STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Berkley Post-Acute	6600 Sepulveda Blvd Van Nuys, CA 91411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38469 Based on interview and record review, the facility failed to ensure a facility staff knocked and asked permission prior to entering a resident's room for one of five sampled residents (Resident 413). This deficient practice violated the resident's rights to be treated with respect and dignity which had the potential to affect the resident's sense of self-worth and self-esteem. Findings: During a review of Resident 413's Admission Record, the document indicated the facility admitted the resident on 8/8/2024 with diagnoses including muscle weakness, history of falling, and chronic kidney disease (kidneys are damaged and can't filter blood the way they should). During a review of Resident 413's History and Physical (a formal assessment that a physician performs on a resident, which includes a medical history, physical exam, and documentation of findings) dated 8/9/2024, the document indicated that the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 8/20/2024 at 8:49 a.m., with Registered Nurse 1 (RN 1), observed RN 1 enter Resident 413's room without knocking. When asked if RN 1 had knocked prior to entering Resident 413's room, RN 1 stated that she forgot and that she should have knocked. RN 1 stated that knocking on the resident's room prior to entering is a sign of respect for the resident's personal space and to uphold their dignity. During a review of the facility's policy and procedure titled, Quality of Life-Dignity, last reviewed on 5/22/2024, the policy indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem . staff are expected to knock and request permission before entering residents' rooms .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38549 Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) fully closed a resident's privacy curtain while providing care for one of 27 sampled residents (Resident 96). This deficient practice violated the resident's right to privacy. Findings: During a review of Resident 96's Admission Record, the document indicated the facility admitted the resident on 3/17/2024 with diagnoses including difficulty in walking, generalized muscle weakness, and glaucoma (a chronic eye disease that can cause vision loss and blindness). During a review of Resident 96's History and Physical (H&P - a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 3/18/2024, the document indicated the resident had the capacity to understand and make decisions. During a review of Resident 96's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/10/2024, the document indicated the resident had intact cognition (thought processes) and required supervision or touching assistance from staff for most activities of daily living (ADLs - activities related to personal care). During an observation on 8/19/2024 at 9:25 a.m., observed Resident 96 fully undressed sitting on the edge of his bed. CNA 1 was assisting Resident 96 with getting dressed. Observed Resident 96's privacy curtain was open at the foot of the bed. During an interview on 8/19/2024 at 9:34 a.m., with CNA 1, CNA 1 verified the observation by stating he should have fully closed Resident 96's privacy curtain when assisting the resident with changing clothes. During an interview on 8/22/2024 at 11:17 a.m., with the Director of Nursing (DON), the DON stated she expected her staff to provide full privacy to all residents when providing ADL care, especially if the resident is fully exposed. The DON stated that residents can possibly feel ashamed or embarrassed if they their privacy curtain is not closed while they are fully exposed. During a review of the facility's policy and procedure titled, Quality of Life - Dignity, last reviewed on 5/22/2024, the policy indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident rooms (Room A) occupied by four residents (Resident 100, Resident 167, Resident 168, and Resident 363) was within the temperature range of 71 degrees Fahrenheit (F, a unit of measure for temperature) to 81 F. This deficient practice had the potential to create an uncomfortable environment and for the residents to become dehydrated (condition occurring when a harmful reduction in the amount of water in the body). Findings: a. During a review of Resident 100's Admission Record, the document indicated the facility admitted the resident on 5/21/2024 and readmitted the resident on 7/15/2024 with diagnoses that included end stage renal disease (chronic irreversible kidney failure) and dependence on dialysis (a medical procedure to remove waste from the body when the kidneys are unable to). During a review of Resident 100's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/19/2024, the document indicated Resident 100 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 100 needed set-up or clean-up assistance (helper sets up or cleans up and resident completes the activity) with eating. b. During a review of Resident 167's Admission Record, the document indicated the facility admitted the resident on 7/25/2024 with diagnoses that included anemia (a condition that occurs when the body doesn't produce enough healthy red blood cells to carry oxygen to the body's tissues). During a review of Resident 167's MDS, dated [DATE], the document indicated Resident 167 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 167 needed set-up or clean-up assistance with eating. c. During a review of Resident 168's Admission Record, the document indicated the facility admitted the resident on 6/30/2024 and readmitted the resident on 7/15/2024 with diagnoses that included anemia. During a review of Resident 168's MDS, dated [DATE], the document indicated Resident 168 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 168 needed set-up or clean-up assistance with eating. d. During a review of Resident 363's Admission Record, the document indicated the facility admitted the resident on 8/7/2024 with diagnoses that included urinary tract infection (an infection in the urinary system). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 363's MDS, dated [DATE], indicated Resident 363 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 363 needed set-up or clean-up assistance with eating. During a concurrent observation and interview on 8/21/2024 at 5:10 p.m., with the Maintenance Supervisor (MS), the MS took the temperature of Room A with an infrared thermometer (or known as a temperature gun, a device that measures an object's temperature from a distance by detecting infrared radiation [a type of energy that is invisible to the human eye but is felt as heat] emitted by the object) which had four residents residing there, Resident 100, Resident 167, Resident 168, and Resident 363. The temperature was taken in four different places inside the room. The temperatures from the window back towards the door were: 87.1 F, 84.9 F, 83.3 F, and 82.7 F. Resident 100, Resident 167, Resident 168, and Resident 363 all complained of the room being warm. The MS stated the normal range of residents' room temperatures was between 71 F and 81 F. During a concurrent observation and interview on 8/21/2024 at 6:10 p.m., with the MS, the MS took the temperature of Room A with an infrared thermometer. The temperatures were: 81.3 F, 79.3 F, and 84.1 F. During an interview on 8/22/2024 at 2:14 p.m., with the Director of Nursing (DON), the DON stated residents' rooms have to be between 71 F and 81 F. The DON stated this was important to keep the rooms within this range so that resident's will not be sweaty and hot. The DON stated keeping residents' rooms within the normal range was important to prevent a resident from suffering from dehydration. During a review of the facility's policy and procedure titled, Homelike Environment (Temperature Log), last reviewed 5/22/2024, the document indicated residents are provided with a safe, clean, comfortable, and homelike environment - specifically to have comfortable temperatures. The policy and procedure indicated staff and management shall take the temperature once a day in five to ten rooms to ensure comfortable temperatures to the extent possible (71 F - 81 F).

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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** 50033 Based on interview and record review, the facility failed to develop and or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act by failing to report to the State Survey Agency (SSA) an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) by one of three sampled residents (Resident 364). This deficient practice resulted in a delay of an onsite inspection by the SSA to ensure the safety of the other residents and had the potential to result in unidentified abuse. Findings: During a review of Resident 364's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe) and respiratory failure (when not enough oxygen passes from the lungs to the blood) with hypoxia (low levels of oxygen in the body's tissues). During a review of Resident 364's History and Physical (H&P), dated 8/5/2024, the H&P indicated Resident 364 had the capacity to understand and make decisions. During a review of Resident 364's Grievance Report, dated 8/14/2024, the Grievance Report indicated Resident 364 called Family Member 1 (FM 1) and stated that on 8/13/2024 at around 8:00 p.m., Certified Nursing Assistant 4 (CNA) was rough when assisting Resident 364 to the wheelchair. The Grievance Report dated 8/14/24 indicated that Resident 364 sustained bruises (an injury or mark where the skin has not been broken but is darker in color) on the arm and that CNA 4 threw Resident 364's teddy bear at Resident 364. During an interview on 8/24/2024 at 2:34 p.m. the Administrator (ADM), the ADM stated that Resident 364 informed ADM on 8/14/2024 that CNA 4 was rough when providing care to Resident 364. The ADM stated that being handled rough while providing care should be considered an allegation of abuse. The ADM stated that Resident 364's allegation of being rough handled by CNA 4 was not reported to the SSA. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program, reviewed 5/22/2024, the P&P indicated the facility shall report all allegations of abuse to the SSA .

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to ensure residents' Quarterly Minimum Data Sets (MDS - a standardized assessment and care screening tool) were completed timely for six of 27 sampled residents (Residents 83, 42, 58, 46, 30, and 62). This deficient practice had the potential to negatively affect the provision of necessary care and services for these residents. Findings: a. During a review of Resident 83's Admission Record, the document indicated the facility originally admitted the resident on 10/14/2022 and readmitted the resident on 9/22/2023 with diagnoses including cellulitis (a bacterial infection that affects the deeper layers of the skin and the tissue underneath) of both lower extremities. During a review of Resident 83's History and Physical (a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 9/25/2023, the document indicated the resident had the capacity to understand and make decisions. During a review of Resident 83's MDS, dated [DATE], the document indicated the resident had intact cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with Registered Nurse 2 (RN 2), reviewed the Centers for Medicare and Medicaid Services (CMS - a federal agency within the United States Department of Health and Human Services [HHS] that administers the Medicare program) Submission Report, dated 8/19/2024. RN 2 stated Resident 83's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the Assessment Reference Date (ARD - the last day of the observation period that the assessment covers). RN 2 stated since the ARD for Resident 83's Quarterly MDS assessment was 7/13/2024, then the assessment should have been completed by 7/27/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/12/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS Resident Assessment Instrument (RAI- a structured assessment tool used to evaluate nursing home residents) Manual. During an interview on 8/22/2024 at 10:21 a.m., with the Director of Nursing (DON), the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the Interdisciplinary Team (IDT - a group of professionals who work together to achieve a common goal) as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule. b. During a review of Resident 42's Admission Record, the record indicated the facility originally admitted the resident on 11/4/2021 and readmitted the resident on 8/9/2024 with diagnoses including metabolic encephalopathy (a group of neurological disorders that cause brain dysfunction due to chemical imbalances in the blood). During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS also indicated the resident required moderate assistance from staff for most ADLs. During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with RN 2, reviewed the CMS Submission Report, dated 8/19/2024. RN 2 stated Resident 42's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the ARD. RN 2 stated since the ARD for Resident 42's Quarterly MDS assessment was 7/15/2024, then the assessment should have been completed by 7/29/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/12/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS RAI Manual. During an interview on 8/22/2024 at 10:21 a.m., with the DON, the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the IDT as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule. c. During a review of Resident 58's Admission Record, the record indicated the facility originally admitted the resident on 1/31/2020 and readmitted the resident on 8/15/2022 with diagnoses including chronic obstructive pulmonary disease (COPD - a common and progressive lung disease that damages the airways or other parts of the lungs, making it difficult to breathe). (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 58's MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills for daily decision making and was dependent on staff for most ADLs. During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with RN 2, reviewed the CMS Submission Report, dated 8/19/2024. RN 2 stated Resident 58's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the ARD. RN 2 stated since the ARD for Resident 58's Quarterly MDS assessment was 7/9/2024, then the assessment should have been completed by 7/23/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/6/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS RAI Manual. During an interview on 8/22/2024 at 10:21 a.m., with the DON, the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the IDT as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule. d. During a review of Resident 46's Admission Record, the record indicated the facility admitted the resident on 4/3/2024 with diagnoses including acute embolism (blockage in the bloodstream that occurs when a blood clot or foreign object enters and obstructs blood flow) and thrombosis (local clotting of the blood) of the left femoral (relating to the femur [long bone in the upper part of the leg] or thigh)vein. During a review of Resident 46's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually had the ability to understand others. The MDS also indicated the resident required supervision or touching assistance from staff for most ADLs. During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with RN 2, reviewed the CMS Submission Report, dated 8/19/2024. RN 2 stated Resident 46's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the ARD. RN 2 stated since the ARD for Resident 46's Quarterly MDS assessment was 7/10/2024, then the assessment should have been completed by 7/24/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/6/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS RAI Manual. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/22/2024 at 10:21 a.m., with the DON, the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the IDT as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule. e. During a review of Resident 30's Admission Record, the record indicated the facility originally admitted the resident on 11/6/2015 and readmitted the resident on 4/30/2022 with diagnoses including COPD. During a review of Resident 30's MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills for daily decision making and was dependent on staff for most ADLs. During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with RN 2, reviewed the CMS Submission Report, dated 8/19/2024. RN 2 stated Resident 30's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the ARD. RN 2 stated since the ARD for Resident 30's Quarterly MDS assessment was 7/10/2024, then the assessment should have been completed by 7/24/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/6/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS RAI Manual. During an interview on 8/22/2024 at 10:21 a.m., with the DON, the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the IDT as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	f. During a review of Resident 62's Admission Record, the record indicated the facility admitted the resident on 1/27/2020 with diagnoses including hypothyroidism (a common thyroid [small gland located at the front of your neck under your skin] disorder that occurs when the thyroid gland doesn't produce enough thyroid hormones). During a review of Resident 62's MDS, dated [DATE], the MDS indicated the resident had intact cognition and required maximal assistance from staff for most ADLs. During a concurrent interview and record review on 8/21/2024 at 8:22 a.m., with RN 2, reviewed the CMS Submission Report, dated 8/19/2024. RN 2 stated Resident 62's Quarterly MDS assessment was completed late. RN 2 stated that Quarterly MDS assessments should be completed within 14 days after the ARD. RN 2 stated since the ARD for Resident 62's Quarterly MDS assessment was 7/7/2024, then the assessment should have been completed by 7/21/2024. RN 2 stated the Quarterly MDS assessment was not completed until 8/6/2024. RN 2 stated an MDS assessment completed late can negatively impact residents because significant changes to the resident may not be identified timely. RN 2 stated he followed the guidance laid out in the MDS RAI Manual. During an interview on 8/22/2024 at 10:21 a.m., with the DON, the DON stated it was important to complete MDS assessments timely in order to ensure that residents' specific needs based on the assessment can be addressed timely. The DON stated that the MDS assessment influenced care planning for the resident. During a review of the CMS RAI 3.0 Manual, the manual indicated that, for a Quarterly MDS assessment, the MDS completion date should be no later than the 14th calendar day of the ARD. During a review of the facility's policy and procedure titled, Resident Assessment Instrument, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to establish an organized RAI process based on the most updated RAI guidelines that is coordinated by a Licensed Professional Nurse, along with the IDT as warranted by the needs of the resident .The MDS Nurse/Coordinator/UM Nurse will maintain a master schedule of the MDS assessment completion and provide a copy of the said schedule to the members of the IDT and/or the IDT will review regularly the resident assessment schedule in the main Electronic Health Record system for timeliness and general assessment schedule.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49947 Based on interview and record review, the facility failed to ensure a water pitcher was not left at bedside for one of one sampled resident (Resident 317) who was on strict fluid restrictions. This failure placed Resident 317 at an increased risk for injury and or hospitalization related to hypo-osmolality (a condition where the levels of electrolytes [substances that have a natural positive or negative electrical charge when dissolved in water], proteins, and nutrients in the blood are lower than normal) and hyponatremia (a condition where the level of sodium in your blood is lower than normal). Findings: During a review of Resident 317's Admission Record, the document indicated the facility admitted the resident on 7/3/2024 with diagnoses that included hypo-osmolality and hyponatremia, hypokalemia (a condition where the level of potassium [a type of electrolyte] in your blood is lower than normal), kidney failure (when the kidneys [organ that filters waste and extra water from the blood and turns it into urine] are not able to filter any more), and muscle weakness. During a review of Resident 317's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 8/6/2024, the document indicated the resident had the capacity to understand and make decisions. During a review of Resident 317's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/9/2024, the document indicated the resident was able to understand and makes decisions and needed minimal to no assistance from staff on eating, hygiene, toileting, and dressing. The MDS further indicated the resident is completely independent on mobility. During a review of Resident 317's Order Summary Report, the document indicated a physician order for fluid restriction of 1200 milliliters (ml - a measurement of volume) per day on 8/5/2024 and ordered to monitor intake and output (I&O - amount consumed/drank and the amount removed/urinated) every shift on 8/5/2024. During a review of Resident 317's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) titled, Potential for Fluid and Electrolyte Imbalance, indicated fluid restriction as ordered, I&O every shift, and no water pitcher at bedside. During an observation on 8/19/2024 at 9:47 a.m., in Resident 317's room, Resident 317 was asleep in bed with a pitcher of water, an empty cup, and large red insulated cup with a lid on Resident 317's bedside table. Observed above Resident 317's bed was a sign that read not to leave water pitchers at bedside. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/19/2024 at 9:55 a.m., with the Director of Staff Development (DSD), in Resident 317's room, observed the extra cups and water pitcher at Resident 317's bedside. The DSD stated the water pitcher cannot be there because Resident 317 is on water restriction. The DSD further stated the resident could be at risk for fluid overload (too much fluid in the blood/body). During an interview on 8/22/2024 at 1:05 p.m., with the Director of Nursing (DON), the DON stated Resident 317 is on strict fluid restrictions and I&O monitoring. The DON also stated it is important to follow the physician's orders to prevent an imbalance in the electrolytes and hospitalization . During a review of the facility's policy and procedure titled, Fluid Restriction Guidelines, reviewed on 5/22/2024, the policy indicated nursing shall notify dietary once the physician prescribes the order for the resident. Dietary shall request a specific amount of fluid with the remaining volume set aside to the nursing department.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34659 Based on observation, interview, and record review, the facility failed to ensure residents were kept safe from injury and accident hazards for three of six sampled residents (Resident 163, Resident 164, and Resident 29) by failing to: 1. Ensure residents' medications, who had no self-administration assessment, were not left unattended at the bedside for Resident 163 and Resident 164. This deficient practice had the potential for other residents to enter the room and take another resident's medication and could experience adverse side effects (undesired harmful effect resulting from a medication or other intervention). 2. Ensure Resident 29 had bedside floor mats (cushioned foam mats which reduce the risk of injury from a fall) placed next to the resident's bed as indicated in the care plan. This deficient practice placed Resident 29 at an increased risk of sustaining an injury from a fall. Findings: 1.a. During a review of Resident 164's Admission Record, the document indicated the facility admitted the resident on 8/14/2024 with diagnoses that included left femur (thigh) fracture. During a review of Resident 164's Nurses Weekly Progress Notes, dated 8/19/2024, the document indicated Resident 164 was alert and oriented and was able to make needs known. During a review of Resident 164's physician's orders, the document indicated an order for acetaminophen (medication that reduces pain and fever) 325 milligrams (mg, a unit of measurement), give two tablets by mouth every six hours as needed for pain mild 1-3 out of 10 pain scale (with zero being no pain and ten being the most excruciating pain), dated 8/15/2024. During a review of Resident 164's Self Administration of Medication Assessment, dated 8/21/2024, the document indicated Resident 164 is alert and oriented (a person's level of awareness of their surroundings, including their person, place, time, and situation) and with no cognitive impairment and able to follow direction consistently. The document indicated it is safe for Resident 164 to self-administer medications. During a review of Resident 164's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) for Self-Administer Medications, initiated 8/21/2024, the document indicated the resident wishes to self-administer medications. The care plan indicated a goal that Resident 164 will be able to safely administer medications without complication through the next review date. The care plan indicated an intervention to assess Resident 164 for the ability to self-administer his medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/19/2024 at 9:28 a.m., with Resident 164, observed a plastic cup containing one pill on Resident 164's bedside table. Resident 164 stated he takes Tylenol for pain. Resident 164 stated a nurse left it there that morning. Resident 164 stated he took one Tylenol tablet already and will take the other one. During a concurrent observation and interview on 8/19/2024 at 9:50 a.m., with Licensed Vocational Nurse 1 (LVN 1), observed one pill in the medication cup at Resident 164's bedside. LVN 1 stated she gave Resident 164 two Tylenol tablets 325 mg each. LVN 1 stated she thought Resident 164 took the Tylenol. During a concurrent interview and record review on 8/21/2024 at 9:49 a.m., with the Director of Nursing (DON), reviewed Resident 164's medical record. The DON confirmed by stating that a self-administration assessment was not conducted for Resident 164 before leaving the medication at the bedside. The DON stated it is important for a resident to have a self-administration assessment to make sure it is safe for the resident and to make sure the resident has the cognitive ability to understand they have to take their medications. 1.b. During a review of Resident 163's Admission Record, the document indicated the facility admitted the resident on 8/5/2024 with diagnoses that included urinary tract infection (UTI, an infection in any part of the urinary system). During a review of Resident 163's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/9/2024, the document indicated Resident 163 was severely impaired in cognition (thought processes) with skills required for daily decision making. The MDS indicated Resident 163 needed setup or clean-up assistance (helper sets up or cleans up with resident completing the activity) with eating, upper body dressing, and lower body dressing. During a review of Resident 163's physician's orders, indicated the following orders: - Vitamin C (used for the growth and repair of tissues in all parts of the body) tablet 500 mg, give one tablet by mouth one time a day for supplement, dated 8/6/2024. - Cranberry capsule (a medication given as a preventative for a UTI) 450 mg give one tablet by mouth one time a day for supplement, related to UTI, dated 8/6/2024. - Multiple Vitamins- Mineral tablet, give one tablet one time a day for supplement, dated 8/6/2024. - May self-administer medication; licensed nurse to prepare medications for resident and may leave medication at bedside for resident to take, dated 8/19/2024 at 11:32 a.m. During a review of Resident 163's Self Administration of Medication Assessment, dated 8/19/2024 at 11:31 a.m., indicated Resident 163 is alert and oriented and with no cognitive impairment and able to follow direction consistently. The document indicated Resident 163 is safe to self-administer medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 163's Nursing Progress Notes, dated 8/19/2024 at 11:32 a.m., the document indicated Resident 163 prefers licensed nurse to prepare Resident 163's medication, and Resident 163 will take it on her own, despite risks and benefits explained. The document indicated Resident 163's physician was notified with order noted for self-administration of medication. During a review of Resident 163's Care Plan for Self-Administration Medication, initiated 8/19/2024, the care plan indicated Resident 163 prefers to self-administer prescribed medications in the absence of a licensed nurse. The care plan indicated an intervention that the licensed nurse prepares medications and resident will take it on her own despite risks and benefits explained. During an observation on 8/19/2024 at 9:45 a.m., observed a plastic cup with three pills on Resident 163's bedside table. During a concurrent observation and interview on 8/19/2024 at 9:50 a.m., with LVN 1, observed the plastic cup with three pills at Resident 163's bedside. LVN 1 stated the pills were: Vitamin C tablet, cranberry capsule, and multi-vitamin tablet. LVN 1 stated Resident 163 was going to take the medication soon, so she left them, and did not come back. LVN 1 stated it was not the usual practice to leave medications at a resident's bedside but was called to another resident's room to give them pain medication. During an interview on 8/21/2024 at 8:04 a.m., with MDS Registered Nurse 2 (MDS 2), MDS 2 stated licensed nurses educate a resident to keep the medications within reach and to take them right away if able to. MDS 2 stated the licensed nurse will check frequently to see if a resident has taken their medications but could not state a time frame for what was meant by frequently. MDS 2 stated when a resident says they want to self-administer their medications, the licensed nurses conduct an assessment to ensure it is safe for a resident to take the medications themselves. During a concurrent interview and record review on 8/21/2024 at 9:49 a.m., with the DON, reviewed Resident 163's Self-Administration Assessment, dated 8/19/24 at 11:31. The DON stated with Resident 163 the process was not followed because the self-administration physician's order and self-administration resident assessment was not done before leaving the medications at Resident 163's bedside. The DON confirmed by stating that Resident 163 did not have a physician's order to self-administer medications prior to the medications left at bedside. The DON stated it is important for a resident to have a self-administration assessment to make sure it is safe for the resident and to make sure the resident has the cognitive ability to understand they have to take their medications. During a review of the facility's policy and procedure titled, Self-Administration of Medications, last reviewed 5/22/2024, the document indicated residents who express a desire to self-administer medications, as part of the evaluation, the staff and practitioner will access each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. The policy and procedure indicated the staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. The policy and procedure indicated self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. During a review of the facility's policy and procedure titled, Accidents, Incidents & Safety - Investigating and Reporting, last reviewed 5/22/2024, indicated the type and frequency of resident supervision is determine on individual resident assessed needs and identified hazards in the environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50033 2. During a review of Resident 29's Admission Record, the record indicated the facility originally admitted the resident on 2/6/2017 and readmitted the resident on 5/7/2024 with diagnoses including fracture of the base of neck of the right femur (broken hip), muscle weakness, and vascular dementia (problems with judgment, memory, and other thought processes caused by brain damage from impaired blood flow). During a review of Resident 29's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 5/8/2024, the H&P indicated the resident had history of dementia with behavioral disturbances (common behavioral disturbances are agitation, restlessness, and aggression) and is confused and forgetful. The H&P further indicated Resident 29 is at high risk for falls and should be on fall precautions (steps taken to prevent falls, such as managing risk factors and making changes to the environment). During a review of Resident 29's MDS, dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS further indicated the resident was dependent on staff for eating, dressing, and toileting and has had one fall since admission. During a review of Resident 29's Morse Fall Risk Screen (tool used to assess a resident's risk of falling), dated 8/20/2024, the Morse Fall Risk Screen indicated Resident 29 is at high risk for falls. During a review of Resident 29's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) titled, High risk for further falls and injury related to poor safety awareness ., last updated on 8/19/2024, the care plan indicated Resident 29 is to have bilateral floor mats for fall management and to reduce or prevent injury. During a concurrent observation and interview on 8/21/2024 at 2:32 p.m., with Registered Nurse (RN) 4, observed no floor mats placed on the sides of Resident 29's bed. RN 4 stated Resident 29 should have floor mats to the sides of her bed for injury prevention as she is a high fall risk. During an interview with the DON on 8/22/2024 at 11:32 a.m., the DON stated Resident 29 should have floor mats next to her bed because she has fallen before and is at risk for injury. The DON further stated Resident 29 has tried to get out of bed unassisted in the past which put her at risk for falling. During a review of the facility's policy and procedure (P&P) titled, Fall - Prevention, reviewed 5/22/2024, the P&P indicated if a resident is assessed to be a high fall risk, a care plan will be initiated and appropriate measures such as regular assessment and the use of assistive devices will be implemented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure a resident was provided a scheduled toileting plan (or bladder [a sac-shaped muscular organ that stores the urine secreted by the kidneys] training, which can involve assisting a resident to the restroom at specific timed intervals) for one of two residents (Resident 4). This deficient practice has the potential for Resident 4 to not to achieve or restore normal bowel (a tube-shaped organ in the abdomen that helps the body digest food and absorb nutrients) and bladder function. Findings: During a review of Resident 4's Face Sheet (admission record), the face sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a general decline in health in older adults) and extrarenal uremia (increased waste products in the blood that is normally removed by the kidney but caused by conditions outside of the kidneys). During a review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/14/2024, the MDS indicated that Resident 4 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 4 needed substantial/maximal assistance (helper does more than half the effort) with walking ten feet. The MDS indicated that Resident 4 is continent of bladder and incontinent of bowel. During a review of Resident 4's Care Plan for Bowel and Bladder, the Care Plan initiated 7/17/2024 indicated an intervention to offer Resident 4 a bedpan and/or urinal at regular intervals . and assist to the bathroom at intervals. During a concurrent record review and interview on 8/21/2024 at 10 a.m. with Minimum Data Set Nurse 2 (MDS 2), MDS 2 reviewed Resident 4`s MDS dated [DATE] which indicated that Resident 4 is continent (able to control) of bladder and incontinent (inability to control) of bowel. During a concurrent record review and interview on 8/21/2024 at 10 a.m. with MDS 2, MDS 2 reviewed the facility's policy and procedure titled Bowel and Bladder Pathway last reviewed on 5/22/2024 which indicated the following: 1. When a resident is determined to be incontinent of bowel and/or bladder, the licensed nurse will initiate an elimination (following a set schedule to go to the bathroom for material elimination or voiding[urinating]). 2. Schedule/voiding (urinating) diary of every two hours and as needed on even hours for three days. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The certified nursing assistants (CNAs) will document the result of each of their visits with the resident. 4. The elimination/voiding diary will be communicated to all nursing staff and medical records. 5. Medical records staff will start to check the completion of the voiding diary by the CNAs every shift. When MDS 2 was asked regarding the CNA documentation of Resident 4's scheduled bowel elimination as per facility policy, MDS 2 was unable to locate that any scheduled bowel elimination was conducted for Resident 4. During an interview with the Director of Nurses (DON) on 8/21/2024 at 10:28 a.m., the DON stated that licensed nurse should have conducted scheduled bowel elimination after Resident 4 was accessed as being incontinent of bowel. The DON stated it is important to try to maintain a resident's continence or if incontinent to find out the reason and possibly be placed on a bowel training program. During a review of the facility policy and procedure titled Bowel and Bladder Pathway last reviewed on 5/22/2024 which indicated the following: 1. When a resident is determined to be incontinent of bowel and/or bladder, the licensed nurse will initiate an elimination (following a set schedule to go to the bathroom for material elimination or voiding[urinating]). 2. Schedule/voiding (urinating) diary of every two hours and as needed on even hours for three days. 3. The certified nursing assistants (CNAs) will document the result of each of their visits with the resident. 4. The elimination/voiding diary will be communicated to all nursing staff and medical records. 5. Medical records staff will start to check the completion of the voiding diary by the CNAs every shift.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to ensure licensed nurses provided non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (PRN) opioid medication (powerful pain-reducing medications) on multiple days for two of 27 sampled residents (Residents 11 and 83). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from opioid pain medication. Findings: a. During a review of Resident 11's Admission Record, the record indicated the facility admitted the resident on 4/27/2024 with diagnoses including encephalopathy (a general term for a group of conditions that affect the brain's function or structure, such as diseases, disorders, or damage), migraine headache (a type of headache that cause moderate to severe, throbbing pain on one side of the head or behind the eye), and osteoarthritis (a chronic disease that causes the breakdown of joint tissues, most often in the hands, knees, hips, and back). During a review of Resident 11's History and Physical (a formal assessment of a resident by a healthcare provider that includes a medical history and a physical exam), dated 4/29/2024, the record indicated the resident could make needs known but could not make medical decisions. During a review of Resident 11's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 8/3/2024, the MDS indicated the resident had severely impaired cognitive (thought processes) skills for daily decision making and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 11's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) for risk for pain related to migraine headaches and osteoarthritis, initiated on 5/15/2024, the care plan indicated the following nursing interventions: Assure/Assist to maintain proper body alignment for comfort and positioning; divert attention from pain by conversing with resident during short frequent visit; and provide difference pain relieving method, i.e. positioning for comfort, progressive relaxation, bathing, soft music of choice to divert attention from pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/21/2024 at 4:13 p.m., with Registered Nurse 4 (RN 4), reviewed Resident 11's physician's orders and Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) dated 6/2024 and 8/2024. RN 4 stated Resident 11 received hydrocodone-acetaminophen (used to relieve moderate to severe pain) 10-325 milligrams (mg - unit of measurement) half tablet by mouth every eight (8) hours as needed for severe pain 7-10/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 4/27/2024. RN 4 stated Resident 11 received hydrocodone-acetaminophen 10-325 mg on 6/26/2024, but he could not find any documented evidence that the licensed nurse attempted non-pharmacological interventions prior to administering the medication. RN 4 stated Resident 11 received hydrocodone-acetaminophen 10-325 mg on 8/8/2024 and 8/14/2024, but he could not find any documented evidence that the licensed nurses had attempted non-pharmacological interventions prior to administering the medication. During an interview on 8/22/2024 at 10:12 a.m., with the Director of Nursing (DON), the DON stated that licensed nurses should initially attempt non-pharmacological interventions prior to administering as needed pain medication. The DON stated that non-pharmacological interventions were important because it was possible that the resident may not even need pain medication. The DON stated it was possible the resident just needed to be calmed down or redirected. The DON stated some possible side effects that residents could experience from receiving too much opioid pain medication included nausea, dizziness, and an increased risk for falls. During a review of the facility's policy and procedure titled, Pain Management, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to follow the plan of care for the management of pain as written in the resident's plan of care. b. During a review of Resident 83's Admission Record, the document indicated the facility originally admitted the resident on 10/14/2022 and readmitted the resident on 9/22/2023 with diagnoses including cellulitis (a bacterial infection that affects the deeper layers of the skin and the tissue underneath) of both lower extremities. During a review of Resident 83's History and Physical dated 9/25/2023, the document indicated the resident had the capacity to understand and make decisions. During a review of Resident 83's MDS, dated [DATE], the document indicated the resident had intact cognition and required maximal assistance from staff for most ADLs. During a review of Resident 83's physician's orders, an order dated 9/22/2023 indicated to give hydrocodone-acetaminophen 5-325 mg one tablet by mouth every six (6) hours as needed for moderate to severe pain 4-10/10. During a review of Resident 83's care plan for alteration in comfort due to pain, initiated on 10/30/2022, the care plan indicated to provide non-pharmacological interventions as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/21/2024 at 4:27 p.m., with RN 4, reviewed Resident 83's MAR dated 6/2024, 7/2024, and 8/2024. RN 4 stated Resident 83 received hydrocodone-acetaminophen 5-325 mg on 6/2/2024. RN 4 stated he could not find any documented evidence that the nurse attempted non-pharmacological interventions prior to administering the as needed opioid pain medication. RN 4 stated Resident 83 received hydrocodone-acetaminophen 5-325 mg on 7/2/2024. RN 4 stated he could not find any documented evidence that the nurse attempted non-pharmacological interventions prior to administering the as needed opioid pain medication. RN 4 stated Resident 83 received hydrocodone-acetaminophen 5-325 mg on 8/13/2024. RN 4 stated he could not find any documented evidence that the nurse attempted non-pharmacological interventions prior to administering the as needed opioid pain medication. During an interview on 8/22/2024 at 10:12 a.m., with the DON, the DON stated that licensed nurses should initially attempt non-pharmacological interventions prior to administering as needed pain medication. The DON stated that non-pharmacological interventions were important because it was possible that the resident may not even need pain medication. The DON stated it was possible the resident just needed to be calmed down or redirected. The DON stated some possible side effects that residents could experience from receiving too much opioid pain medication included nausea, dizziness, and an increased risk for falls. During a review of the facility's policy and procedure titled, Pain Management, last reviewed on 5/22/2024, the policy indicated it is the policy of the facility to follow the plan of care for the management of pain as written in the resident's plan of care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49947 Based on interview and record review, the facility failed to complete a post-dialysis (the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) assessment for one of one sampled resident (Resident 102). This deficient practice placed Resident 102 at risk for complications of dialysis such as redness at the dialysis access site (way to reach the blood for hemodialysis), edema (too much fluid trapped in the body's tissues), excessive bleeding, and a change in vital signs (clinical measurements that indicate the state of a patient's essential body functions). Findings: During a review of Resident 102's Admission Record, the document indicated the facility admitted the resident on 6/23/2024 with diagnoses including end stage renal disease (ESRD - a condition when the kidneys cannot filter blood anymore), dependence on renal dialysis, and muscle weakness. During a review of Resident 102's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 6/24/2024, the document indicated the resident had the capacity to understand and make decisions. During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/29/2024, the document indicated the resident had mildly impaired cognition (mental action or process of acquiring knowledge and understanding), required set up/clean up assistance with eating, substantial assistance with all other activities of daily living (ADLs - activities related to personal care). The MDS indicated Resident 102 was on dialysis. During a review of Resident 102's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) titled, ERSD with Dialysis, dated 6/23/2024, the care plan indicated to assess the dialysis access site for bruit (rumbling sound) and thrill (vibration) and for complications such as bleeding. During a review of Resident 102's Dialysis Assessment Form dated 8/20/2024, the document indicated the post dialysis assessment section was not filled out with information including, vital signs (clinical measurements that indicate the state of a patient's essential body functions) and access site description including bruit and thrill. During a review of Resident 102's Electronic Chart, it did not indicate an assessment, notes, or vital signs were completed after Resident 102 returned to the facility from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/21/2024 at 3:40 p.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 162's Dialysis Assessment form dated 8/20/2024. LVN 3 verified by stating the post dialysis assessment section of the form was not completed on 8/20/2024. LVN 3 stated he did not remember to fill out the form after the resident returned from dialysis on 8/20/2024 or write an assessment note in the resident's electronic record. LVN 3 further stated an assessment is important after dialysis to ensure there are not any complications. During an interview on 8/21/2024 at 3:55 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses are responsible to complete the post dialysis assessment upon the resident's return to the facility from dialysis and should include the vital signs and signs or symptoms of bleeding to ensure that the resident is stable and there are no signs of complications. During a review of the facility's policy and procedure titled, End Stage Renal Disease, Care of Resident with, last reviewed 5/22/2024, indicated the licensed nurses look for signs and symptoms of an infection, complications, and training in the care of residents receiving dialysis from an outside facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38469 Based on interview and record review, the facility failed to meet professional standards of quality of care by failing to ensure a lidocaine patch (eases pain by numbing the nerves and making them less sensitive to pain) was removed after 12 hours from application as per physician's order for one of five sampled residents (Resident 413). This deficient practice had the potential in excessive dosing and a potential to cause adverse reaction (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 413's Admission Record, the document indicated the facility admitted the resident on 8/8/2024 with diagnoses including muscle weakness, history of falling, and chronic kidney disease (your kidneys are damaged and can't filter blood the way they should). During a review of Resident 413's History and Physical (a formal assessment that a physician performs on a resident, which includes a medical history, physical exam, and documentation of findings) dated 8/9/2024, indicated that the resident had the capacity to understand and make decisions. A review of Resident 413's physician orders dated 8/9/2024, indicated an order for lidocaine externa patch 5%, apply to both knees topically one time a day for pain management, one patch 12 hours on, 12 hours off and remove per schedule. During a concurrent medication administration observation and interview on 8/20/2024 at 8:49 a.m., with Registered Nurse 1 (RN 1), observed RN 1 remove two lidocaine patches to administer to Resident 413. RN 1 removed the lidocaine patch from both knees and then applied the new ones to both knees. After the medication administration, RN 1 verified by stating that the patches prior to the one that she just applied should have been removed yesterday for 12 hours per the physician's order. During a review of Resident 413's Medication Administration Record (MAR- used to document medications taken by each resident) dated 8/2024, the MAR indicated that lidocaine patch was applied on 8/19/2024 at 9:00 a.m., which was not removed after 12 hours as evidenced by the lidocaine patch still attached to Resident 413's knees during the medication administration observation on 8/20/2024 at 8:49 a.m. During a concurrent interview and record review on 8/21/2024 at 3:31 p.m., with the Director of Nursing (DON), reviewed the lidocaine patch package insert. The medication insert indicated that excessive dosing by applying longer than the recommended time could result in increased absorption of lidocaine and high blood concentration leading to serious adverse effects. The DON stated that the lidocaine patch should have been removed after 12 hours based on Resident 413's physician's orders. The DON stated that not removing the lidocaine patch could result in the resident receiving excessive dose and it's also uncomfortable to have the lidocaine patch longer than it should be. The DON agreed with the manufacturer's package insert by stating that adverse side effects could potentially result if the patch is nor removed after 12 hours.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 38549 Based on interview and record review, the facility failed to ensure licensed nurses monitored for side effects while a resident received an anticoagulant medication (medications that prevent and treat blood clots in the heart and blood vessels) for two of 27 sampled residents (Resident 73 and Resident 364). This deficient practice had the potential to result in the residents experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from the anticoagulant. Findings: a. During a review of Resident 73's Admission Record, the record indicated the facility originally admitted the resident on 8/17/2021 and readmitted the resident on 3/12/2024 with diagnoses including atherosclerotic heart disease (a vascular disease that occurs when arteries thicken and stiffen, restricting blood flow to the heart and other organs). During a review of Resident 73's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 8/2/2024, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 73's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) for risk for bleeding and easy bruising related to anticoagulant therapy due to the resident being on apixaban (anticoagulant), initiated on 8/20/2024, the care plan indicated to monitor for bleeding or bruising. During a concurrent interview and record review on 8/21/2024 at 3:41 p.m., with Registered Nurse 4 (RN 4), reviewed Resident 73's physician's orders. RN 4 stated Resident 73 had an order for apixaban 2.5 milligrams (mg, a unit of measurement) by mouth twice a day for deep vein thrombosis (DVT - a blood clot that forms in a deep vein in the body, usually in the leg but can also occur in the arms, pelvis, and other areas) prophylaxis (measures designed to preserve health and prevent the spread of disease). RN 4 stated he could not find any documentation indicating that nurses were monitoring for side effects of apixaban. During an interview on 8/22/2024 at 11:10 a.m., with the Director of Nursing (DON), the DON stated nurses should be monitoring for bruising or bleeding when a resident is on an anticoagulant. The DON stated it was important to monitor the side effects of anticoagulants because it increased the resident's risk for bleeding. During a review of the facility's policy and procedures titled, Anticoagulation - Clinical Protocol, last reviewed on 5/22/2024, the policy indicated that the staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. 50033 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 364's Admission Record, the record indicated the facility admitted the resident on 8/4/2024 with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), respiratory failure (when not enough oxygen passes from the lungs to the blood) with hypoxia (low levels of oxygen in the body's tissues), and generalized muscle weakness. During a review of Resident 364's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 8/5/2024, the H&P indicated Resident 364 had the capacity to understand and make decisions. During a review of Resident 364's care plan titled, Risk for bleeding and easy bruising related to: Anticoagulant therapy heparin (anticoagulant), dated 8/4/2024, the care plan indicated to monitor for bleeding, bruising, blood in the urine, and blood in the stool. During a concurrent interview and record review on 8/21/2024 at 3:36 p.m., with Licensed Vocational Nurse (LVN) 3, reviewed Resident 364's Order Summary Report. The Order Summary Report indicated an order for one (1) milliliter (ml, a unit of measurement) of heparin sodium 5000 units/ml solution to be injected subcutaneously (into the fatty tissue just under the skin) every eight hours for DVT prophylaxis. LVN 3 stated Resident 364 should be monitored for the side effects of heparin such as bleeding and bruising. LVN 3 stated they usually document the side effects of anticoagulants on the Medication Administration Record (MAR, a report detailing the drugs administered to a resident), but this was not done for Resident 364. LVN 3 stated there is no other area of Resident 364's medical record where monitoring for the side effects of heparin is documented. During an interview on 8/22/2024 at 2:06 p.m., with the DON, the DON stated Resident 364 should be monitored for the side effects of heparin as the resident is at increased risk of bleeding, skin impairment, and having blood in the stool. During a review of the facility's policy and procedures titled, Anticoagulation - Clinical Protocol, last reviewed on 5/22/2024, the policy indicated that the staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview and record review, the facility failed to ensure a vial of insulin (hormone that lowers the level of glucose [sugar] in the blood) that was past the discard date, was not stored in one of three medication carts (Medication Cart A) for one of one sampled resident (Resident 85). This deficient practice had the potential for an expired insulin to be administered to Resident 85 which could result in uncontrolled blood glucose (the primary sugar in the blood and the body's main source of energy). Findings: During a review of Resident 85's Admission Record, the document indicated the facility admitted the resident on [DATE], with diagnosis of diabetes mellitus (DM - a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 85's Minimum Data Set (MDS - a standardized assessment and screening tool) dated [DATE], the document indicated the resident had the ability to sometimes understand others and the ability to sometimes make self-understood. The MDS indicate that Resident 85 required assistance for self-care. A review of Resident 85's Order Summary Report indicated a physician's order dated [DATE] to administer insulin lispro injection solution (Humalog- a fast-acting insulin) 100 unit per milliliters (U/ml, a unit of measurement) per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) subcutaneously (administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) before meals and at bedtime for DM. During a concurrent medication cart inspection and interview on [DATE] at 9:49 a.m., with Licensed Vocational Nurse 2 (LVN 2), inspected Medication Cart A. Observed a vial of insulin lispro belonging to Resident 85 with an open date of [DATE]. LVN 2 stated that the insulin vial should have been discarded after 28 days from opening. LVN 2 stated that insulin that is past 28 days will loss it's efficacy. LVN 2 stated that if the insulin is used, it will not be effective and the resident can experience hyperglycemia (high blood sugar) which could lead to the resident being confused and may fall and sustain an injury. A review of the Solostar insulin manufacturer's literature (provided by the facility), undated, indicated that when stored at room temperature, Humalog U-100 (brand of insulin lispro) can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time. Food and Drug Administration guidelines for storing Humalog (insulin lispro) are as follows: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unopened vials- Store in the refrigerator at 36 Fahrenheit (F, unit of temperature) -46 F (2 Celsius [C, unit of temperature] -8 C) and keep away from heat and direct light. You can use them until the expiration date on the label, but you should throw them away after 28 days if you store them at room temperature. Do not freeze Humalog, and do not use it if it has been frozen. Opened vials- Store in the refrigerator or at room temperature up to 86 F (30 C) for up to 28 days. Keep them away from heat and direct light, and throw them away after 28 days, even if they still contain insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34659 Based on observation, interview, and record review, the facility staff (Cook 1) failed to check the temperature of all of the food items on the tray line (a system of food serving in which a tray is moved along an assembly line to ensure a resident gets their prescribed diet) during mealtime service on 8/21/2024 at 1:25 p.m. This deficient practice had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 110 of 114 medically compromised residents who received food from the kitchen. Findings: During a kitchen tray line observation on 8/21/2024 at approximately 12 p.m., observed [NAME] 1 check the temperatures of the food on the tray line. Observed [NAME] 1 fail to check the temperature of the following food trays : 1. Puree (a very smooth, crushed, or blended food) potato 2. Chopped Turkey 3. Chicken During an interview with [NAME] 1 on 8/21/2024 at 1:25 p.m., [NAME] 1 stated that the temperature of all foods that are to be served during mealtime to residents are to be checked. [NAME] 1 stated that she (Cook 1) missed checking the temperature for the pureed potatoes, chopped turkey, and chicken during the tray line on 8/21/2024 at 12:00 p.m. [NAME] 1 stated that it was important to check the temperature of all the cooked foods served to resident's in order to prevent bacterial contamination (occurs when bacteria multiply on food and cause it to spoil). During a review of the facility's policy and procedure titled, Meal Service, last reviewed 5/22/2024, the policy and procedure indicated the food and nutrition services staff member will take the food temperatures prior to service of the meal with a thermometer .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to implement infection control policy and procedure by failing to: 1. Ensure two visitors were for two of four days screened for signs and symptoms of Coronavirus disease-2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection). This deficient practice had the potential to spread COVID-19 to residents in the facility. 2. Ensure Dietary Aide 1 (DA 1) washed their hands after touching a trash can lid. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 110 of 114 residents who received food from the kitchen. 3. Ensure a resident's oxygen nasal cannula tubing (a device that gives additional oxygen through the nose) was labeled for one of one sampled resident (Resident 85). This deficient practice had the potential for contamination of the oxygen tubing, placing the resident at risk for acquiring an infection leading up to respiratory distress (trouble breathing). 4. Ensure a resident's urinal (container used to collect urine) was labeled with a resident identifier for one of 27 sampled residents (Resident 214). This deficient practice had the potential to increase the residents' risk of developing an infection. 5. Ensure a resident's oxygen tubing (medical device that connects an oxygen source to a nasal mask or cannula to deliver oxygen during oxygen therapy) was not touching the floor for one (Resident 56) out of 27 sampled residents. This deficient practice had the potential to increase the residents' risk of developing an infection. Findings: 1. During a concurrent interview and record review on 8/22/2024 at 11:51 a.m., with the Director of Nursing (DON), reviewed the Visitor Screening Tool logs from 8/13/2024 to 8/16/2024. The Visitor Screening Tool logs indicated two visitors were not screened for signs and symptoms of COVID-19 or having close contact with someone with COVID-19 on 8/13/2024 and 8/14/2024. The DON stated they should have been screened as they need to know if a visitor has an illness to protect the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, COVID-19: Testing Policy, dated 6/20/2024, the P&P indicated passive visitor screening for COVID-19 will be conducted. The P&P further indicated if a visitor has symptoms consistent with COVID-19 or had close contact with a confirmed positive case, they should reschedule their visit. 34659 2. During a concurrent observation and interview on 8/21/2024 at 11:31 a.m., with DA 1, during the kitchen tray line service, observed DA 1 working in the kitchen, touched a plastic trash can lid, and did not wash their hands after. DA 1 put on gloves without washing their hands first. When asked, DA 1 stated he usually washes his hands first after touching a contaminated surface and before putting on gloves. The Dietary Supervisor (DS) who was present, stated kitchen staff are to wash hands first after touching a contaminated surface and before putting on gloves. During an interview on 8/21/2024 at 12:30 p.m., with the Infection Preventionist (IP), the IP stated DA 1 should have washed their hands before putting on gloves. The IP stated the importance of following this infection control standard is to not introduce bacteria to residents' food. During a review of the facility's policy and procedure titled, Hand Washing Procedure, last reviewed 5/22/2024, the document indicated hand washing is important to prevent the spread of infection. The policy and procedure indicated hands need to be washed after handling soiled dishes and utensils. 49947 3. During a review of Resident 85's Admission Record, the document indicated the facility admitted the resident on 7/19/2024, with diagnoses including respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), acute pulmonary edema (a medical emergency that occurs when fluid builds up in the lungs and makes it difficult to breathe), and muscle weakness. During a review of Resident 85's Physician's Progress Note dated 7/30/2024, the document indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/9/2024, the document indicated the resident had severe cognitive (thought processes) impairment and is dependent on facility staff for all activities of daily living (ADLs - activities related to personal care). During a review of Resident 85's Order Summary Report, the document indicated a physician order for oxygen (O2) three (3) liters (L, a metric unit of volume) via nasal cannula continuously, ordered on 7/19/2024. During a concurrent observation and interview on 5/15/2024 at 3:55 p.m., with Registered Nurse 1 (RN 1), inside Resident 46's room, observed Resident 46's nasal cannula not labeled with the date it was last changed. RN 1 stated they place a sticker label with the name, date, room number, and time the tubing was changed for the staff to know when to replace the tubing again. RN 1 stated they change the nasal cannula tubing every week to prevent growth of bacteria in the tubing that can cause respiratory infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley Post-Acute	6600 Sepulveda Blvd Van Nuys, CA 91411

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Policies and Practices- Infection Control, last reviewed on 1/18/2024, the policy indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. 38549 4. During a review of Resident 214's Admission Record, the record indicated the facility admitted the resident on 8/18/2024 with diagnoses including difficulty in walking. During an observation on 8/19/2024 at 9:36 a.m., observed Resident 214 awake in bed. Observed an unlabeled urinal hanging from Resident 214's side rail (a metal or plastic bar that attaches to the side of a bed to help residents stay safe and independent). During a concurrent observation and interview on 8/19/2024 at 9:38 a.m., with the Director of Staff Development (DSD), the DSD verified the observation by stating that Resident 214's urinal was not labeled and stated it should have been labeled with a resident identifier. During an interview on 8/22/2024 at 10:15 a.m., with the DON, the DON stated it was the facility's practice to label urinals with the resident's name for infection control purposes. The DON stated it was important to prevent cross contamination with other residents. During a review of the facility's policy and procedure titled, Urinal Use, last reviewed on 5/22/2024, the policy indicated that urinals must be labeled with a black permanent marker with the resident's name and room number in a visible area. 5. During a review of Resident 56's Admission Record, the record indicated the facility originally admitted the resident on 4/21/2021 and readmitted the resident on 4/16/2022 with diagnoses including chronic obstructive pulmonary disease (COPD - a common, progressive lung disease that damages the airways and other parts of the lungs, making it difficult to breathe) and respiratory failure. During a review of Resident 56's History and Physical (H&P - a formal assessment by a healthcare provider that includes a resident's medical history and a physical exam), dated 8/19/2024, the record indicated the resident had the capacity to understand and make decisions. During a review of Resident 56's MDS dated [DATE], the MDS indicated the resident had intact cognition and was dependent on staff for assistance with most ADLs. During an observation on 8/19/2024 at 10:07 a.m., observed Resident 56 awake in bed and wearing a nasal cannula. Observed the nasal cannula tubing touching the floor. During a concurrent observation and interview on 8/19/2024 at 10:10 a.m., with Registered Nurse 4 (RN 4), RN 4 verified the observation by stating that Resident 56's nasal cannula tubing was touching the floor. RN 4 stated it should not have been on the floor and stated he would change it immediately. During an interview on 8/22/2024 at 11:27 a.m., with the DON, the DON stated that oxygen tubing should be kept off the floor for infection control. (continued on next page)

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	056253	A. Building B. Wing	08/22/2024

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Berkley Post-Acute	6600 Sepulveda Blvd Van Nuys, CA 91411

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Infections - Clinical Protocol, last reviewed on 5/22/2024, the policy indicated that the physician or provider and staff will identify infection transmission risks and will implement relevant precautions. During a review of the facility's policy and procedure titled, Policies and Practices- Infection Control, last reviewed on 1/18/2024, the policy indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections.