feeding tubing was reused and not changed when using a new tube feeding bottle. A review of the facility's policy and procedure titled, Enteral Feedings-Safety Precautions, dated 7/1/2023, indicated the facility will remain current in and follow accepted best practices in enteral nutrition. Administration set changes: Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer. Change administration sets for closed-system enteral feedings according to manufacturer's instructions. A review of the Jevity 1.5 tube feeding bottle label indicated, Precautions: Feeding sets are for single patient use only. Use clean technique to avoid set and/or product contamination. Hang product up to 48 hours after initial connection when clean technique and only one new feeding set are used. Otherwise, hang no longer than 24 hours. Use by date on container. Protect contents for light during storage.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review, the facility failed to provide sufficient staffing to accommodate resident needs for two of two sampled residents (Resident 28 and 99). This deficient practice had the potential for the residents to not receive timely and efficient care and needed services. Findings: a. A review of the Certified Nursing Assistant's (CNA) Assignments for 5/19/2024, indicated that on 5/19/2024, eight CNAs were working during the 11 PM-7 AM shift attending 147 residents. On 5/19/2024, one CNA was no call, no show and was not replaced. Her assignment was split between eight working CNAs during the 11 PM-7 AM shift, each CNA was assigned to 17-19 residents. A review of Resident 99's Admission Record indicated the facility readmitted the resident on 1/31/2024 with diagnoses that included need for assistance with personal care, severe morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems), hypertension (high blood pressure), and chronic obstructive pulmonary disease (a lung diseases that block airflow and make it difficult to breathe). A review of Resident 99's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/5/2024, indicated the resident was cognitively intact (had the ability to think, understand, and reason) and required set up or clean-up assistance for eating. The MDS indicated Resident 99 required supervision or touching assistance with oral hygiene and personal hygiene. The MDS indicated Resident 99 required partial/moderate assistance with upper body dressing. The MDS further indicated Resident 99 was dependent on help for toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 6/17/2024 at 9:27 AM, Resident 99 was observed lying in bed. Resident 99 stated the facility was short staffed and they had to wait for care. Resident 99 stated sometimes they had to wait for an hour for care and stated that it was frustrating because they needed help using the bathroom. 47883 b. A review of Resident 28's Admission Record indicated she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of malignant neoplasm of rectosigmoid junction (the development of cancer in the colon or rectum), dementia (impaired ability to remember or makes decision that interferes with doing everyday activities), and depression (an illness characterized by persistent sadness and a loss of interest in activities, accompanied by an inability to carry out daily activities). A review of Resident 28's History and Physical (H&P) dated 4/7/2024, indicated the resident had fluctuating capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Park Convalescent Hospital	2312 West 8th Street Los Angeles, CA 90057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 28's MDS dated [DATE], indicated that the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated that Resident 28 was dependent on two or more staff for eating, oral and toileting hygiene, showering and dressing. During observation and concurrent interview with Resident 28's Family Member 1 (FM 1) on 6/17/2024 at 2:39 P.M., Resident 28 was observed in the Geri chair with the FM1 at bedside. Family Member 1 (FM1) stated, Sometimes during the night the wait time can be too long to get help. During an interview with CNA 6 on 6/17/2024 at 2:39 P.M., she stated, Sometimes during the night shift CNA's have 20-22 residents, which makes it harder to take care of residents. During an interview on 6/20/2024 at 12:44 PM, the Director of Staff Development (DSD) stated, We try to schedule nine CNAs for the 11PM-7AM shift. The problem is the no call, no show. When the nurses call off, we try to get somebody. Sometimes we are successful and sometimes we are not. During an interview on 6/20/2023 at 1:20 PM, the Director of Nursing (DON) stated the facility had good staffing according to the facility assessment. The DON stated the facility did not use any registry for staffing and that usually they offer employees overtime or call extra people. Occasionally when it was a short notice like no call, no show, she expected desk nurse to help CNAs with assignments. A review of the facility's Annual Facility Assessment, indicated the facility provided services and care based on residents' needs. The Facility Assessment further indicated that there would be 9 CNAs during the night shift from 11PM to 7AM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety by not labeling: -one plastic container of Aji- Mirin Sweet Cooking Rice seasoning with open and use by dates. -one plastic bag of carrots with open and use by dates. -one plastic bag of ginger with open and use by dates. -one plastic bag of Dried [NAME] with open and use by dates. -one plastic container of Salted Shrimp with no open and used by dates. In addition, the facility failed to discard several items by the use by date. These deficient practices had the potential to cause food-borne illnesses. Findings: During a concurrent observation and interview on [DATE] at 8:03 A.M., the Dietary Assistant (DA) observed one plastic container of Aji-Mirin Sweet Cooking Rice seasoning, one bag of carrots, one plastic container of Salted Shrimp, one plastic bag of ginger, and one plastic bag of Dried [NAME] with no open or use by dates. There was one bottle of [NAME] Rice vinegar with an open date of [DATE] and a use by date of [DATE] in the dry storage area. One plastic bag of Dried Seaweed-Sliced with an open date of [DATE] and a use by of [DATE]. One clear plastic container of garlic with an open date of [DATE] and a use by date of [DATE], and four packs of tofu with an open date of [DATE] and a use by date of [DATE] in the refrigerator. The DA stated that all food stored in the dry food storage room and the refrigerator should be labeled with open and use by dates. During an interview on [DATE] at 12:06 P.M., the Dietary Supervisor (DS) stated the staff should place the label with the open and use by dates when the food container had been open. The DS stated that according to facility policy, all food should have been discarded after its use by date. During an interview on [DATE] at 12:06 P.M., the Dietary [NAME] (DC) stated that it was important to place the labels with the open and use by dates when the food container was opened to prevent the residents getting sick. The DC stated that according to facility policy, all food should have been discarded after its use by date. During an interview on [DATE] at 1:45 P.M., the Director of Nursing (DON) stated the staff should be checking the food items for expiration dates, open dates, and use by dates so as not to harm the residents with expired food products. The DON stated the kitchen staff should have removed the items that were not properly dated and labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's undated policy and procedure titled, Food Storage, indicated food should be dated as it was placed on the shelves if required by state regulation. For refrigerator food storage all food should be covered, labeled, and dated. All foods will be checked to assure that food will be consumed by their safe use by date.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 48661 Based on interview and record review, the facility failed to include verbiage in the Arbitration Agreement (a contractual agreement to settle disputes out of court using a neutral third party called an arbitrator) that allowed residents the freedom to choose a venue to meet. This deficient practice had the potential for residents who have entered into a binding arbitration agreement to have a say in a convenient meeting place for both parties. Findings: A review of the facility's undated Arbitration Agreement form, indicated there were no residents who entered into a binding arbitration agreement for selection of a venue of choice that was convenient. During an interview on 6/20/2024 at 11:10 AM, the Admissions Coordinator (AC) stated the form did not indicate where the residents would meet. The AC stated having that verbiage would be a good thing to add so the residents who have entered into a binding arbitration agreement would have a say in where the meeting spot would be. During an interview on 6/20/2024 at 11:57 AM, the Business Office Manager (BOM) stated the form did not indicate a venue to meet conveniently. The BOM stated having verbiage indicating a venue to meet conveniently would be necessary for the resident's opinion to have that choice. A review of the facility's policy and procedure (P&P) titled, Arbitration for Skilled Nursing Facility (SNF) residents, dated July 2023, indicated the hearing would be conducted at a mutually agreed-upon time and place.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to ensure space requirements of 80 square feet for each resident were met for one of 87 resident rooms (room [ROOM NUMBER]). This deficient practice resulted in inadequate space to provide safe nursing care and privacy. Findings: During multiple room observation conducted in room [ROOM NUMBER], from 6/17/2024 to 6/20/2024, between the hours of 7:30 AM to 4 PM, observations of nursing staff showed adequate space to provide care to the residents, and each resident was provided privacy curtains for privacy. There were no concerns observed related to space or to the safe provisions of care to the residents residing in the room. A review of the Room Waiver letter dated 6/18/2024, from the Administrator, indicated the room waiver would not adversely affect the health and safety of the residents in room [ROOM NUMBER]. A review of the Client Accommodations Analysis dated 6/20/2024, indicated the following rooms with their corresponding measurements: Rooms: Number of Beds: Total Square Feet 66 3 203.3 The square footage requirements for a three-bed capacity room must be at least 240 square feet. During an interview on 6/20/2024 at 10:40 AM, Resident 139 stated there was enough room to move around and there were no complaints. During an interview on 6/20/2024 at 10:48 AM, Resident 69 stated there was enough room and the living area was comfortable. During an interview on 6/20/2024 at 11 AM, Certified Nursing Assistant (CNA) 5 stated the residents in room [ROOM NUMBER] were unable to walk and need assistance. CNA 5 stated there was enough room to provide care and the residents had never complained of needing more space. During an interview on 6/20/2024 at 11:40 AM, Licensed Vocational Nurse (LVN) 3 stated there was enough room to provide care and the residents have never complained of needing more space.