STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056291	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Bonita Convalescent Hospital	535 E Bonita Avenue San Dimas, CA 91773

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 68 and Resident 31), were treated with dignity while eating. Resident 68, who had limited mobility, did not have a clothing protector, while having breakfast in bed. For Resident 31, Treatment Nurse 1 remained standing and did not position themselves at the resident's eye level while assisting with the lunch meal. This deficient practice resulted in Resident 68 having food and drink spillage on Resident 68 causing potential feelings of humiliation and embarrassment. For Resident 31, there was a potential feeling of disconnection and dominance or authority from the staff during the feeding process. Findings: a. During a review of Resident 68's admission Record (AR), the AR indicated Resident 68 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die) affecting left non-dominant side and aphasia (a disorder that makes it difficult to speak). During a review of Resident 68's Alteration in Nutritional Status care plan dated 2/23/2023, the care plan interventions indicated to set up meal tray, assist and give verbal cues if needed, and up in chair to dining room at mealtime. During a review of Resident 68's History and Physical Examinations (H&P), dated 2/20/2025, the H&P indicated Resident 68 did not have the capacity to understand and make decisions. During a review of Resident 68's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2025, the MDS indicated Resident 68's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 68 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). (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	During an observation on 6/10/2025 at 7:59 AM, Resident 68 was in bed having breakfast by herself. Resident 68 was using her right hand with no movement noted from her left hand. Resident 68 was drooling milk, had messy spills of food and drinks on Resident 68's chest, neck, gown, tray, bedside table and on Resident 68's maroon colored comforter, despite having a plate guard (a device used to prevent food from being pushed off the plate while eating to keep food contained on the plate and minimize spills or messes). Resident 68's plastic cup of milk was tipped over and milk spillage was on the tray. CNA 3 was observed feeding Resident 68's roommate while Resident 68 was eating breakfast. Resident 68 was within sight from the hallway. During a concurrent interview, CNA 3 stated CNA 3 was supposed to put something, a towel over Resident 68's chest to protect Resident 68. During an interview on 6/11/2025 at 9:45 AM, Registered Nurse (RN) 1 stated Resident 68 was able to feed herself and used a plate guard. RN 1 stated staff was supposed to put a towel over Resident 68's chest to protect Resident 68 from fluid or food dropping into Resident 68's gown. RN 1 stated a towel was also used for hygiene, wiping, and for dignity. b. During a review of Resident 31's AR, the AR indicated the facility admitted Resident 31 on 2/25/2021, and re-admitted the resident on 5/15/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and severe protein-calorie malnutrition (a condition where the body lacks sufficient protein and calories, leading to a breakdown of body tissues, muscle wasting, and fluid retention). During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 44's cognition (the ability to think and process information) was moderately intact. The MDS indicated Resident 31 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent (helper does all of the effort) with mobility. During an observation on 6/9/2025 at 12:30 PM, Resident 31 was observed lying in bed with the head of the bed in a semi-recumbent (lying down with the upper body elevated at an angle, typically between 30 and 45 degrees) position. Treatment Nurse (TN) 1 was positioned standing at the bedside, leaning over Resident 31 while providing feeding assistance. TN 1 was observed hovering above the resident, holding the spoon at an elevated angle, and did not assume a seated position or align at eye level with Resident 31 during the feeding process. During an interview on 6/9/2025 at 1:47 PM, Resident 31 stated that she could tell when staff were standing over her during meals. Even though she could not see them, she could feel it by the way they talked and how quickly they gave her each bite. Resident 31 stated it made her feel rushed, like she had to hurry up. Resident 31 noted that this did not happen all the time, but it did occur on occasion. Resident 31 expressed that she preferred when staff sat next to her and took their time, as it made her feel more at ease and not hurried. During an interview on 6/10/2025 at 1:37 PM, Treatment Nurse 1 stated she should have sat next to Resident 31 while assisting with the lunch meal on 6/9/2025. LVN 1 acknowledged that she should have grabbed a chair and sat beside the resident while feeding her. LVN 1 stated that sitting at eye level promoted dignity and helped the resident feel more comfortable. LVN 1 expressed understanding that maintaining a calm and supportive approach during mealtime enhanced the resident's overall experience and promoted person-centered care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025 at 12:29 PM, the Director of Nursing (DON) stated the facility's expectation was for staff to uphold resident dignity during all aspects of care, including meal assistance. The DON explained that sitting at eye level while assisting a resident with meals enhanced comfort and promoted dignity. The DON emphasized that residents were expected to feel respected and supported, and staff was trained to provide that level of care consistently. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated each resident shall be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. The policy indicated that when assisting with care, residents were supported in exercising their rights. For example, residents were provided with a dignified dining experience. During a review of the facility's P&P titled, Resident Rights, dated 2/2021, the P&P indicated employees shall treat all residents with kindness, respect, and dignity.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident 2), was provided care in accordance with professional standards of practice by failing to conduct an Interdisciplinary Team (IDT - a group of healthcare professionals from various disciplines who collaborate, assess, coordinate, and manage each resident's comprehensive health care, including his or her medical, psychological, social, and functional needs) in accordance with the facility's policy and procedure (P&P) when Resident 2 had continuous episodes of hyperglycemia (high blood sugar). This deficient practice had the potential to result in Resident 2 developing serious health complications. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), type 2 diabetes mellitus (DM - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic (relating to or affected with a psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) disturbance, mood disturbance, anxiety (intense, excessive, and persistent worry and fear about everyday situations, and sepsis (a life threatening blood infection), unspecified organism. During a review of Resident 2's History and Physical (H&P), dated 4/20/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 2's cognitive status (memory, orientation, and judgement of the resident) was severely impaired. The MDS indicated Resident 2's primary reason for admission was due to medically complex conditions and the resident had a feeding tube (e.g., nasogastric or abdominal [PEG]). During a review of Resident 2's trend of blood glucose (sugar) levels, dated 5/4/2025 to 5/14/2025, the trend indicated Resident 2's blood glucose levels ranged anywhere from 306 mg/dL (milligrams per deciliter - a unit of measurement used to express the concentration in blood glucose testing) to 500 mg/dL. During a review of Resident 2's undated Hospital Tracking Portal (HTP), the HTP indicated Resident 2 was transferred to the GACH for abnormal blood sugar. During a review of Resident 2's Discharge Summary Report (DSR), dated, 5/14/2025, timed at 10:55 a.m., the DSR indicated Resident 2 was discharged to the GACH for uncontrolled hyperglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Order Summary Report (OSR), active orders as of 5/31/2025, the OSR indicated an order on 5/14/2025 for puree texture, nectar/mildly thick consistency oral diet small portion for three meals per day and an order on 5/8/2025 for enteral feed (a method of providing nutrition directly into the gastrointestinal tract through a feeding tube) Glucerna 1.2 at 53 cubic centimeter (cc- a unit of volume) per hour for 20 hours. During a concurrent interview and record review on 6/12/2025 at 11:26 a.m., with Registered Nurse (RN) 3, Resident 2's medical records were reviewed. RN 3 stated the facility did not have any IDT documentation for Resident 2's hyperglycemia. RN 3 stated there was a Change of Condition (COD) on 5/14/2025 for Resident 2's hyperglycemia. During a concurrent interview and record review on 6/12/2025 at 11:59 a.m., with the Director of Nursing (DON), Resident 2's blood glucose levels for May 2025 and medical records were reviewed. The DON stated the DON could not find any documentation that an IDT was conducted to address Resident 2's hyperglycemia. The DON stated an IDT was conducted if there were any issues or trend (in general). The DON stated there should have been an IDT conducted for Resident 2's hyperglycemia, adding her blood sugar is consistently high, it's uncontrolled. The DON stated it was important to conduct an IDT to discuss the issues, problems and identify and create appropriate interventions and to see if the interventions were working and the progress of the patient. During a review of the facility's undated policy and procedure (P&P) titled, IDT Conference, the P&P indicated the care plans would be reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments, and/or if there were any significant changes. The P&P indicated the content of the IDT would include but were not limited to areas reviewed including diagnosis / health condition.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the low air loss mattress (LAL - pressure reducing mattress) was placed at the correct setting for two of two sampled residents (Resident 86 and Resident 32). This deficiency had the potential to place Resident 86 and 32 at increased risk of developing pressure injuries. Findings: A. During a review of Resident 86's admission Record (AR), the AR indicated Resident 86 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including functional quadriplegia (complete immobility due to severe disability or frailty) and encephalopathy (disease or disorder of the brain, characterized. During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 86 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for toileting and rolling from left lying position to a right lying position. The MDS further indicated Resident 86 was at risk for developing pressure ulcers and had a pressure reducing device for the bed. During a review of Resident 86's Braden Scale for Predicting Pressure Sore Risk (BS), dated 3/26/2025, the BS indicated Resident 86 had a score of 8, very high risk. During a review of Resident 86's Order Summary Report (OSR) with active orders as of 6/12/2025, the Order Summary Report indicated a physician's order for low air loss mattress for wound care and management set at 160 every shift with order start date of 12/6/2024. During an interview on 6/11/2025 at 9:44 AM with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 86 had a LAL, indicated for residents that either had pressure injuries or to prevent a resident from developing pressure injuries. During a concurrent observation and interview on 6/11/2025 at 9:58 AM with Licensed Vocational Nurse (LVN) 3 in Resident 86's room, Resident 86's LAL setting of 200 was observed. LVN 3 stated the current observed setting was incorrect and the mattress should be set at 160 based on Resident 86's weight. LVN 3 stated the mattress settings were checked every day during morning rounds and LVN 3 did not know why it was at the incorrect setting. LVN 3 stated the purpose of the LAL was to prevent pressure injuries. During an interview on 6/12/2025 at 1:11 PM with the Director of Nursing (DON), the DON stated the LAL mattress was for residents at high risk of developing pressure injuries and was used to prevent the development or worsening of pressure injuries. The DON stated if the LAL setting was incorrect, the resident could develop pressure injuries or current injuries could worsen. During a review of the facility's policy and procedure (P&P) titled, Pressure-Reducing Mattress, undated, the P&P indicated the purpose of the mattress was to prevent and/or minimize pressure on the skin, and to offer enhanced comfort when preferred by the resident. The P&P further indicated to adjust the LAL to desired firmness based on the resident's weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 32's AR, the AR indicated the facility admitted Resident 32 on 2/19/2021, and re-admitted the resident on 5/26/2025, with diagnoses including, chronic respiratory failure with hypoxia (when the lungs are unable to adequately transfer oxygen into the bloodstream, resulting in a chronically low level of oxygen in the blood and tissues), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and pressure ulcer of sacral region Stage 4 (a severe, deep wound that has extended through the skin and into the muscle, tendon, or even bone located at the bottom of the spine and lies between the fifth segment of the lumbar spine [L5] and the coccyx [tailbone]) region). During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32's cognition was severely impaired. The MDS indicated Resident 32 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent with mobility. During a review of Resident 32's Weights and Vitals Summary, dated 6/2/2025, indicated Resident 32's weight was 107 lbs. During an observation on 6/9/2025 at 10:49 a.m., Resident 32 was noted lying on a Low Air Loss Mattress (LALM), the digital control panel on the LALM was visibly illuminated and displayed a weight setting of 400 lbs. During an interview on 6/10/2025 at 12:50 p.m., Treatment Nurse (TN) 2 stated the purpose of the LALM was to help prevent pressure ulcers by redistributing the resident's body weight and reduce pressure on high-risk areas of the body. TN 2 stated the mattress was designed to automatically adjust air pressure based on the resident's weight input to ensure proper therapeutic support. TN 2 stated that accurately setting the mattress to the resident's actual weight was essential and when set correctly, the system maintained optimal pressure to prevent excessive force on bony prominences and other vulnerable skin areas. TN 2 stated if the weight was set significantly higher or lower than the resident's true weight, the mattress did not function effectively, thereby increasing the risk of skin breakdown, and the development or worsening of pressure injuries. During a review of Resident 32's Order Summary Report, dated 6/12/2025, the Order Summary Report indicated Resident 32 had an active physician's order for a LALM for wound care and management (LALM set @ 80) every shift. The Order Summary Report indicated the start date of the LALM order was 6/10/2025. During an interview on 6/12/2025 at 12:29 p.m., the Director of Nursing (DON) stated it was important to maintain the correct settings on LALM to ensure optimal care, especially for residents at high risk of pressure ulcers or skin breakdown. The DON explained these mattresses were designed to redistribute pressure, minimize friction, and deliver continuous airflow to the skin - critical for immobile or frail residents. The DON stated that incorrect settings could compromise the mattress's effectiveness, potentially leading to discomfort or worsening of pressure-related injuries. (continued on next page)

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F 0686 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, Pressure-Reducing Mattresses, undated, the P&P indicated to follow the manufacturer's instruction and adjust LALM to a desired firmness based on the resident's weight and/or using the hand check method as described: slide one hand with the thumb facing up, between two LALM air tubes to feel the space between the bed frame and resident's buttocks. The space should not be too tight or too loose, with an acceptable range of approximately 1-1.5 inches. During a review of the manufacturer's operation manual titled, Proactive Medical Products, undated, the operation manual for the Protekt Aire 4000DX / 4600DX / and 5000DX the weight / pressure set up indicated users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 87) was free from a significant medication error. Facility staff opened a specially formulated (how the drug is prepared and put together to make it into a usable medicine that can be taken) antibiotic capsule which disrupted the time-release (when the medicine is designed to release small amounts of the drug into your body over a long period, rather than all at once) mechanism of the medication. This deficient practice resulted in Resident 87 receiving the medication in a manner that altered its intended pharmacokinetics (what your body does to a drug after you take it), potentially impacting its therapeutic effectiveness and increasing the risk of adverse effects. Findings: During a review of Resident 87's admission Record (AR), the AR indicated the facility admitted Resident 87 on 1/15/2025, with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and encephalopathy (a serious health problem that affects brain function or structure). During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 4/22/2025, the MDS indicated Resident 87's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 87 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with mobility. During a review of Resident 87's Order Summary Report (OSR), the OSR indicated to administer the following medications to Resident 87: a. Acetaminophen Oral Tablet 500 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) give 1 tablet by mouth one time a day for pain management due to rheumatoid arthritis. Start Date: 3/21/2025. b. Amlodipine Besylate Tablet 5 mg give 1 tablet by mouth one time a day for hypertension, hold if systolic blood pressure (SBP - the pressure in the arteries when the heart contracts and pumps blood throughout the body) less than 110. Start Date: 1/16/2025. c. Claritin Oral Tablet 10 mg (Loratadine) give 1 tablet by mouth one time a day for itchiness. Start Date: 3/18/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Colchicine Tablet 0.6 mg give 1 tablet by mouth one time a day every other day for gout. Start Date: 1/16/2025. e. Folic Acid Tablet 1 mg give 1 tablet by mouth one time a day for supplement. Start Date: 1/16/2025. f. Multiple Vitamins - Minerals Tablet give 1 tablet by mouth one time a day for supplement. Start Date: 1/16/2025. g. Ascorbic Acid Tablet 500 mg give 1 tablet by mouth two times a day for supplement. Start Date: 1/15/2025. h. Carvedilol Tablet 12.5 mg give 1 tablet by mouth two times a day for hypertension, hold if SBP less than 110 or heart rate (the number of times your heart beats in one minute) less than 60 and give with food. Start Date: 1/16/2025. i. Chlorhexidine Gluconate Solution 0.12 % give 30 ml (ml-metric unit used to measure capacity that's equal to one-thousandth of a liter) orally two times a day for good oral hygiene. Start Date: 6/11/2025. j. Cranberry Oral Tablet 450 mg (Vaccinium macrocarpon) give 1 tablet by mouth two times a day for urinary tract infection (UTI - an infection in the bladder/urinary tract) prophylaxis (measures designed to preserve health). Start Date: 6/8/2025. k. Macrobid Oral Capsule 100 mg (Nitrofurantoin Monohyd Macro) give 1 capsule by mouth two times a day for abnormal urinalysis (a simple examination of your pee to check for various health problems) for 5 days. Start Date: 6/7/2025. l. Gabapentin Capsule 300 mg give 1 capsule by mouth three times a day for neuropathic pain (nerve pain). Start Date: 3/17/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. LiquaCel Oral Liquid (Amino Acids) give 30 ml by mouth three times a day for skin integrity. Start Date: 1/19/2025. During a review of Resident 87's Medication Administration Record (MAR,) the MAR indicated Resident 87 was administered Macrobid 100 mg oral capsule on 6/11/2025 at 9 AM. During an observation on 6/11/2025 at 8:30 AM, Licensed Vocational Nurse (LVN) 1 was observed opening a nitrofurantoin macrocrystals (Macrobid) 100 mg oral capsule, pouring the contents into a medication cup, and mixing with applesauce. During an interview on 6/11/2025 at 9:15 AM, LVN 1 stated that opening any capsule medication had to be verified or clarified with the pharmacist. LVN 1 stated that some capsules should not be opened, as doing so could alter how the medication worked, cause side effects, or reduce its effectiveness. LVN 1 stated that if there was any uncertainty, capsules were not to be opened from the pharmacy. Once verification had been received, the contents could be mixed with a small amount of applesauce if the resident had difficulty swallowing or preferred medications to be crushed. LVN 1 stated that opening Macrobid without proper verification could compromise the medication's safety and effectiveness. LVN 1 also stated that, particularly for antibiotics, proper delivery was important to ensure full treatment of infection and to prevent harm to the resident. During an interview on 6/12/2025 at 12:29 PM, the Director of Nursing (DON) stated it was important for nursing staff to have clarified with the pharmacist prior to opening any capsule medication, as altering the form of the medication could have affected its intended absorption, efficacy, and safety. The DON stated that this was especially important for capsule-form antibiotics, which were often time-released or specially formulated to deliver medication in a specific manner. The DON stated that failure to verify whether a capsule could be opened might have resulted in reduced effectiveness or unintended side effects. The DON further stated that if a resident preferred to take medications in crushed form, or had difficulty swallowing whole capsules, the physician should have been notified so that an alternative formulation - such as a liquid or tablet that was safe to crush - could have been ordered. The DON emphasized that ensuring the proper formulation helped maintain the integrity of the treatment plan and safeguarded the resident's health. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications dated 2001, the P&P indicated medications were administered in a safe and timely manner, and as prescribed. The P&P also indicated each nurses' station had a current Physician's Desk Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for F755-761 (Pharmacy Services) available. Manufacturer's instructions or user's manual related to any medication administration devices were kept with the devices or at the nurses' station. During a review of the facility's Job Description (LVN - Sub-Acute) dated 3/7/2024, the Job Description indicated the LVN administered medication and treatment following regulatory guidelines.

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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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain its infection prevention and control program for one of five sampled residents (Resident 59) by failing to wear appropriate personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when handling soiled linens under Enhanced Barrier Precautions (EBP-extra measures, like wearing gowns and gloves, used during high-contact care activities with residents who are at a higher risk of having or spreading germs that are hard to treat, like multidrug-resistant organisms (MDROs). This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents. Findings: During a review of Resident 59's admission Record (AR), the AR indicated the facility admitted Resident 59 on 12/25/2021, with diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and cellulitis (a skin infection that causes swelling and redness) of left lower limb. During a review of Resident 59's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 59's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 59 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and partial/moderate assistance with mobility). During an observation on 6/9/2025 at 10:19 AM, there was signage indicating EBP located outside of Resident 59's room. During an observation on 6/9/2025 at 10:25 AM, Certified Nursing Assistant (CNA) 1 was observed removing soiled linen from Resident 59's bed. CNA 1 exited the resident's room while visibly carrying the soiled linen in both hands and placed it directly into the soiled linen container located in the hallway outside the resident's room. CNA 1 was not wearing a gown at any point during the linen removal process nor while exiting the resident's room with the soiled linen. During an interview on 6/9/2025 at 10:39 AM, CNA 1 explained that EBP were implemented to help prevent the spread of germs, particularly drug-resistant organisms. CNA 1 stated that when a resident was on EBP, staff were expected to wear gloves and a gown when performing tasks such as providing personal care, cleaning the resident's environment, or handling soiled laundry. CNA 1 emphasized that staff should wear a gown during direct contact tasks, such as changing soiled linens, because germs could transfer onto clothing. CNA 1 added that following these precautions helped protect both residents and staff, and that failure to wear appropriate personal protective equipment could contribute to the spread of germs to other residents or environmental surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025 at 11:35 AM, the Infection Preventionist (IP) stated staff were expected to always follow EBP, particularly when handling soiled linens. The IP emphasized staff were required to wear gowns and appropriate PPE during such tasks to prevent the spread of infection. The IP stated that adhering to these precautions was essential to protect both residents and staff from potential exposure to harmful pathogens. During a record review of Resident 59's Order Summary Report, dated 6/12/2025, the order summary report indicated Resident 59 had an active order for EBP, with an order date of 6/27/2024. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions dated 2001, the P&P indicated EBPs were utilized to prevent the spread of multi-drug organisms (MDROs) to residents. The P&P indicated: -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown were applied prior to performing the high contact resident care activity (as opposed to before entering the room). -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: b. Changing linens.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (promotes the appropriate use of antibiotics) for two of five sampled residents (Resident 21 and Resident 87) to monitor the use of antibiotics for unnecessary or inappropriate use and ensure protocols were in place to reduce the risk of adverse events, including the development of antibiotic-resistant organisms. For Resident 87's swelling of the tooth and for Resident 21's vaginal discharge, the proper antibiotic screening forms were not used to accurately determine if the residents met the criteria of a true infection. These deficient practices had the potential for residents to develop antibiotic -resistant organisms, from unnecessary or inappropriate antibiotic use. Findings: a. During a review of Resident 21's admission Record (AR), the AR indicated Resident 21 was re-admitted to the facility on [DATE] with diagnoses including vascular dementia (loss of intellectual function) and generalized weakness. During a review of Resident 10's History and Physical (H&P), dated 10/27/2024, the H&P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Change in Condition (COC), dated 6/1/2025, the COC indicated the resident had a greenish vaginal discharge (bodily fluid produced by glands in the vagina and cervix), had no pain or discomfort, and a normal body temperature of 97.8 degrees. The COC indicated Resident 21's urine was yellow, had no foul odors, and no hematuria (blood in the urine). During a review of the Physician's Orders dated 6/1/2025, the order indicated Resident 21 was to receive Diflucan (an antibiotic) 100 milligrams (mg, unit of measurement) to be taken by mouth in the evenings for five days. During a review of Resident 21's Medication Administration Record (MAR), the MAR indicted Resident 21 was administered Diflucan 100 milligrams mg on 6/1 - 6/5/2025. During a review of Resident 21's Lab Results Report, for a urine culture (a laboratory test used to detect and identify bacteria or other microorganisms in a urine sample) / urine analysis with culture and sensitivity (a lab test used to identify bacteria or other microorganisms in a urine sample and determine which antibiotics are most effective in treating an infection caused by them) collected on 6/4/2025, indicated antibiotic therapy was not recommended without signs and symptoms of localizing to the urinary tract. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Infection Control Nurse (ICN) on 6/11/2025 at 3:23 pm, the ICN stated the facility used the McGreer's criteria (a set of standardized definitions used for surveillance of infections in long-term care facilities) for infection surveillance based on the location of the possible infection. The ICN stated for Resident 21, the Surveillance Data Collection Form for other infections, (SDCF-[NAME], a McGreer's criteria infection analysis specified for certain areas of the body) was used. The ICN stated the McGreer's UTI surveillance form should have been used to screen Resident 21 to determine if antibiotics were needed because the resident had vaginal discharge potential to having a UTI. The ICN stated it was important to have the proper antibiotic (McGreer's) screening done to determine if antibiotic use was needed and to prevent the development of [NAME] drug resistant organism (MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs). The ICN stated the ICN normally monitored every resident placed on an antibiotic to determine if the McGreer's criteria was met. The ICN stated, I missed it and did not have a chance to review for the month of June. b. During a review of Resident 87's AR, the AR indicated Resident 87 was admitted to the facility on [DATE] with diagnoses including neuralgia (intense, typically intermittent pain along the course of a nerve) and generalized weakness. During a review of the Physician's Orders dated 1/13/2025, it indicated Azithromycin (an antibiotic) 250 mg was to be given by mouth daily for four days, for a tooth infection. During a review of a Minimum Data Set (MDS, a resident assessment tool), dated 4/22/2025, indicated Resident 87 had moderate cognitive impairment, clear speech, usually understands and could be understood. The MDS indicated Resident 87 needed supervision (helper sets up and cleans up) with toilet needs, lower body dressing and sit to stand (ability to stand/sit from a chair). During an interview with the ICN on 6/11/2025, the ICN stated the nurse who completed the SDCF-[NAME] used the wrong antibiotic surveillance form. The ICN stated the correct antibiotic surveillance should be specified for skin / mucosal (__) because Resident 87 had an increased swelling of the tooth. The ICN stated it was important to complete the proper antibiotic screening forms to accurately determine if Resident 87 met the criteria of a true infection and qualified for the use of antibiotic. The ICN stated the ICN did not follow up and verify if the accurate antibiotic screening was done for Resident 87. During a review of Resident 87's MAR, the MAR indicted Resident 87 was administered Azithromycin on 6/12/2025. During a review of the facility's undated policy titled, Antimicrobial Stewardship Program, undated, indicated it was the policy of the facility to implement an Antimicrobial Stewardship program that would focus on coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of optical antimicrobial drug regimen including dosing, duration of therapy and route of administration. The policy indicated the goal was to curb the emergence and spread of antimicrobial resurgent infection and the leadership team was to review and monitor antibiotic usage patterns on a regular basis. The policy indicated the IP was the designated person responsible for the implementation of the facility's infection Prevention and Control Program, collection, and review of the data. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised 4/2023, it indicated antibiotic usage and outcome data would be collected and documented using a facility-approved antibiotic surveillance tracking form. The data would be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility - wide antibiotic stewardship.