STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056313	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review, the facility failed to ensure a resident's call light was within reach for one of 20 random sampled residents (Resident 42). This deficient practice had a potential for the resident not able to call for assistant as needed. Findings: During review of Resident 42's admission record, indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (high blood pressure), type 2 diabetes mellitus (a group of diseases that result in too much sugar in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 10/08/2024, indicated Resident 42's cognitive skills for daily decision-making were intact. The MDS indicated Resident 42's required extensive assistance from staff for transfer, dressing, toilet use, bathing, and personal hygiene. During a concurrent observation and interview on 12/17/24 at 11:10 a.m. with Resident 42, Resident 42's complains of distress, coughing and unable to reach the call light. Call light was observed wrap at the back of the bed rails on the left side. During an interview on 12/17/24 at 11:21 a.m. with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated she was assigned to resident 42's but forget to place the call light within reach after cleaning up the Resident 42's. During an interview on 12/19//24 at 11:22 a.m. with Licensed vocational Nurse (LVN 2), LVN 2 stated resident's should be able to reach call light at all times. LVN 2 stated it is very import in case of emergency so r Resident be able to reach the call light and it hard for resident not to get help when they needed help. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/24 at 08:35a.m. with the Director of staff Development (DSD). DSD stated call light should be within reach of Residents, not on the side rails or where Resident can't reach the call light. DSD stated if residents is not able to reach the call light, they could not get help if they need too. During an interview with The Director of Nursing (DON) on 12/20/24 at 1:54 p.m. DON stated Call light should be always within reach. DON added if call light is not within reached, we would not be able to reach the resident needs. A review of the facility's policy and procedure -of undated, titled Answering the Call Light, indicated when the resident is in bed or confined to a chair to be sure the call light is within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 49145 Based on interview and record review, the facility failed to accurately document an advance directive (a legal document indicating resident preference on end-of-life treatment decisions) for five of seven residents (Residents 5, 21, 36, 65, and 68). These failures had the potential to result in causing a conflict with Resident 5, 21, 36, 65, and 68's wishes regarding their health care. Findings: During a review of Resident 5's Admission Record, Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities) and chronic obstructive pulmonary disease ({COPD}- a chronic lung disease causing difficulty in breathing). During a review of Resident 5's Minimum Data Set ({MDS}- resident assessment tool), the MDS indicated Resident 5 had moderate cognitive impairment (a noticeable decline in thinking abilities, problem-solving, and judgement). The MDS indicated required substantial/maximal assistance (helper does more than half the effort) with personal hygiene, toileting, and bathing. During a review of Resident 5's advance directive acknowledgement of receipt, the advance directive acknowledgement of receipt was completed by the Interdisciplinary Team ({IDT}- a group of professionals from different disciplines who work together to achieve a common goal) on 6/17/2019 and was signed by the Physician on 10/28/2021. During a review of Resident 21's Admission Record, Resident 21 was admitted to the facility 12/8/2014 and readmitted on [DATE] with diagnoses that included epilepsy (a chronic brain condition that causes seizures {sudden uncontrolled body movements and changed in behavior that occur because of abnormal electrical activity of the brain}) and hypertensive heart disease (heart problems that occur because of high blood pressure). During a review of 21's MDS, dated [DATE], the MDS indicated Resident 21 had severe cognitive impairment (someone with significant difficulty with thinking, remembering, making decisions, and understanding things). The MDS indicated Resident 21 required partial/moderate assistance (helper does less than half the effort) with dressing, personal hygiene, and transferring. During a review of Resident 21's advance directive acknowledgement of receipt, the advance directive acknowledgement of receipt indicated there was no decision checked whether to formulate an advance directive or not and there was no physician signature. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 36's Admission Record , the Admission record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), epilepsy , and COPD. During a review of Resident 36's History and Physical (H&P), dated 7/5/2024, the H&P indicated, Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 needed substantial to maximal assistance with transferring to a chair, shower, and toilet. The MDS indicated Resident 36 needed partial to moderate assistance dressing, personal hygiene, rolling from left to right, sitting, standing, and lying. The MDS indicated Resident 36 was independent with eating, and oral hygiene. During a review of Resident 36's Acknowledgment of Receipt Advance Directive/Medical Treatment Decisions, dated 6/28/2021, the Acknowledgment of Receipt Advance Directive/Medical Treatment Decisions did not have a witnessed dated signature and did not indicate a reason that Resident 36 is unable to sign name. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did not have a physician's dated signature and no documentation Resident 36's diagnoses, prognosis and mental condition was discussed. The Acknowledgment of Receipt Advance Directive/Medical Treatment Decisions did not indicate Resident 36's mental condition was consistent with the Advance Directive/Preferred Intensity of Care. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did indicate documentation of Acknowledgment of Durable Power of Attorney (a legal document that allows someone you designate (called an agent) to make financial and legal decisions on the resident's behalf, even if the resident becomes incapacitated or unable to make decisions for themselves due to illness or injury) or dated signature. During a review of Resident 65's Admission Record, the Admission record indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to dementia (a progressive state of decline in mental abilities), schizophrenia, and bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 65's H&P, dated 7/17/2024, the H&P indicated, Resident 65 had fluctuating capacity to understand and make decisions. During a review of Resident 65's MDS, dated [DATE], the MDS indicated, Resident 65 needed partial to moderate assistance with showering, dressing, personal hygiene, and transferring in an out of the shower. The MDS indicated Resident 65 needed supervision or touching assistance with oral hygiene, toileting, and putting on and taking off footwear. The MDS indicated Resident 65 needed supervision or touching assistance with rolling from left to right, changing positions from sitting to lying and changing positions from lying to sitting. The MDS indicated Resident 65 needed supervision or touching assistance with changing positions from sitting to standing and transferring to a chair or toilet. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's Acknowledgment of Receipt Advance directive/Medical Treatment Decisions , dated 1/31/2023, indicated the Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did not have a physician's dated signature. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did not indicate documentation Resident 65's diagnoses, prognosis and mental condition was discussed. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did not indicate Resident 65's mental condition is consistent with the Advance Directive/Preferred Intensity of Care. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did indicate documentation of Acknowledgment of Durable Power of Attorney signed and dated. During a review of Resident 68's Admission Record, the Admission record indicated Resident 68 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to acute kidney failure (a sudden loss of kidney function that occurs within a few hours or days), schizophrenia, and bipolar. During a review of Resident 68's H&P, dated 8/4/2024, the H&P indicated, Resident 68 had fluctuating capacity to understand and make decisions. During a review of Resident 68's MDS , dated 11/19/2024, the MDS indicated, Resident 68 needed substantial to maximal assistance with lower body dressing. The MDS indicated Resident 68 needed partial to moderate assistance with upper body dressing, showering, toileting, oral hygiene, personal hygiene, and putting on and taking off footwear. The MDs indicated Resident 68 needed supervision with rolling from left to right, sitting, lying, and standing. The MDS indicated Resident 68 was independent with eating. During a review of Resident 68's Acknowledgment of Receipt Advance directive/Medical Treatment Decisions , dated 8/2/2024, did not indicated a check mark regarding Resident 68's right to choose to formulate any Advance Directive. The Acknowledgment of Receipt Advance directive/Medical Treatment Decisions did indicate documentation of a physician's dated signature or an Acknowledgment of Durable Power of Attorney. During a phone interview on 12/19/2024 at 10:16 a.m. with the Social Services Director (SSD), the SSD stated she is responsible for ensuring the Advance Directives are accurately completed. SSD stated if there is no physician signature or if a physician signature is dated two years after the advance directive was completed, it is considered incomplete. SSD stated its important that the advance directives are completed because it represents the residents preferences and wishes for their care and if not, their wishes may not be met. During a concurrent interview and record review on 12/19/2024 at 10:52 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 5's and Resident 21's advance directives were invalid because they were not completed accurately. RNS stated an invalid advance directive can cause a delay in care or treatment for the residents. During an interview on 12/20/2024 at 1:40 p.m. with the Director of Nursing (DON), the DON stated it is important that the advance directives are accurately completed so they can follow the resident's wishes. The DON stated if the resident were to transfer to the hospital and the advance directive was incomplete, things may or not be done that the residents may or may not have wanted done. (continued on next page)

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F 0578 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, Advance Directives, undated, the P&P indicated, The Director of Nursing or designee will notify the Attending Physician if advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. During a review of the facility's Social Services Director- Job Description, undated, the Job Description indicated, The Social Services Director will oversee the process of Advance Care Planning for each resident upon admission, and make sure that any Advance Directives are reviewed with the resident/resident representative on a regular basis. During a review of the facility's policy and procedure (P&P), titled Advance Directives, undated, the P&P indicated, Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).

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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** 49889 Based on observation, interview, and record review the facility failed to ensure Resident 81 bed was not broken for 1 out of 3 Residents. This deficient practice had the potential to put Resident 81 at risk for accidents while in bed. Findings: During a review of Resident 81's Admission Record dated 12/19/24, indicated Resident 81 was admitted on [DATE] and readmitted on [DATE] with diagnoses of hypertensive heart, psychosis (loss of contact with reality), glaucoma (a group of eye diseases that cause blindness), muscle weakness. During a review of Resident 81's History and Physical (H&P), dated 6/12/24 indicated, Resident 81 does have the capacity to understand and make decisions. During a review of Resident 81's Minimum Data Set (MDS- a resident assessment tool) dated 11/22/24 the MDS indicated Resident 81 has moderate cognitive impairment. The MDS also indicated Resident 81 needed partial/moderate assist with activities of daily living (ADL's- activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated Resident 81 needed supervision or touch assistance with bed mobility (the ability to move around in bed). During a review of Resident 81's Care plan dated 12/11/2024 indicated Resident 81 had a moderate risk for falls due to gait (the way a person walks) imbalance. The care plan also indicated Resident 81 needs a safe environment bed in lowest position at night and handrails. During a review of the Maintenance Report log dated 11/20/24 indicated that Resident 81's bed does not work it does not go up and down. During an observation on Resident's 81 room and interview on 12/17/24 at 9:54 a.m., Resident 81 stated I have been in this room for about 3 months and the bed was broken from the day I came here, the bed remote control does not work, and my bed is leaning to the left side. Resident 81 stated he told the nurses, and he told maintenance a few times. During an observation and interview on 12/19/24 with Certified Nursing Assistant (CNA) in Resident 81's room, CNA 1 stated the bed is not working and it is leaning to the left side. CNA 1 stated that if a bed is not working, she would tell charge nurse and put it in the maintenance log. CNA1 stated resident 81 is at risk for falls if the bed is not working properly. During an observation and interview on 12/19/24 with LVN 2 in Resident 81's room, LVN2 stated she was aware Resident 81's bed is broken and that she told maintenance it was broken a few weeks ago. LVN 2 stated that residents should not have a broken bed and that there is a safety issue resident could fall and get injured. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/19/24 at 10:08 a.m. with Maintenance supervisor (MS), in Resident 81's room, MS tested the remote control and Resident 81's bed remote was not working and the bed leaned to the left side. During a concurrent interview on 12/19/24 at 11:08 a.m. and record review on Maintenance Report log with Maintenance Supervisor (MS). MS stated that He is responsible on reviewing the maintenance report log daily and that on 11/20/24 there was an entry in the maintenance report log that resident 81's bed was not working. MS stated that residents in the facility should not have broken beds because this is their home, and residents could get injured when the bed is not working properly. During an interview on 12/20/24 at 1:00 p.m. with Administrator (ADM), ADM stated that residents need to have beds that work and that their quality of life could be affected when their bed is broken. During a review of the facility's undated Policy & Procedure (P&P) titled Bed maintenance and inspection, the P&P indicated, that it is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, as part of a regular maintenance program. Bed frames mattress, and bed rail inspection will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's requirements. If bed equipment is found to be outside of the manufacturer's requirements for any reason the facility will perform maintenance to the bed equipment or remove from use if not able to bring specs to the manufacturer's requirements. The maintenance department or other designated employee will keep records of bed inspections and maintenance.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on interview and record review, the facility failed to record dates on the Minimum Data Set ([MDS] a resident assessment tool) to indicate the start and end of therapy services since most recent entry (admission) to the facility for three of nine sampled residents (Resident 14, 21, and 26) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move). This failure resulted in incomplete information submitted to the Federal database. Findings: a. During a review of Resident 14's Admission Record, the facility admitted Resident 14 on 8/27/2024 with diagnoses including lack of coordination, type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 14's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 8/28/2024, the OT Evaluation indicated reasons Resident 14 would benefit from OT services, including to improve activity tolerance and independence with activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility). The OT Plan of Treatment for Resident 14 included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform ADLs), and self-care management training, five times per week for four weeks. During a review of Resident 14's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, the PT Evaluation indicated reasons Resident 15 would benefit from PT services, including to promote safety awareness, minimize falls, improve leg strength and ROM, increase coordination, and increased independence with gait (manner of walking). The PT Plan of Treatment for Resident 14 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and wheelchair management training (training on proper positioning and ability to propel the wheelchair), five times per week for four weeks. During a review of Resident 14's OT Discharge Summary, dated 10/1/2024, the OT Discharge Summary indicated Resident 14 reached the highest level of functional independence. During a review of Resident 14's PT Discharge Summary, dated 10/1/2024, the PT Discharge Summary indicated Resident 14 reached the highest level of independence. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14's entry date was on 8/27/2024. Section O of Resident 14's MDS did not indicate the start and end dates for PT and OT services since Resident 14's most recent entry on 8/27/2024. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review on 12/19/2024 at 1:26 p.m. with the Director of Rehabilitation (DOR), the DOR reviewed Resident 14's PT and OT records. The DOR stated Resident 14 received PT and OT Evaluations on 8/28/2024 and was discharged from PT and OT on 10/1/2024. During an interview on 12/20/2024 at 11:33 a.m. with the MDS Coordinator (MDSC), the MDSC stated the MDS collected information on each resident, including any special treatments a resident received. During a concurrent interview and record review on 12/20/2024 at 11:41 a.m. with the MDS Coordinator (MDSC), Resident 14's PT Evaluation, dated 8/28/2024, OT Evaluation, dated 8/28/2024, PT Discharge Summary, dated 10/1/2024, OT Discharge Summary, dated10/1/2024, MDS, dated [DATE], and the RAI Manual, dated 10/2023, were reviewed. The MDSC stated Resident 14's therapy dates were not included in the MDS, dated [DATE]. The MDSC stated there was another MDS for the Medicare payment system which included Resident 14's PT and OT Evaluation and discharge date s. The MDSC reviewed the RAI manual and stated she did not know the therapy start and end dates were supposed to be recorded in the quarterly MDS. During an interview on 12/20/2024 at 1:47 p.m. with the Director of Nursing (DON), the DON stated the MDS (in general) was an assessment to determine a resident's care and to indicate the care provided to the resident. The DON stated the MDS information was submitted to the Federal database. The DON stated the MDS provided an incomplete picture of a resident if the start and end dates for therapy were not included in the MDS. b. During a review of Resident 21's Admission Record, the facility admitted Resident 26 on 5/3/2024 with diagnoses including bipolar disorder, major depressive disorder, and epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking). During a review of Resident 21's OT Evaluation and Plan of Treatment, dated 5/4/2024, the OT Evaluation indicated reasons Resident 21 would benefit from OT services, including, to improve activity tolerance, improve safety awareness, and maximize independence with ADLs to enhance Resident 21's quality of life. The OT Plan of Treatment for Resident 21 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training, five times per week for four weeks. During a review of Resident 21's PT Evaluation and Plan of Treatment, dated 5/5/2024, the PT Evaluation indicated reasons Resident 21 would benefit from PT services, including to promote safety awareness, improve balance, minimize falls, improve leg strength and ROM. The PT Plan of Treatment for Resident 21 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, wheelchair management training, five times per week for four weeks. During a review of Resident 21's OT Discharge Summary, dated 7/17/2024, the OT Discharge Summary indicated Resident 21 reached the highest practical level. During a review of Resident 21's PT Discharge Summary, dated 7/17/2024, the PT Discharge Summary indicated Resident 21 reached the highest practical. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 21's MDS, dated [DATE] (annual) and 10/30/2024 (quarterly), the MDS indicated Resident 21's most recent entry date was on 5/3/2024. Section O of Resident 21's MDS did not indicate the start and end dates for PT and OT services since Resident 21's most recent entry on 5/3/2024. During a concurrent interview and record review on 12/19/2024 at 1:09 p.m. with the DOR, the DOR reviewed Resident 21's PT and OT records. The DOR stated Resident 21 received an OT Evaluation on 5/4/2024, PT Evaluation on 5/5/2024, and was discharged from PT and OT on 7/17/2024. During a concurrent interview and record review on 12/20/2026 at 12:03 p.m. with the MDSC, Resident 21's OT Evaluation, dated 5/4/2024, PT Evaluation, dated 5/5/2024, PT and OT Discharge Summaries, dated 7/17/2024, MDS, dated [DATE] and 10/30/2024, and RAI Manual were reviewed. The MDSC stated Resident 21's therapy dates were not included in the MDS, dated [DATE] and 10/30/2024. The MDSC stated there was another MDS for the Medicare payment system which included Resident 21's PT and OT Evaluation and discharge date s. During an interview on 12/20/2024 at 1:47 p.m. with the DON, the DON stated the MDS (in general) was an assessment to determine a resident's care and to indicate the care provided to the resident. The DON stated the MDS information was submitted to the Federal database. The DON stated the MDS provided an incomplete picture of a resident if the start and end dates for therapy were not included in the MDS. c. During a review of Resident 26's Admission Record, the facility admitted Resident 26 on 5/3/2024 with diagnoses including contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of both knees and the left ankle, type 2 DM, bipolar disorder, and major depressive disorder. During a review of Resident 26's OT Evaluation and Plan of Treatment, dated 5/4/2024, the OT Evaluation indicated reasons Resident 26 would benefit from OT services, including, to improve activity tolerance, improve safety awareness, and maximize independence with ADLs to enhance Resident 26's quality of life. The OT Plan of Treatment for Resident 26 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training, five times per week for four weeks. During a review of Resident 26's PT Evaluation and Plan of Treatment, dated 5/6/2024, the PT Evaluation indicated reasons Resident 26 would benefit from PT services, including to promote safety awareness, minimize falls, improve leg strength and ROM, and develop a Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) Program. The PT Plan of Treatment for Resident 26 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, manual therapy (hands-on treatment involving techniques to treat muscles and joints), and orthotic (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) management and training, five times per week for four weeks. During a review of Resident 26's OT Discharge Summary, dated 7/5/2024, the OT Discharge Summary indicated Resident 26 achieved the maximum potential. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 26's PT Discharge Summary, dated 7/5/2024, the PT Discharge Summary indicated Resident 26 achieved the maximum potential. During a review of Resident 26's MDS, dated [DATE] (quarterly) and 10/12/2024 (annual), the MDS indicated Resident 26's most recent entry date was on 5/3/2024. Section O of Resident 26's MDS did not indicate the start and end dates for PT and OT services since Resident 26's most recent entry on 5/3/2024. During a concurrent interview and record review on 12/19/2024 at 12:56 p.m. with the DOR, the DOR reviewed Resident 26's PT and OT records. The DOR stated Resident 26 received an OT Evaluation on 5/4/2024, PT Evaluation on 5/6/2024, and was discharged from PT and OT on 7/5/2024. During a concurrent interview and record review on 12/20/2026 at 12:16 p.m. with the MDSC, Resident 26's OT Evaluation, dated 5/4/2024, PT Evaluation, dated 5/6/2024, PT and OT Discharge Summaries, dated 7/5/2024, MDS, dated [DATE] and 10/12/2024, and RAI Manual were reviewed. The MDSC stated Resident 26's therapy dates were not included in the MDS, dated [DATE] and 10/12/2024. The MDSC stated there was another MDS for the Medicare payment system which included Resident 26's PT and OT Evaluation and discharge date s. During an interview on 12/20/2024 at 1:47 p.m. with the DON, the DON stated the MDS (in general) was an assessment to determine a resident's care and to indicate the care provided to the resident. The DON stated the MDS information was submitted to the Federal database. The DON stated the MDS provided an incomplete picture of a resident if the start and end dates for therapy were not included in the MDS. During a review of Page O-23 in the Long-term Care Facility Resident Assessment Instrument Manual ([RAI Manual] guidance on the completion of the MDS), dated ,d+[DATE], the RAI Manual indicated to record a resident's most recent therapy start and end dates since the most recent entry to the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 49145 Based on interview and record review, the facility failed to ensure a preadmission screening and annual resident review (PASARR) was accurately documented for five of eight residents (Resident 19, 21, 45, 65, and 84). This deficient practice had the potential to result in an inappropriate placement and delay of needed services for Resident's 19, 21, 45, 65, and 84. Findings: During a review of Resident 19's Admission Record, Resident 19's Admission Record indicated Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 10/7/2024, the MDS indicated Resident 19 was cognitively intact. The MDS indicated Resident 19 had delusions (having false or unrealistic behaviors). During a review of Resident 19's care plan initiated 9/2024, the care plan focus was, Resident 19 was at high risk to experience complications related to the use of psychotropic medications with goals that included minimal to no side effects of the medication. Interventions for Resident 19 included to monitor resident's mood state and evaluate the effectiveness and side effects of the medication. During a review of Resident 19's Order Summary Report, the Order Summary Report indicated an order was placed 5/24/2021 for Zyprexa (medication to treat schizophrenia). During a review of Resident 19's PASARR Level I document, dated 7/30/2020, the PASARR document indicated a negative Level I screening. The PASARR I indicated Resident 19 had a mental illness and was prescribed psychotropic (affecting the mind or mental process) medication. During a review of Resident 21's Admission Record, Resident 21's Admission Record indicated Resident 21 was admitted to the facility 12/8/2014 and readmitted [DATE] with diagnoses of schizophrenia and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 had severe cognitive impairment (someone with significant difficulty with thinking, remembering, making decisions, and understanding things). The MDS indicated Resident 21 required partial/moderate assistance (helper does less than half the effort) with dressing, personal hygiene, and transferring. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Order Summary Report, the Order Summary Report indicated an order was placed 11/5/2024 for Risperidone (medication to treat schizophrenia). During a review of Resident 21's PASARR Level I screening, dated 7/18/2024, the PASARR Level I screening indicated a positive Level I screening requiring a PASARR Level II screening to be completed. Resident 21's PASARR Level II's screening was not completed because facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I screening. During a review of Resident 45's Admission Record, Resident 45's Admission Record indicated Resident 45 was admitted [DATE] and readmitted [DATE] with diagnoses of schizophrenia, bipolar disorder, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 has moderate cognitive impairment. The MDS indicated Resident 45 experiences hallucinations (when you see, hear, smell, taste, or feel something that seems real but isn't actually there). During a review of Resident 45's Order Summary Report, the Order Summary Report indicated an order was placed 6/19/2024 for Risperdal (medication to treat schizophrenia). During a Review of Resident 45's PASARR Level I screening, completed 1/17/2023, the PASARR Level I screening indicated a positive Level I screening requiring a PASARR Level II screening to be completed. No PASARR Level II screening was completed. During a review of Resident 65's Admission Record, the Admission record indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to dementia (a progressive state of decline in mental abilities), schizophrenia, and bipolar (. During a review of Resident 65's History and Physical (H&P) dated 7/17/2024, the H&P indicated Resident 65 had fluctuating capacity to understand and make decisions. During a review of Resident 65's MDS dated [DATE], the MDS indicated, Resident 65 needed partial to moderate assistance with showering, dressing, personal hygiene, and transferring in an out of the shower. The MDS indicated Resident 65 needed supervision or touching assistance with oral hygiene, toileting, and putting on and taking off footwear. The MDS indicated Resident 65 needed supervision or touching assistance with rolling from left to right, changing positions from sitting to lying and changing positions from lying to sitting. The MDS indicated Resident 65 needed supervision or touching assistance with changing positions from sitting to standing and transferring to a chair or toilet. During a concurrent interview and record review on 12/19/2024 at 2:02 pm with Infection Preventionist Nurse (IPN), Resident 65's PASRR Level I Screening, dated 7/19/2024. The PASRR Level I Screening indicated Resident 65 had a positive diagnosis of a serious mental illness. IPN stated Resident 65 needs a Level II screening (Level II Mental Health Evaluation is required when the Level I Screening result is positive) mental health evaluation. IPN stated she missed the Level II screening and never followed up. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's Admission Record, Resident 84's Admission Record indicated Resident 84 was readmitted to the facility 8/13/2024 with a diagnosis of Hyperlipidemia (high cholesterol), type 2 diabetes mellitus (body does not produce enough insulin), extrapyramidal and movement disorder (involuntary movement side effects of antipsychotic medications (EPS). During a review of Resident 84's History and Physical (H&P), dated 8/15/24 the H&P indicated Resident 84 does not have the capacity to understand and make decisions. During a review of Resident 84's MDS dated [DATE] the MDS indicated Resident 84 has moderate cognitive impairment. The MDS also indicated Resident 84 was independent with activities of daily living ({ADL's}-activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated Resident 84 was taking antipsychotic medication. During a review of Resident 84's All Active Orders dated 12/19/24 indicated resident 84 had orders for Zyprexa (antipsychotic medication) 5mg two times a day for the diagnosis of psychosis manifested by (M/B) mumbling to self-talking to walls and making gestures that she is talking on the phone with someone, During a review of Resident 84's PASSAR Level1 Screening dated 12/17/2024 indicated, Resident 84 has no serious mental illness and is not taking any psychotropic medications. During an interview on 12/19/2024 at 1:43 p.m. with the Infection Prevention Nurse (IPN), the IPN stated ensuring the PASARR is documented accurately and a PASARR II is completed if indicated is important to the residents will get the appropriate care they need at the appropriate level. During a continued interview and record review on 12/19/2024 at 1:43 p.m. with the IPN, the IPN stated Resident 19's PASARR II should have been done because he had a positive Level I PASARR. The IPN stated Resident 21's PASARR II was not done because the facility was not responsive to the calls and now the case is closed and now a new Level I PASARR is required. IPN stated Resident 45's PASARR Level II was not done and should have been done because the PASARR Level I was positive. During an interview on 12/20/2024 at 1:26 p.m. with the Director of Nursing (DON), the DON indicated it is important that the PASARR Is accurately documented and that a PASARR II is completed if indicated so the resident receives the care and services they need and deserve. During a review of the facility's policy and procedure (P&P) titled Resident Assessment - Coordination with PASARR Program, undated, the P&P indicated, The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. 49889

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to develop and implement a comprehensive person focused care plan for two of three sampled residents (Resident 6 and 339) by failing to: 1. develop a comprehensive care plan that will address Resident 339's fabrication (making something up) of stories. 2. develop and implement care plan for skin redness and swelling of the right eye and right cheek for Resident 6. These failures placed Resident 6 and Resident 339 at risk for a delay of care and treatment. Findings: 1.During a review of Resident 339's Admission Record, the Admission Record Resident 339 was admitted to the facility 10/9/2020 with diagnoses including bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 339's Minimum Data Set ({MDS}- resident assessment tool), dated 10/9/2024, the MDS indicated Resident 339 is moderately cognitively impaired. The MDS indicated Resident 339 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene, dressing, and bathing. During a review of Resident 339's care plan, dated 7/24/2024, the care plan focus was Resident 339's was at risk for behaviors for a diagnosis of anxiety (a feeling of fear, dread, or uneasiness that can be a normal reaction to stress). The goal for Resident 339 was to minimize the episodes of irritability with interventions including monitoring behaviors and notify the physician for any significant changes in behaviors and when interventions are ineffective. During a concurrent interview and record review on 12/19/2024 at 7:51 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 339 can make up stories at times and this should be included in the care plan because its important to communicate with the staff who care for him, so they are aware of his behavior. LVN 2 verbally confirmed there is no care plan that addresses Resident 339's fabrication of stories. During an interview on 12/20/2024 at 1:06 p.m. with the Director of Nursing (DON), the DON stated Resident 339 is known for making up stories and there should be a care plan for this, so the staff know what to expect when they are taking care of him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder and hypertensive heart disease (a condition that occurs when the heart is damaged by long-term high blood pressure). During a review of Resident 6's History and Physical (H&P), dated 7/17/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated, Resident 6 needed set-up or clean-up assistance with eating. The MDS indicated Resident 6 needed partial to moderate assistance with oral hygiene, personal hygiene, and rolling from left to right. The MDS indicated Resident 6 needed partial to moderate assistance with changing positions from sitting to lying and changing positions from lying to sitting. The MDS indicated Resident 6 needed substantial to maximal assistance with transferring to the toilet and chair. The MDS indicated Resident 6 needed substantial to maximal assistance with toileting, showering, and dressing. During an observation on 12/17/2024 at 11:03 pm, Resident 6 had redness, swelling on the right side of the face and a small bump under the right eye. During an interview on 12/19/2024 at 9:51 am with Licensed Vocational Nurse (LVN) 6, LVN 6 stated on 12/17/2024 Resident 6 had redness on the right side of the eyes and right cheek. LVN 6 stated he did not document a care plan for the redness on Resident 6's right cheek and eye. LVN 6 stated Resident 6 could experience infection, neglect, or hospitalization when care plan is not done since there is no intervention in placed. During an interview on 12/20/2024 at 1:00 pm with the Director of Nursing (DON), DON stated the licensed nurses are responsible for developing and implementing Care Plans. DON stated licensed nurses formulate a plan of care to determine if the resident condition is improving or deteriorating. During a review of the facility's policy and procedure (P&P) titled, Reviewing and Revising the Care Plan, undated, the P&P indicated, The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. During a review of the facility's P&P titled, Care Plans- Comprehensive, undated, the P&P indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Each resident's comprehensive care plan is designed to incorporate identified problem areas. 49145

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview, and record review, the facility failed to ensure Resident was provided care and services to maintain good grooming and personal hygiene by failing to clean and cut Resident 29 fingernail for one of three sampled residents (Resident 29). This deficient practice resulted in Resident 29 not receiving fingernail care and can potentially impact Resident 29's self-esteem Findings: During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest),bipolar disorder (; mood swings that range from the lows of depression to elevated periods of emotional highs) During a review of Resident 29's Minimum Data Set ([MDS], a resident assessment tool) dated 10/23/2024, the MDS indicated Resident 29 cognitive for skills and daily decision making is severely impaired. The MDS also indicated the resident required extensive assistance or was totally dependent on staff for ADL's including bed mobility, transfer, eating, toilet use, personal hygiene, and dressing. During observation on 12/17/2024 at 10:06 a.m. with Resident 29, Resident 29 was observed to have long and dirty fingernails on both hands. During an observation on 12/18/24 at 12:14 pm Resident 29 was observe in bed lying down quietly. Resident was able to stretch out his hands and observed to have fingernails long with brown looking stuff around his fingers. During an interview on 12/18/2024 at 2:50 p.m. with the Certified Nursing Assistant (CNA 3), CNA3 stated she did not clean Resident 29 nails today because he refused, CNA 3 stated it was not documented that Resident 29 refused. CNA 3 also stated she supposed to notify the charge Nurse about resident refusal of care. During an interview with licensed Vocational Nurse (LVN 2) on 12/19/24 at 11:22 a.m. LVN 2 stated treatment nurses were trained to assist with trimming resident's fingernails and was not sure why this was not done for Resident 29. LVN 2 stated it was important to ensure Fingernail care was provided to promote resident's quality of life, prevent skin breakdown, and maintain self-esteem. During an interview with The Director of Nursing (DON) on 12/20/24. DON stated CNA supposed to clean and cut nails during ADLs, and treatment nurse also can assist with cutting of the nails, DON stated Resident would get sick if they used dirty nails to eat and CNA should document right after caring for the resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated P&P titled, Quality of Care: Dignity , the P&P indicated residents should be groomed as they wish to be groomed (hair styles, nails etc.) Residents shall be always treatment with dignity and respect by maintaining his or her self-esteem and self-worth.

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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** 44898 Based on observation, interview, and record review the facility failed to ensure Resident 6 who had redness on the right side of the cheek was monitored and received treatment for one of 22 sampled residents. This failure had the potential for Resident 6 not receiving necessary care and treatment. Findings: During a review of Resident 6's Admission Record (face Sheet) , the Face Sheet indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), gastro-esophageal reflux disease (a digestive condition where stomach contents flow back up into the esophagus, the tube connecting the mouth to the stomach) and hypertensive heart disease (a condition that occurs when the heart is damaged by long-term high blood pressure). During a review of Resident 6's History and Physical (H&P), dated 7/17/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS -a resident assessment tool) , dated 10/11/2024, the MDS indicated, Resident 6 needed set-up or clean-up assistance with eating. The MDS indicated Resident 6 needed partial to moderate assistance with oral hygiene, personal hygiene, and rolling from left to right. The MDS indicated Resident 6 needed partial to moderate assistance with changing positions from sitting to lying and changing positions from lying to sitting. The MDS indicated Resident 6 needed substantial to maximal assistance with transferring to the toilet and chair. The MDS indicated Resident 6 needed substantial to maximal assistance with toileting, showering, and dressing. During a concurrent observation and interview on 12/ 17/2024 at 11:03 am in Resident 6's room, Resident 6 had redness and swelling to the right eye and small bump with redness below the right eye. Resident 6 stated she had a bug bite on the right eye and reported it to nursing staff. During an interview on 12/19/2024 at 9:37 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated while bathing the residents she checks the skin and reports to the treatment nurse or charge nurse if there is redness, rashes, skin tears and skin changes she has not seen before and documents it on the skin inspection sheet. CNA 5 stated on 12/17/2024 she noticed Resident 6 had redness on the right eye but did not document or report it to anyone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 9:51 am with Licensed Vocational Nurse (LVN) 6, LVN 6 stated on 12/17/2024 Resident 6 had redness on the right cheek. LVN 6 stated redness on the right side of Resident 6's cheek has change of condition. LVN 6 stated he did not do a change of condition (COC- internal document), a care plan or notify the doctor for the redness on Resident 6's right cheek LVN 6 stated he missed on reporting Resident 6's skin changes and tried to take a short cut by assuming it was her glasses that left a red mark on Resident 6's face. LVN 6 stated a change of condition needs to be done to alert staff to check and address the resident's problem. LVN 6 stated the doctor and the family need to be notified. During an interview on 12/19/2024 at 10:09 am with Registered Nurse Supervisor (RNS) 1, RNS 1 stated when there is a new skin finding the treatment nurse is notified to do a skin assessment, and the doctor is notified for any new orders or a wound consult. RNS 1 stated there is no documentation on 12/17/2024 of a skin inspection, a skin assessment, a care plan, or a change of condition for Resident 6's redness to the right eye or right cheek,. During an interview on 12/20/2024 at 1:00 pm with the Director of Nursing (DON), DON stated any skin issue need to be checked and reported to the supervisor, documented in the nurses' progress notes, and the notify the doctor. DON stated a COC and a care plan needs to be done by the licensed nurses. DON stated a COC is anything out of the ordinary and is important to document so the resident's condition can be monitored on the resident's condition. During a review of the facility's policy and procedures (P&P) titled, Skin Audits by Nursing Assistants, undated, the P&P indicated, Nursing assistants shall inspect all skin surfaces during bath/shower and report any concerns to the resident's nurse immediately after the task . Skin conditions that shall be reported include, but are not limited to redness, bruising, swelling, rashes, hives blisters (clear or blood-filled) skin tears, open areas, ulcers, lesions. Notification shall be made to the nurse verbally or in writing. During a review of the facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status, undated, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative {sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights.

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	056313	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide services to three of nine residents (Resident 5, 20, and 68) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) by failing to: 1. Provide Resident 5 with passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) to both arms from 12/1/2024 to 12/19/2024 in accordance with the physician's order and care plan. 2. Provide PROM to Resident 5's ankles on 12/19/2024 in accordance with the physician's order and care plan. 3. Provide PROM to Resident 20's elbows, wrists, hands, knees, and ankles in accordance with the physician's order and care plan. 4. Provide PROM to Resident 20's hands and ankles prior to applying rolled hand towels (rolled towel placed in the palm) and ankle splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion). 5. Position Resident 20's right rolled hand towel through the thumb's webspace 6. Ensure Resident 20's rolled hand towels were positioned securely in both hands. 7. Provide PROM to Resident 68's left hand in accordance with the physician's orders and care plan. These deficient practices have a potential for Resident 5 unable to get the exercises at risk to develop contractures or limitation on both arms. The deficient practice of not applying the hand towels correctly and not providing appropriate exercises has a potential for Resident 20 decline in ROM. Findings: a. During a review of Resident 5's Admission Record, the facility admitted Resident 5 on 5/7/2024 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue) and dementia (a progressive state of decline in mental abilities). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in both arms and both legs), dated 5/8/2024, the JMA indicated Resident 5 had ROM limitations in both arms and legs, including moderate (50 to 75 percent [%] available ROM) limitations in the left shoulder, moderate/severe (25 to 50% available ROM) limitation in the right shoulder, minimal (75 to 100% available ROM) limitation in both elbows, moderate limitation in both wrists, severe (0-25% available ROM) limitation in both hands, and severe limitation in both knees. The JMA indicated the ROM in Resident 5's hips and ankles were within functional limits ([WFL] sufficient movement without significant limitation). During a review of Resident 5's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Discharge Summary, dated 7/11/2024, the OT Discharge recommendations indicated for Resident 5 to receive a Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) Program for PROM to both arms, five times per week. During a review of Resident 5' Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 7/11/2024, the PT Discharge recommendations indicated for Resident 5 to receive RNA Program for PROM to both legs and application of splints to both knees. During a review of Resident 5's care plan titled, Rehab to RNA Care Plan, dated 7/11/2024, the care plan indicated a plan to provide PROM to both arms, five times per week, and PROM of both legs followed by application of both knee splints to prevent decline in ROM. During a review of Resident 5's physician orders, dated 7/11/2024, the physician's orders indicated to provide PROM to both arms to resident's tolerance, five times per week. Another physician's order, dated 7/11/2024 and revised 11/18/2024, indicated to provide Resident 5 with PROM to both legs followed by the application of both knee splints, five times per week. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 5 had clear speech, expressed ideas and wants, clearly understood others, and was moderately impaired for cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 5 had ROM limitations in both arms and legs and required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting, bathing, lower body dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. During a review of Resident 5's RNA treatment record, dated 11/2024, the RNA treatment record included PROM to both arms and legs followed by the application of both knee splints, five times per week. During a review of Resident 5's RNA treatment record, dated 12/2024, the RNA treatment record included PROM to both legs followed by application of both knee splints, five times per week. The RNA treatment record did not include PROM to both arms. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/18/2024 at 12:51 p.m. in Resident 5's room, Resident 5 was awake while side lying in bed. The joints of Resident 5's elbows, wrists, hands, hips, and knees were observed in a flexed (bent) position. Both of Resident 5's hands were positioned in closed fists with the left wrist bent sideways, away from Resident 5's body. Resident 5 was observed to partially move both shoulders upward and extended both elbows. Resident 5 was unable to fully extend both elbows which continued to be bent. Resident 5 was observed to attempt to straighten both legs, which resulted slight movement at Resident 5's hip joint. During an observation on 12/19/2024 at 8:50 a.m. in Resident 5's room, Restorative Nursing Aide 1 (RNA 1) stood on the left side of the bed. RNA 1 performed PROM to both of Resident 5's legs, including hip extension (straightening the leg at the hip joint away from the body) with knee extension, hip flexion (bending the leg at the hip joint toward the body) with knee flexion, and hip abduction (moving the leg at the hip joint away from the body). RNA 1 did not provide PROM to both ankles and both arms. During an interview on 12/19/2024 at 8:56 a.m. with RNA 1, RNA 1 stated Resident 5's physician orders for RNA was to provide PROM to both legs. RNA 1 stated Resident 5 received PROM to extend, bend, and abduct both legs. RNA 1 stated both knee splints would be applied after Resident 5 was changed. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated she forgot to provide PROM to Resident 5's ankles. During a concurrent interview and record review on 12/19/2024 at 11:09 a.m. with the Director of Rehabilitation (DOR), Resident 5's JMA, dated 5/8/2024, OT Discharge Summary, dated 7/11/2024, and PT Discharge Summary, dated 7/11/2024, and RNA treatment record, dated 11/2024 and 12/2024. The DOR stated Resident 5's JMA indicated Resident 5 had ROM limitations in both shoulders, elbows, wrists, hands, and knees. The DOR stated Resident 5's OT Discharge recommendations indicated for RNA to provide PROM to both arms. The DOR stated Resident 5's PT Discharge recommendations indicated for RNA to provide PROM to both legs followed by application of both knee splints. The DOR stated PROM exercises (in general) prevented further decline in ROM. The DOR reviewed Resident 5's RNA treatment record for 11/2024 and 12/2024. The DOR stated PROM to both arms was not included in the RNA treatment record for 12/2024 when the facility transitioned to the new electronic documentation system. During a telephone interview on 12/19/2024 at 11:38 a.m. with Physical Therapist 1 (PT 1), PT 1 stated the RNAs were expected to provide ROM exercises at the shoulder, elbow, wrist, finger, hip, knee, and ankle joints to prevent any decline in ROM. During a concurrent interview and record review on 12/19/2024 at 11:47 a.m. with the Director of Medical Record (DMR), Resident 5's physician orders, dated 7/11/2024 to provide PROM to both arms and RNA treatment records, dated 11/2024 and 12/2024, The DMR stated the physician's order to provide Resident 5 with PROM to both arms was not included in the RNA treatment record for 12/2024. During a concurrent interview and record review on 12/19/2024 at 11:49 a.m. with the DOR, Resident 5's RNA treatment records, dated 11/2024 and 12/202, the DOR stated the facility did not provide Resident 5 with PROM to both arms for 12/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 11:58 a.m. with the DOR, the DOR stated the residents (in general) had an increased possibility for developing contractures and experiencing a decline in ROM if ROM was not performed to the joints. During a review of the facility's undated Policy and Procedure (P&P) titled, Prevention of Decline in Range of Motion/Joint Mobility, the P&P indicated the facility shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care. The P&P further indicated interventions will be documented in a resident's care plan and will monitor for consistent implementation of the care plan interventions. b. During a review of Resident 20's Admission Record, the facility admitted Resident 20 on 9/5/2023 with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), parkinsonism (group of conditions with symptoms including slow movements, stiffness, tremors, and balance issues), and attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). During a review of Resident 20's Functional Maintenance Program - OT, dated 9/6/2023, the Functional Maintain Program indicated for the RNA to provide PROM to both arms, five days per week as tolerated, and to apply both hand rolls or rolled washcloths for five hours, five days per week as tolerated. During a review of Resident 20's Functional Maintenance Program - PT, dated 9/6/2023, the Functional Maintenance Program indicated for the RNA to provide gentle PROM to both legs followed by application of both ankle splints for two to four hours or as tolerated. During a review of Resident 20's physician orders, dated 9/6/2023 and revised 11/18/2024, the physician's orders indicated RNA program to provide exercises (unspecified) to both arms, apply both hand rolls or rolled washcloth for five hours, and provide PROM to both legs followed by application of both ankle splints for two hours, five times per week. During a review of Resident 20's care plan for limitations in joint mobility, dated 9/2024, the care plan indicated Resident 20 had limitations due to contractures (stiffening/shortening at any joint that reduces the joint's range of motion) in both shoulders, both elbows, both wrists, both hands, and both ankles. The treatment plan included RNA orders to provide Resident 20 with PROM to both arms and legs, five times per week; apply hand rolls or washcloths, five times per week; and apply both ankle splints for two hours, five times per week. During a review of Resident 20's undated JMA, the JMA indicated Resident 20 had ROM limitations in both arms and legs, including severe (0 to 25% available ROM) limitation in both shoulders, elbows, wrists, hands, and ankles. The JMA indicated Resident 20 had WFL ROM in both hips and knees. The undated JMA indicated to continue with RNA. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had moderately impaired cognition and ROM limitations in both arms and legs. The MDS also indicated Resident 20 was dependent for oral hygiene, toileting, bathing, dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/18/2024 at 12:38 p.m. in Resident 20's room, Resident 20 was lying in the bed with visible tremors (small, rapid movements) in both arms and unclear speech. Both of Resident 20's shoulder joints were turned inward toward the body, both elbows were bent (flexed), and both wrists were bent downward. Resident 20's right-hand fingers were observed bent into a closed fist. Resident 20's left-hand large knuckles were bent upward (hyperextension) while the tips of the fingers were bent downward. Resident 20's legs laid flat on the bed's surface. During an observation on 12/19/2024 at 9:00 a.m. in Resident 20's room, Resident 20's knees were fully extended while both legs rested on the bed. Both of Resident 20's ankles were positioned in plantarflexion (ankle bent away from the body). RNA 1 stood on the left side of the bed to provide PROM to both of Resident 20's legs, including hip flexion with the knee extended and hip abduction with the knee extended. RNA 1 covered Resident 20's legs with a sheet and proceeded to perform PROM to Resident 20's arms. RNA 1 provided Resident 20 with PROM into shoulder flexion (lifting the arm upward at the shoulder joint) and abduction (lifting the arm up and away from the body at the shoulder joint). Resident 20's right-hand fingers were observed bent into a closed fist. RNA 1 placed a rolled hand towel in Resident 20's palm underneath the middle, ring, and small fingers. Resident 20's left-hand large knuckles were bent in hyperextension while the tips of the fingers were bent downward. RNA 1 placed a rolled hand towel in Resident 20's left-hand underneath the tips of the bent fingers. RNA 1 applied both ankle splints. RNA 1 did not perform PROM on both of Resident 20's elbows, wrists, hands, knees, and ankles. During an interview on 12/19/2024 at 9:16 a.m. with RNA 1, RNA 1 stated she provided PROM to both hips, shoulders, and elbows (not observed). RNA 1 stated she provided PROM to Resident 20's legs, including leg raises (hip flexion) and abduction. RNA 1 stated PROM was not provided to Resident 20's knees since both knees did not bend. RNA 1 stated Resident 20 also received PROM to both arms, including arm raises (shoulder flexion), abduction, gentle stretches to the elbows, and hand rolls were placed in both hands. RNA 1 was asked to demonstrate the gentle stretches to Resident 20's elbows. RNA 1 extended both of Resident 20's elbows, which continued to have a 90-degree bend when the elbows were extended. RNA 1 stated Resident 20 tolerated wearing both ankle splints for one to two hours. RNA 1 stated both hand towel rolls did not stay in Resident 20's hands for long, including the amount of time indicated in the physician's order (5 hours) due to the positioning of both hands. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated PROM to both of Resident 20's ankles, wrists, and hands should have been done but was not done due to RNA 1 feeling nervous. RNA 1 stated she should have performed PROM to both of Resident 20's ankles and hands prior to placing the rolled hand towels in both hands and prior to applying both ankle splints. During an interview on 12/19/2024 at 10:39 a.m. with the DOR, the DOR stated ROM exercises should be performed to increase mobility prior to the application of splints. During a telephone interview on 12/19/2024 at 11:38 a.m. with Physical Therapist 1 (PT 1), PT 1 stated the RNAs were expected to provide ROM exercises at the shoulder, elbow, wrist, finger, hip, knee, and ankle joints to prevent any decline in ROM. During an interview on 12/19/2024 at 11:58 a.m. with the DOR, the DOR stated the residents (in general) had an increased possibility for developing contractures and experiencing a decline in ROM if ROM was not performed to the joints during ROM exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/19/2024 at 12:13 p.m. with the DOR, Resident 20's Functional Maintenance Program for OT and PT, dated 9/6/2023, the physician's orders for RNA, dated 9/6/2023, and undated JMA were reviewed. The DOR stated Resident 20 was readmitted to the facility on [DATE] and received a JMA on 9/6/2023, which indicated Resident 20 had severe ROM limitations in both shoulders, elbows, wrists, hands, and ankles. The DOR stated the JMA indicated Resident 20's hips and knees had WFL ROM. The DOR stated Resident 20's Functional Maintenance Program - PT, dated 9/6/2023, indicated for the RNA to provide PROM to both legs followed by application of both ankle splints. The DOR stated Resident 20's Functional Maintenance Program - OT, dated 9/6/2023, indicated a recommendation for RNA to provide PROM to both arms followed by application of hand rolls or rolled washcloths. The DOR stated the rolled washcloth was a rolled-up face towel placed in the hands and the hand roll had a strap to maintain the roll in the hands. The DOR stated the facility usually used the rolled washcloth, which should be positioned through the thumb webspace and in the palm of the hand to prevent further decline in ROM of the fingers. The DOR stated the rolled washcloth was useless if it was not placed through the thumb webspace. The DOR stated Resident 20 would benefit more from a hand roll with a strap to prevent the roll from falling out of both hands due to the positioning of Resident 20's fingers. The DOR stated the undated JMA was supposed to be for 9/2024, which indicated Resident 20 had severe ROM limitations in both shoulders, elbows, wrists, hands, and ankles and WFL ROM in both hips and knees. During a concurrent interview and record review on 12/20/2024 at 9:25 a.m. with PT 1, PT 1 reviewed Resident 20's undated JMA. PT 1 stated Resident 20's undated JMA was from 9/2024. PT 1 stated the JMA indicated Resident 20 had WFL ROM in both hips and ankles. PT 1 stated WFL in both knees indicated Resident 20 had sufficient movement in both knees into flexion and extension. During a concurrent observation and interview on 12/20/2024 at 10:09 a.m. with PT 1 in the dining room, Resident 20 was sitting in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) but did not want PT 1 to move both legs. PT 1 stated Resident 20 bent both knees during the JMA in 9/2024. PT 1 stated it was not reported to PT 1 that Resident 20 could not bend both knees. During a review of the facility's undated P&P titled, Prevention of Decline in Range of Motion/Joint Mobility, the P&P indicated the facility shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care. The P&P further indicated interventions will be documented in a resident's care plan and will monitor for consistent implementation of the care plan interventions. The P&P indicated general guidelines for ROM included moving each joint through its ROM. c. During a review of Resident 68's Admission Record, the facility admitted Resident 68 on 8/2/2024 with diagnoses including hemiplegia (weakness of the arm, leg, and trunk on the same side of the body) and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area). During a review of Resident 68's JMA, dated 8/15/2024, the JMA indicated Resident 68's left shoulder was limited to 90 degrees for shoulder abduction and flexion and the left elbow had ROM limitations between mild and moderate. The JMA indicated Resident 68 had WFL ROM in the right shoulder, right elbow, both wrists, both hands, both hips, both knees, and both ankles. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Functional Maintenance Program - OT, dated 8/5/2024, the recommendation indicated for the RNA to provide Resident 68 with active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) to the right arm and PROM to the left arm, five times per week as tolerated, to maintain ROM, maintain strength, and to prevent contractures. During a review of Resident 68's care plan titled, Rehab to RNA Care Plan, dated 8/5/2024, the care plan indicated for Resident 68 to received RNA for AROM to the right arm and PROM to the left arm, five times per week as tolerated, to maintain ROM, maintain strength, and prevent contractures. During a review of Resident 68's physician orders, dated 8/5/2024, the physician's orders indicated for RNA to provide AROM to the right arm and PROM to the left arm, five times per week as tolerated. During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68 was moderately impaired for cognition and had impairment in one arm. The MDS also indicated Resident 68 required setup or clean up assistance for eating, supervision (verbal uses and/or touching/steadying assistance) for rolling to both sides, sitting at the edge of the bed to lying down, and lying down to sitting at the edge of the bed, and partial/moderate assistance (helper does less than half the effort) for toileting, bathing, upper body dressing, and chair/bed-to-chair transfers. During a concurrent observation and interview on 12/18/2024 at 1:13 p.m. in Resident 68's room, Resident 68 was lying in bed and partially awake. Resident 68 stated the left arm and leg were weak and was observed to slowly move the left arm and leg. During an observation on 12/19/2024 at 9:24 a.m. with RNA 1 in Resident 68's room, Resident 68 transferred from lying down to sitting at the edge of bed without any physical assistance by hooking the right leg underneath the left leg to carry the left leg over the edge of the bed. Resident 68 transferred from the edge of the bed to the manual wheelchair, which was positioned on Resident 68's right side without any physical assistance. Resident 68 performed exercises with RNA 1 while seated in the wheelchair. RNA 1 demonstrated AROM exercises for Resident 68 to perform at the left shoulder and elbow joints. RNA 1 was observed performing PROM on Resident 68's left shoulder, elbow, and wrist joints. RNA 1 did not perform PROM to Resident 68's left hand. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated Resident 68 performed AROM exercises at the left shoulder and elbow joints. RNA 1 stated she performed PROM exercises to Resident 68's right shoulder, elbow, and wrist joints. RNA 1 stated she forgot to perform PROM to Resident 68's right hand. During a concurrent interview and record review on 12/19/2024 at 11:58 a.m. with the DOR, Resident 68's JMA, dated 8/5/2024, and Functional Maintenance Program - OT, dated 8/5/2024, was reviewed. The DOR stated the JMA indicated Resident 68's left shoulder ROM was limited to 90 degrees, the left elbow ROM was between minimal and moderate limitations, and all other joints were WFL. The DOR stated the Functional Maintenance Program - OT indicated recommendations for RNA for PROM to the left arm and AROM to the right arm. The DOR stated PROM to the left arm should include the shoulder, elbow, wrist, and hand joints. The DOR stated the residents (in general) had an increased possibility for developing contractures and experiencing a decline in ROM if ROM was not performed to the joints during ROM exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled, Prevention of Decline in Range of Motion/Joint Mobility, the P&P indicated general guidelines for ROM included moving each joint through

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36943 Based on observation, interview, and record review, the facility failed to ensure the facility's Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) staff were competent to provide range of motion ([ROM] full movement potential of a joint [where two bones meet]) exercises and apply splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to three of nine residents (Resident 5, 20, and 68) with limited ROM and mobility (ability to move) in accordance with the facility's undated job description titled, Restorative Aide. This failure had the potential for Resident 5, 20, and 68 to develop further ROM limitations. Findings: 1. During a review of Resident 5's Admission Record, the facility admitted Resident 5 on 5/7/2024 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue) and dementia (a progressive state of decline in mental abilities). During a review of Resident 5's physician orders, dated 7/11/2024 and revised 11/18/2024, the physician's orders indicated for RNA to provide Resident 5 with passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) to both legs followed by the application of both knee splints, five times per week. During a review of Resident 5's care plan titled, Rehab to RNA Care Plan, dated 7/11/2024, the care plan indicated a plan to provide PROM of both legs followed by application of both knee splints to prevent decline in ROM. During an observation on 12/19/2024 at 8:50 a.m. in Resident 5's room, Restorative Nursing Aide 1 (RNA 1) stood on the left side of the bed. RNA 1 was observed providing PROM to both hips and knees. RNA 1 did not perform PROM to both ankles. During an interview on 12/19/2024 at 8:56 a.m. with RNA 1, RNA 1 stated Resident 5's physician orders for RNA was to provide PROM to both legs. RNA 1 stated both knee splints would be applied after Resident 5 was changed. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated she forgot to provide PROM to Resident 5's ankles. 2. During a review of Resident 20's Admission Record, the facility admitted Resident 20 on 9/5/2023 with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), parkinsonism (group of conditions with symptoms including slow movements, stiffness, tremors, and balance issues), and attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056313	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's physician orders, dated 9/6/2023 and revised 11/18/2024, the physician's orders indicated an RNA program to provide exercises (unspecified) to both arms, apply both hand rolls or rolled washcloth for five hours, and PROM to both legs followed by application of both ankle splints for two hours, five times per week. During a review of Resident 20's care plan for limitations in joint mobility, dated 9/2024, the care plan indicated Resident 20 had limitations due to contractures (stiffening/shortening at any joint that reduces the joint's range of motion) in both shoulders, both elbows, both wrists, both hands, and both ankles. The treatment plan included RNA orders for PROM to both arms and legs, five times per week; apply hand rolls or washcloths, five times per week; and apply both ankle splints for two hours, five times per week. During an observation on 12/19/2024 at 9:00 a.m. in Resident 20's room, Resident 20's knees were fully extended while both legs rested on the bed. Both of Resident 20's ankles were positioned in plantarflexion (ankle bent away from the body). RNA 1 was observed providing PROM to Resident 20's hips and shoulders. Resident 20's right-hand fingers were observed bent into a closed fist. RNA 1 placed a rolled hand towel in Resident 20's palm underneath the middle, ring, and small fingers. Resident 20's left-hand large knuckles were bent upward (hyperextension) while the tips of the fingers were bent downward. RNA 1 placed a rolled hand towel in Resident 20's left-hand underneath the tips of the bent fingers. RNA 1 then applied both ankle splints. RNA 1 did not provide PROM on both elbows, wrists, hands, knees, and ankles. During an interview on 12/19/2024 at 9:16 a.m. with RNA 1, RNA 1 stated Resident 20 received PROM to both legs and arms. RNA 1 stated both of Resident 20's knees did not bend. RNA 1 stated PROM should have been provided to both of Resident 20's ankles and hands prior to placing the rolled hand towels in both hands and prior to applying both ankle splints. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated PROM to both of Resident 20's ankles, wrists, and hands should have been done but was not provided due to RNA 1 feeling nervous. 3. During a review of Resident 68's Admission Record, the facility admitted Resident 68 on 8/2/2024 with diagnoses including hemiplegia (weakness of the arm, leg, and trunk on the same side of the body) and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area). During a review of Resident 68's physician orders, dated 8/5/2024, the physician's orders indicated for RNA to provide AROM to the right arm and PROM to the left arm, five times per week as tolerated. During a review of Resident 68's care plan titled, Rehab to RNA Care Plan, dated 8/5/2024, the care plan indicated for the RNA to provide Resident 68 with AROM to the right arm and PROM to the left arm, five times per week as tolerated, to maintain ROM, maintain strength, and prevent contractures. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/19/2024 at 9:24 a.m. with RNA 1 in Resident 68's room, Resident 68 performed exercises with RNA 1 while seated in the wheelchair. RNA 1 demonstrated AROM exercises for Resident 68 to perform at the left shoulder and elbow joints. RNA 1 was observed performing PROM exercises to Resident 68's left shoulder, elbow, and wrist. RNA 1 did not perform PROM to Resident 68's left hand. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated Resident 68 performed AROM exercises at the left shoulder and elbow joints. RNA 1 stated she provided PROM exercises to Resident 68's right shoulder, elbow, and wrist. RNA 1 stated she forgot to perform PROM to the right hand. During an interview on 12/19/2024 at 10:39 a.m. with the DOR, the DOR stated ROM exercises should be performed to increase mobility prior to the application of splints. During a telephone interview on 12/19/2024 at 11:38 a.m. with Physical Therapist 1 (PT 1), PT 1 stated the RNAs were expected to provide ROM exercises at the shoulder, elbow, wrist, finger, hip, knee, and ankle joints to prevent any decline in ROM. During an interview on 12/19/2024 at 11:58 a.m. with the DOR, the DOR stated the residents (in general) had an increased possibility for developing contractures and experiencing a decline in ROM if ROM was not performed to the joints during ROM exercises. During an interview on 12/19/2024 at 2:51 p.m. with the DSD, RNA 1 and RNA 2's competencies, dated 12/10/2024, were reviewed. The DSD stated the RNAs were observed while providing restorative tasks, including PROM exercises and the application of splints. During an interview on 12/20/2024 at 9:37 a.m. with the DOR, the DOR reviewed in-services provided to the RNAs. The DOR stated an in-service provided to the RNAs for the application of splints was on 5/6/2021 (3 years ago) and for ROM exercises was on 2/18/2022 (2 years ago). The DOR stated the DSD was not present during both in-services. During an interview on 12/20/2024 at 1:47 p.m. with the Director of Nursing (DON), the DON stated the therapy staff established the RNA program for the residents. The DON stated the DSD completed the RNA competencies. The DON stated the DSD would not know the therapists' expectations for providing ROM exercises and applying splints if the DSD did not attend the therapists' in-services. The DON stated the residents (in general) could develop limitations in ROM and function if the RNAs were not competent. During a review of the In-service Attendance Sheet titled, Proper Application of B (both) Ankle Plantarflexion (ankle bent away from the body) Splint(s), dated 5/6/2021, the training included a review of splint application, including premedication prior to application and nurse notification if the resident had complaints of pain. During a review of the Inservice Training Attendance Record titled, ROM and Transfers, dated 2/18/2022, the training objectives indicated to refresh knowledge on ROM and transfers. During a review of Restorative Nursing Aide 1's (RNA 1) and RNA 2's Certified Nurse Aide (CNA)/RNA Competency, dated 12/10/2024, the CNA/RNA Competency indicated the Director of Staff Development (DSD) completed their competencies. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P) titled, Prevention of Decline in Range of Motion/Joint Mobility, the P&P indicated general guidelines for ROM included moving each joint through its ROM. During a review of the facility's undated job description titled, Restorative Aide, the job description indicated major duties and responsibilities, including performing RNA services in accordance with care plans and facility policies and procedures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Administer risperidone (a medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), calcium (a supplement used to treat low level of calcium) and vitamin D (a vitamin used to treat low level of vitamin D) in accordance with physician's orders affecting one of four sampled residents during medication administration (Resident 54). 2. Clarify dose and frequency of physician's order for docusate sodium (a medication used to relieve constipation) affecting one of four sampled residents (Resident 440). 3. Accurately account for the administration of Vimpat (generic name - lacosamide, a controlled substance [a medication with a high potential for abuse] used to treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and lorazepam (a controlled substance used to treat anxiety) on Controlled Drug Record (CDR - a log signed by the nurse with the date and time each time a controlled substance is given to a resident) for two residents (Residents 23 and 13) in one of two inspected medication carts (South Medication Cart). These deficient practices failed to administer medications in accordance with the physician orders or professional standards of practice, and provide accurate accountability for controlled substances, increasing the risk for hospitalization due to inappropriate treatment of mental disorders, constipation, and had a potential to result in misuse, drug loss and/or diversion of controlled substances. Findings: 1. During a review of Resident 54's Admission Record (a document containing demographic and diagnostic information), dated 12/18/2024, the facility originally admitted Resident 54 on 3/24/2022 and readmitted Resident 54 on 9/18/2024 with diagnoses including, but not limited to, hypertensive (a condition described as high blood pressure) heart disease without heart failure (a condition when heart cannot pump enough blood and oxygen to the body's organs), Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication, vitamin D deficiency, anxiety disorder and bipolar disorder. During a review of Resident 54's History and Physical, dated 9/20/2024, the document indicated Resident 54 had fluctuating capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 54's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 9/30/2024, the MDS indicated Resident 54's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 54 needed setup or cleanup assistance for eating and oral hygiene. The MDS indicated Resident 54 needed maximal assistance with lower body dressing, and moderate to supervision assistance for other activities of daily living such as shower, toileting, upper body dressing and personal hygiene. During a review of Resident 54's Order Summary Report (a list of all currently active medical orders), dated 12/19/2024, the order summary report indicated the following medication orders: a. Artificial Tears (eye drops solution used to relieve burning and irritation in eyes due to dry eyes Ophthalmic (eye) Solution, instill 1 drop in both eyes two times a day for dry eyes, order date 10/1/2024, start date 10/8/2024 b. Cholecalciferol (a dietary supplement used to treat low level of vitamin D) tablet 1000 unit (a unit of measurement for mass), give 1 tablet by mouth one time a day for vitamin D deficiency, order date 10/1/2024, start date 10/8/2024 c. Oyster shell Calcium (a supplement used to treat lack of calcium) tablet 500 mg, give 1 tablet by mouth two times a day for supplement, order date 10/1/2024, start date 10/8/2024. d. Risperdal (generic name - risperidone), give 0.25 mg by mouth two times a day for psychosis m/b auditory hallucination stating, 'the voices are telling me not to go out of my room', order date 10/1/2024, start date 10/8/2024. e. Divalproex sodium (a medication used to treat seizure tablet delayed release 125 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth two times a day for bipolar disorder manifested by (mb) fluctuations of emotions from pleasant to angry, order date 10/1/2024, start date 10/2/2024. f. DSS (docusate sodium) oral capsule 250 mg, give 1 capsule by mouth one time a day for bowel management hold for loose stools, order date 10/1/2024, start date 10/8/2024 g. Duloxetine hydrochloride (HCl) (a medication used to treat depression [a mental disorder that can affect a person's thoughts, mood and sense of well-being], anxiety and nerve pain) 20 mg, give 1 capsule by mouth one time a day for depression m/b making negative statement such as of hopelessness, order date 10/11/2024, start date 10/13/2024. h. Gabapentin (a medication used to treat seizures and nerve pain) capsule 100 mg, give 1 capsule by mouth two times a day for neuropathy (nerve pain), order date 10/1/2024, start date 10/2/2024. i. Jardiance (generic name - empagliflozin [a medication used to treat high blood sugar]) oral tablet 25 mg, give 1 tablet by mouth in the morning for DM, order date 10/1/2024, start date 10/8/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Lisinopril (a medication used to treat high blood pressure) tablet 5 mg, give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure ([SBP] - the pressure caused by heart while contracting) less than 110 or heart rate (HR) less than 60, order date 10/1/2024, start date 10/2/2024. During an observation of medication administration on 12/18/2024 between 8:57 a.m. and 9:10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered following list of medications to Resident 54 that did not include risperidone 0.25 mg: 1. One drop of Artificial tears in both eyes 2. One tablet of vitamin D (a vitamin used to treat lack of vitamin D) 25 micrograms (mcg - a unit of measurement of mass), 1000 Internation Units (IU - a unit of measurement of mass) by mouth 3. One tablet of divalproex delayed release (DR) 125 mg by mouth 4. One tablet of Colace (generic name - docusate sodium) 250 mg by mouth 5. One capsule of duloxetine (a medication used to treat depression (low mood) and anxiety) 20 mg by mouth 6. One tablet of calcium 500 mg with vitamin D 5 mcg by mouth 7. One capsule of gabapentin (a medication used to treat nerve pain and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) 100 mg by mouth 8. One tablet of Jardiance (generic name - empagliflozin, a medication used to treat high blood sugar) 25 mg by mouth 9. One tablet of lisinopril (a medication used to treat high blood pressure) 5 mg by mouth During a medication reconciliation review on 12/18/2024 at 12:21 p.m. Resident 54's order summary report and observed administered medications list were reviewed. The order summary report indicated one tablet of risperidone 0.25 mg to be administered two times a day. The order summary report indicated separate physician orders for one tablet of calcium 500 mg two times a day and one tablet of vitamin D 1000 units one time a day. During a concurrent interview and record review on 12/18/2024 at 12:21 p.m. with LVN 1, Resident 54's list of medications administered during medication pass observation and the container package label of calcium 500 mg with vitamin D 5 mcg (combination) were reviewed. LVN 1 stated it was her mistake because she remembered administering nine medications that did not include risperidone 0.25 mg. LVN 1 stated she made a mistake in administering a combination of calcium with vitamin D instead of only calcium 500 mg in addition to separate vitamin D3 (cholecalciferol) 25 mcg (1000 IU). LVN 1 stated it was important to follow physician orders to prevent medication errors that can negatively affect resident 54's health. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 3:39 p.m. with the Director of Nursing (DON), the DON stated facility nurse should have checked the stock calcium with vitamin D with physician order to prevent administering additional vitamin D from a combination bottle. DON stated the facility nurse should always follow physician orders. DON stated by not receiving risperidone 0.25 mg, Resident 54 could have experienced mental and behavioral episodes that could have negative impact on Resident 54's health. 2. During a review of Resident 440's Admission Record, dated 12/18/2024, the admission record indicated the facility originally admitted Resident 440 on 10/11/2024 and readmitted Resident 440 on 12/2/2024 with diagnoses that included but not limited to major depressive disorder (a mental disorder that can affect a person's thoughts, mood, and sense of well-being). During a review of Resident 440's History and Physical, dated 12/3/2024, the document indicated Resident 440 had the capacity to understand and make decisions. During a review of Resident 440's MDS, dated [DATE], the MDS indicated Resident 440's cognition was moderately impaired. The MDS indicated Resident 440 needed moderate to maximal assistance from facility staff for toileting, showering, personal hygiene, and dressing, and needed clean up assistance for eating. During a review of Resident 440's Order Summary Report, dated 12/19/2024, the order summary report indicated the following medication without dose and frequency:a. Docusate sodium oral tablet, give 1 tablet by mouth as needed for constipation, order date 12/2/2024, start date 12/2/2024. During a concurrent interview and record review on 12/18/2024 at 12:54 p.m. with LVN 2, of the order details for Resident 440's docusate sodium, LVN 2 stated the docusate sodium order should have been clarified with the physician for dose and frequency. LVN 2 stated there was a risk for Resident 440 to be overtreated or undertreated with docusate sodium increasing the risk for hospitalization due to diarrhea and dehydration because of no hold parameters or dose and frequency specified on the order. During an interview on 12/19/2024 at 3:39 p.m. with the DON, the DON stated facility staff should have called physician to clarify docusate for Resident 440. DON stated the order did not indicate specific dose, 50 mg or 100 mg or a frequency to be safely administered and there was a risk for diarrhea. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration, , the P&P indicated, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The P&P indicated, Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. 3a. During a review of Resident 23's Admission Record, dated 12/29/2024, the admission record indicated the facility originally admitted Resident 23 on 1/31/2019 and readmitted Resident 23 on 8/15/2024 with diagnoses that included but not limited to, epilepsy, unspecified, without status epilepticus (a medical emergency that occurs when a person has a seizure that lasts longer than five minutes) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's History and Physical, dated 9/11/2024, the document indicated Resident 23 had fluctuating capacity to understand and make decisions. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognition was moderately impaired. The MDS indicated Resident 23 needed moderate to maximal assistance from facility staff for activities of daily living such as dressing, personal hygiene, toileting, and showering. The MDS indicated Resident 23 needed touching assistance for oral hygiene and clean up assistance for eating. During a review of Resident 23's Order Summary Report, dated 12/19/2024, the order summary report indicated (not limited to) the following medication order: a. Vimpat oral tablet 200 mg (lacosamide) give 1 tablet by mouth two times a day related to epilepsy, order date 9/8/2024, start date 10/8/2024. During a concurrent inspection, interview and record review on 12/17/2024 at 3:34 p.m. with LVN 2 of South Medication Cart, Resident 23's medication card / bubble pack for lacosamide (generic for Vimpat) 200 mg, facility's CDR and the medication administration details. Resident 23's medication card / bubble pack for lacosamide 200 mg contained a quantity of 42 tablets remaining. The facility's CDR indicated a quantity of 43 tablets remaining with the last dose administered on 12/16/2024 at 5:00 p.m. The administration details indicated Vimpat oral tablet 200 mg (lacosamide) for Resident 23 was administered on 12/17/2024 at 10:17 a.m. LVN 2 stated lacosamide 200 mg was administered to Resident 23 on 12/17/2024 at 10:17 a.m. LVN 2 stated it was her mistake and the book (CDR) should have been documented and signed immediately after medication was administered. LVN 2 stated lacosamide was a controlled substance with a high potential for abuse and diversion. LVN 2 stated there was a possibility and risk for medication error leading to seizures, fall, injury and hospitalization . 3b. During a review of Resident 13's Admission Record, dated 12/19/2024, the admission record indicated the facility originally admitted Resident 13 on 1/31/2024 and readmitted Resident 13 on 9/24/2024 with diagnoses that included, but not limited to, anxiety disorder. During a review of Resident 13's History and Physical, dated 9/26/2024, the history and physical indicated Resident 13 had the capacity to understand and make decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13's cognition was intact. The MDS indicated Resident 13 needed moderate assistance to supervision assistance from facility staff for personal hygiene, dressing, showering, toileting, oral hygiene and eating. During a review of Resident 13's Order Summary Report, dated 12/19/2024, the order summary report indicated, but not limited to the following medication: a. Ativan oral tablet 1 mg (lorazepam), give 1 tablet by mouth two times a day for anxiety manifested by (m/b) psychomotor agitation, irritability throwing himself to the floor angry and banging his head on the wall, order date 9/24/2024, start date 10/28/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent inspection, interview and record review on 12/17/2024 at 3:34 p.m. with LVN 2 of South Medication Cart, Resident 13's medication card / bubble pack for lorazepam (generic for Ativan) 1 mg, facility's CDR and the medication administration details were reviewed. Resident 13's medication card / bubble pack for lorazepam 1 mg contained a quantity of 14 tablets remaining. The facility's CDR indicated a quantity of 15 tablets remaining with the last dose administered on 12/16/2024 at 5:00 p.m. The administration details indicated Ativan oral tablet 1 mg (lorazepam) for Resident 13 was administered on 12/17/2024 at 8:51 a.m. LVN 2 stated lorazepam 1 mg was administered to Resident 13 on 12/17/2024 at 8:51 a.m. LVN 2 stated it was her mistake again and the book (CDR) should have been documented and signed immediately after medication was administered. LVN 2 stated lorazepam was a controlled substance with a high potential for abuse and diversion. LVN 2 stated there was a possibility and risk for medication error. LVN 2 stated Resident 13 would not be able to function properly and could suffer from angry outbursts and anxiety if the medication was not administered as prescribed by physician. During an interview on 12/18/2024 at 4:28 p.m. with the DON, DON stated controlled substances should have been documented in the CDR immediately after they were administered to Residents 23 and 13 because otherwise there would not be a method to track the movement of controlled substance which increased the risk for medication discrepancies. During a review of the facility's P&P titled, Controlled Substances, dated 11/2017, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: (Note: Refer .proper storage) a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose. During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, Policy Explanation and Compliance Guidelines: If medication is a controlled substance, sign narcotic book.

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	056313	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to monitor one of three sampled resident's (Resident 439) behaviors while prescribed with psychotropic medications (medications can alter brain chemistry, impact body functions, and modify a person's thoughts, moods, feelings, awareness, and perceptions). This failure had the potential to result in unnecessary medications. Findings: During a review of Resident 439's Admission Record, Resident 439's Admission Record indicated Resident 439 was admitted on [DATE] and readmitted to the facility on [DATE] with a diagnosis of Atrial fibrillation (rapid heart rate), presence of a pacemaker, psychosis (loss of contact with reality) During a review of Resident 439's History and Physical (H&P), dated 11/8/24 indicated, Resident 439 does not have the capacity to understand and make decisions. During a review of Resident 439's Minimum Data Set ({MDS}- a resident assessment tool) dated 11/16/24 the MDS indicated Resident 439 has severe cognitive impairment. The MDS also indicated Resident 439 was dependent with activities of daily living ({ADL's}- activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated Resident 439 was taking antipsychotic medication and has a psychotic disorder. During a review of Resident 439's Active Orders dated 12/19/24 indicated Resident 439 had orders for Risperdal (psychotropic medications) 0.5mg to be given two times a day for psychosis manifested by (m/b) auditory hallucinations the voices are telling me something I don't want to do . During a review of Resident 439's Care plan dated 12/12/2024 indicated Resident 439 has a behavior problem of psychosis m/b auditory hallucination The voices are telling me something I don't want to do . The goal is that Resident 439 to have fewer episodes. The care plan also indicated Resident 439 intervention are to administer medications as ordered and monitor/document for side effects and effectiveness of the Risperdal. During a concurrent interview and record review on 12/20/21 at 10:41 a.m. with Licensed Vocational Nurse LVN 2 of Resident 439's Active Orders dated 12/19/24. LVN2 stated anytime a resident is taking psychotropic medication we have to monitor for that specific behavior that the resident is taking the medications for. LVN2 stated she did not see that Resident 439's behavior was being monitored about hearing voices that are telling me something I don't want to do . LVN2 stated without the monitoring of that specific behavior you would not be able to see if the medication is working. LVN2 stated when the behavior monitoring is not being done the resident is at risk for receiving unnecessary medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/20/21 at 11:03a.m. with Registered Nurse supervisor (RNS), Resident 439's Active Orders dated 12/19/24 were reviewed. RNS stated she was unable to locate the symptoms monitoring for Resident 439's Risperdal use. RNS stated when not monitoring for the effectiveness of the medication, resident is at risk of receiving unnecessary medications. During a concurrent interview and record review on 12/20/24 at 1:20 p.m. with Director of nursing (DON. DON stated that there was no monitoring of behaviors for the Risperdal use of Resident's 439. DON stated without the monitoring of the behaviors they would not be able to see if the medication was effective and the facility would not be able to do gradual dose reductions and that it could be considered an unnecessary medication. During a review of the facility's undated policy and procedure (P&P) titled Use of Psychotropic medications indicated, the effects of the psychotic medications on a residents physical, mental, and psychosocial well-being will be evaluated on an ongoing basis. The residents response to the medications, including progress towards goals and presence/absence of adverse consequences shall be documented in the residents medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for one of four sampled residents (Resident 54) by failing to provide risperidone (a medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), calcium (a supplement used to treat low level of calcium) and vitamin D (a vitamin used to treat low level of vitamin D) in accordance with physician's orders. This deficient practice of medication administration error rate of 7.14% exceeded the five (5) percent threshold. Findings: During a review of Resident 54's Admission Record (a document containing demographic and diagnostic information), dated 12/18/2024, the facility originally admitted Resident 54 on 3/24/2022 and readmitted Resident 54 on 9/18/2024 with diagnoses including, but not limited to, hypertensive (a condition described as high blood pressure) heart disease without heart failure (a condition when heart cannot pump enough blood and oxygen to the body's organs), Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication, vitamin D deficiency, anxiety disorder and bipolar disorder. During a review of Resident 54's History and Physical(H & P), dated 9/20/2024, the H &P indicated Resident 54 had fluctuating capacity to understand and make decisions. During a review of Resident 54's Minimum Data Set (MDS- a resident assessment) dated 9/30/2024, the MDS indicated Resident 54's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 54 needed setup or cleanup assistance for eating and oral hygiene. The MDS indicated Resident 54 needed maximal assistance with lower body dressing, and moderate to supervision assistance for other activities of daily living such as shower, toileting, upper body dressing and personal hygiene. During a review of Resident 54's Order Summary Report (a list of all currently active medical orders), dated 12/19/2024, the order summary report indicated the following medication orders: 1. Artificial Tears (eye drops solution used to relieve burning and irritation in eyes due to dry eyes Ophthalmic (eye) Solution, instill 1 drop in both eyes two times a day for dry eyes, order date 10/1/2024, start date 10/8/2024 2. Cholecalciferol (a dietary supplement used to treat low level of vitamin D) tablet 1000 unit (a unit of measurement for mass), give 1 tablet by mouth one time a day for vitamin D deficiency, order date 10/1/2024, start date 10/8/2024 3. Oyster shell Calcium (a supplement used to treat lack of calcium) tablet 500 mg, give 1 tablet by mouth two times a day for supplement, order date 10/1/2024, start date 10/8/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Risperdal (generic name - risperidone), give 0.25 mg by mouth two times a day for psychosis m/b auditory hallucination stating, 'the voices are telling me not to go out of my room', order date 10/1/2024, start date 10/8/2024. 5. Divalproex sodium (a medication used to treat seizure tablet delayed release 125 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth two times a day for bipolar disorder manifested by (mb) fluctuations of emotions from pleasant to angry, order date 10/1/2024, start date 10/2/2024. 6. DSS (docusate sodium) oral capsule 250 mg, give 1 capsule by mouth one time a day for bowel management hold for loose stools, order date 10/1/2024, start date 10/8/2024 7. Duloxetine hydrochloride (HCl) (a medication used to treat depression [a mental disorder that can affect a person's thoughts, mood and sense of well-being], anxiety and nerve pain) 20 mg, give 1 capsule by mouth one time a day for depression m/b making negative statement such as of hopelessness, order date 10/11/2024, start date 10/13/2024. 8. Gabapentin (a medication used to treat seizures and nerve pain) capsule 100 mg, give 1 capsule by mouth two times a day for neuropathy (nerve pain), order date 10/1/2024, start date 10/2/2024. 9. Jardiance (generic name - empagliflozin [a medication used to treat high blood sugar]) oral tablet 25 mg, give 1 tablet by mouth in the morning for DM, order date 10/1/2024, start date 10/8/2024. 10. Lisinopril (a medication used to treat high blood pressure) tablet 5 mg, give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure (SBP- the pressure caused by heart while contracting) less than 110 or heart rate (HR) less than 60, order date 10/1/2024, start date 10/2/2024. During an observation of medication administration on 12/18/2024 between 8:57 a.m. and 9:10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered following list of medications to Resident 54 that did not include risperidone 0.25 mg: 1. One drop of Artificial tears in both eyes 2. One tablet of vitamin D (a vitamin used to treat lack of vitamin D) 25 micrograms (mcg - a unit of measurement of mass), 1000 Internation Units (IU - a unit of measurement of mass) by mouth 3. One tablet of divalproex delayed release (DR) 125 mg by mouth 4. One tablet of Colace (generic name - docusate sodium) 250 mg by mouth 5. One capsule of duloxetine (a medication used to treat depression (low mood) and anxiety) 20 mg by mouth 6. One tablet of calcium 500 mg with vitamin D 5 mcg by mouth (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. One capsule of gabapentin (a medication used to treat nerve pain and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) 100 mg by mouth 8. One tablet of Jardiance (generic name - empagliflozin, a medication used to treat high blood sugar) 25 mg by mouth 9. One tablet of lisinopril (a medication used to treat high blood pressure) 5 mg by mouth During a medication reconciliation review on 12/18/2024 at 12:21 p.m. Resident 54's order summary report and observed administered medications list were reviewed. The order summary report indicated one tablet of risperidone 0.25 mg to be administered two times a day. The order summary report indicated separate physician orders for one tablet of calcium 500 mg two times a day and one tablet of vitamin D 1000 units one time a day. During a concurrent interview and record review on 12/18/2024 at 12:21 p.m. with LVN 1, Resident 54's list of medications administered during medication pass observation and the container package label of calcium 500 mg with vitamin D 5 mcg (combination) were reviewed. LVN 1 stated it was her mistake because she remembered administering nine medications that did not include risperidone 0.25 mg. LVN 1 stated she made a mistake in administering a combination of calcium with vitamin D instead of only calcium 500 mg in addition to separate vitamin D3 (cholecalciferol) 25 mcg (1000 IU). LVN 1 stated it was important to follow physician orders to prevent medication errors that can negatively affect resident 54's health. During an interview on 12/19/2024 at 3:39 p.m. with the Director of Nursing (DON), the DON stated facility nurse should have checked the stock calcium with vitamin D with physician order to prevent administering additional vitamin D from a combination bottle. DON stated the facility nurse should always follow physician orders. DON stated by not receiving risperidone 0.25 mg, Resident 54 could have experienced mental and behavioral episodes that could have negative impact on Resident 54's health. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration, the P&P indicated, Medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The P&P indicated, Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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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. 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure storage and/or labeling of brimonidine tartrate ophthalmic solution (a medication in form of eye drops used to treat high intraocular pressure [a term used to describe fluid pressure inside the eye]), bisacodyl (a medication used to treat constipation) suppositories (a medication designed to be inserted into the anus), and removal of expired Lantus ([generic name - insulin glargine] a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) Solostar Pen from medication refrigerator, in accordance with manufacturer requirements affecting at least two residents (Resident 34 and 51) in one of two inspected medication rooms (Medication Room). 2. Ensure removal of expired zinc sulfate (a mineral supplement used for wound healing and treat low level of zinc), vitamin D3 (a vitamin used to treat low level of vitamin D) and hydrogen peroxide (a product used as an antiseptic and for wound cleaning) from one of two inspected medication rooms (Central Supply Room). 3 and 4. Ensure storage, labeling and/or removal of expired medications including Fiasp (generic name - insulin aspart), Novolog (generic name - insulin aspart), latanoprost (a medication in form of eye drops used to treat high pressure in the eyes) eye drops, budesonide inhalation solution (a medication used to reduce swelling of airways for better breathing) and Serevent ([Generic name - Salmeterol] a medication used to relax airways for better breathing), in accordance with manufacturer requirement affecting eight residents (Residents 12, 49, 61, 64, 70, 76, 83 and 290) in two of two inspected medication carts (South Medication Cart and North Medication Cart 3). These deficient practices had the potential to result in Residents 12, 34, 49, 51, 61, 64, 70, 76, 83, 290 and other facility residents receiving medications that had become expired, ineffective, or toxic due to improper storage or labeling possibly leading to health complications such as hyperglycemia (high blood glucose [simple sugar- the body's primary source of energy from food]), trouble breathing, eye complications and hospitalization . Findings: 1.During a concurrent inspection and interview on 12/17/2024 at 12:13 p.m. with Licensed Vocational Nurse (LVN) 2 of the Medication Room, the following medications were found either expired or stored in a manner contrary to their respective manufacturer's requirements: 1a. 25 Bisacodyl Suppositories 10 milligrams (mg - a unit of measure for mass) found in the freezer of medication refrigerator with the refrigerator temperature at 42-degree Fahrenheit [(F) is a unit of temperature] labeled with pharmacy label that indicated house stock. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the manufacturer's product labeling, bisacodyl suppositories should be stored at room temperature at 15-to-30 degree Celsius [(C) is a unit of temperature] (59-to-86-degree Fahrenheit (F), not to exceed 30 C (86 F). LVN 2 stated they did not have a method to monitor freezer temperatures and bisacodyl suppositories were not stored according to manufacturer requirements. LVN 2 stated bisacodyl suppositories would not be safe and effective to use for residents. 1b. One sealed bottle of Brimonidine tartrate ophthalmic solution 0.2% 5 milliliters (mL - a unit of measurement for volume) for Resident 34 stored at 42 F in medication refrigerator. According to the manufacturer's product labeling, Brimonidine should be stored at 15 C to 25 C or 59 F to 77 F. LVN 2 stated the brimonidine eye drops for Resident 34 should not have been stored in the refrigerator. LVN 2 stated there would be a risk for eye redness, irritation, and worsening of eye condition if administered to Resident 34 as they would not be safe or effective to use due to improper storage. 1c. One opened Lantus Solostar pen for Resident 51 that indicated date of 7/28 and stored at 42 F in medication refrigerator. According to the manufacturer's product labeling, unopened / not in-use pen if stored at room temperature (a below 86 F [30 C]) and opened / in-use pen must be used within 28 days. LVN 2 stated the Lantus Solostar for Resident 51 indicated opened date as 7/28/2024 and should have been discarded within 28 days after opening. LVN 2 stated Lantus Solostar had expired and would not be safe and effective if administered to Resident 51. LVN 2 stated there was a risk for Resident 51 to experience high blood glucose that could lead to hospitalization . 2. During a concurrent inspection and interview on 12/17/2024 at 1:38 p.m. with LVN 3 of the Central Supply Room, the following medication and products were expired: 2a. One sealed box of zinc sulfate 220 mg, quantity of 100 with an expiration date of 02/2024. 2b. One sealed bottle of hydrogen peroxide 3% 473 mL with an expiration date of 06/2022. 2c. Two sealed bottles of vitamin D3 125 microgram (mcg - a unit of measure for mass) 5000 international units (IU - a unit of measure for mass), quantity of 200 each, with expiration dates of 11/2024 on each bottle. 2d. One open bottle of vitamin D3 50,000 IU with an expiration date of 03/2020. LVN 3 stated these products should have been discarded and disposed because they were expired. LVN 3 stated these products would not be safe and effective to administer or use for facility residents. LVN 3 stated there was a potential for side effects to residents such as inadequate wound healing, nausea, vomiting and other health complications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent inspection and interview on 12/17/2024 at 2:40 p.m. with LVN 2 of the South Medication Cart, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 3a. One open vial of Fiasp 100 units/mL for Resident 290 with no opened date. According to the manufacturer's product labeling, unopened / not in-use Fiasp vial should be stored between 2 to 8 C (36 to 46 F) in a refrigerator, and opened / in-use vial, stored at room temperature (a below 86 F [30 C]) must be used within 28 days. 3b. One open vial of insulin aspart 100 units/mL for Resident 83 with no opened date. According to the manufacturer's product labeling, unopened / not in-use insulin aspart vial should be stored between 2 to 8 C (36 to 46 F) in a refrigerator, and opened / in-use vial, stored at room temperature (a below 86 F [30 C]) must be used within 28 days. 3c. One open vial of Novolog 100 units/mL for Resident 76 labeled with open date of 9/14. According to the manufacturer's product labeling, unopened / not in-use Novolog vial should be stored between 2 to 8 C (36 to 46 F) in a refrigerator, and opened / in-use vial, stored at room temperature (a below 86 F [30 C]) must be used within 28 days. Resident 76's Novolog expired on 10/12/2024. LVN 2 stated the expired insulin should have been removed from the medication cart to prevent medication errors. LVN 2 stated there was a risk for residents to receive the expired insulin which would increase the risk for high blood glucose. 3d. One bottle of latanoprost eye drops 0.005% for Resident 64 with no opened date. 3e. One bottle of latanoprost eye drops 0.005% for Resident 12 with opened date of 9/12/2024. Resident 12's latanoprost eye drops expired on 10/24/2024. 3f. One bottle of latanoprost eye drops 0.005% for Resident 49 with opened date of 10/11/2024. Resident 49's latanoprost eye drops expired on 11/22/2024. According to the manufacturer's product labeling, unopened bottle(s) should be stored under refrigeration at 2 C to 8 C (36 F to 46 F) and open or in-use bottle should be stored at room temperature up to 25 C (77 F) for six weeks. LVN 2 stated latanoprost eye drops were supposed to be labeled with an open date to be able to determine expiration date and should have been removed from the medication cart once they had expired. LVN 2 stated there was a risk for eye complications if expired and unlabeled latanoprost were administered to Resident 64, 12 and 49. 4. During a concurrent inspection and interview on 12/18/2024 at 3:01 p.m. with LVN 4 of the North Medication Cart 3, the following medications were found without an open date label as required by their respective manufacturer's specifications (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4a. Five ampules Budesonide 0.5 mg/2 mL inhalation solution for Resident 61 with no opened date on foil package. According to the manufacturer's product labeling, budesonide inhalation suspension ampules should be stored at controlled room temperature 20 C to 25 C (68 F to 77 F). The product labeling indicated when an envelope has been opened, the shelf life for unused is two weeks. LVN 4 stated budesonide for Resident 61 was for breathing and if improperly stored, the medication would lose its potency and not be effective and safe to treat Resident 61 increasing the risk for troubled breathing and hospitalization . 4b. One blister pack of Serevent inhaler for Resident 70 removed from foil pouch with no opened date. According to the manufacturer's product labeling, Serevent inhaler should be discarded six weeks after removal from moisture-protective foil pouch or after all blisters have been used (when the dose indicator reads 0. LVN 4 stated Resident 70's Serevent was not labeled in accordance with manufacturer requirements. LVN 4 stated there was a risk for untreated troubled beathing and hospitalization for adverse reactions if Resident 70 received an expired inhaler. During an interview on 12/19/2024 at 3:08 p.m. with the Director of Nursing (DON), DON stated the medications for facility residents such as bisacodyl suppositories, brimonidine eye drops, latanoprost eye drops, insulin, Serevent and budesonide inhalation solution were not stored in accordance with manufacturer requirements. DON stated there was a risk for untreated constipation, high blood glucose, breathing difficulties, medication errors, side effects, and hospitalization . DON stated the medications such as zinc sulfate, vitamin D and hydrogen peroxide were found expired in the central supply room should have been discarded because they were expired in order to prevent medication errors and health complications for facility residents. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, undated, the P&P indicated, It is the policy of this facility to ensure all medications hosed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure .security. The P&P indicated, Refrigerated Products: temperatures are maintained within 36-46 degrees F The P&P indicated, Unused medications: the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed Unused Drugs Policy. The P&P indicated, Light Protection: All drugs, which require light protection while in storage, remain in the original package, in closed drawers until the time of administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Insulin Labeling, undated, the P&P indicated, The facility shall ensure that all insulin vials, pens, and cartridges are properly labeled to maintain safety, prevent medication errors, and comply with regulatory requirements. The P&P indicated, Facility Labeling Upon Opening: once opened, insulin vials, pens, or cartridges, must be labeled with: The date opened. For multi-dose vials, follow the facility's policy for beyond-use dates (typically 28 days unless otherwise specified by the manufacturer). Storage of Labeled Insulin: opened insulin must be separated from unopened stock and clearly labeled to avoid confusion. During a review of the facility's P&P titled, Expired Medications, undated, the P&P indicated, The facility shall ensure that all expired medications are promptly identified, removed from use, and properly disposed of in accordance with state and federal regulations to maintain resident safety and compliance with applicable laws.

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	056313	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure the food in the refrigerator are not outdated when: a. chicken stored in the refrigerator in a clear plastic container with a cracked lid dated [DATE], b. seasoned hash brown potatoes stored in the refrigerator with an expiration date of [DATE], c. potato salad stored in the refrigerator with an expiration date of [DATE], d. macaroni salad stored in the refrigerator with an expiration date of [DATE], e. tomatoes stored in the refrigerator a plastic container covered with plastic wrap dated [DATE], f. bread stored in the refrigerator in a plastic container covered with foil dated [DATE], g. lettuce stored in the refrigerator in a plastic container covered with plastic wrap dated [DATE] and h. freezer burned meat stored in the freezer were discarded. These failures have the potential to result in residents being exposed to food borne illnesses, any illness resulting from food spoilage or contaminated food and eating compromised quality of meat due to dryness and altered texture. Findings: During an observation on [DATE] at 8:32 am in the kitchen refrigerator, there was chicken stored in a plastic container dated [DATE], seasoned hash brown potatoes dated [DATE], potato salad dated [DATE] , macaroni salad dated [DATE], tomatoes dated [DATE], bread dated [DATE], lettuce dated [DATE] and freezer burned meat stored in the freezer. During a concurrent observation and interview on [DATE] at 8:43 am with, [NAME] (1), [NAME] (1) [NAME] (1) stated the dated tomatoes, bread and lettuce is only good for three days. [NAME] 1 stated food in the refrigerator are dated so we know when it is good or not. During a concurrent observation interview on [DATE] 9:37 am with Dietary Manager (DM), there was chicken stored in a plastic container dated [DATE], seasoned hash brown potatoes dated [DATE], potato salad dated [DATE] macaroni salad dated [DATE], tomatoes dated [DATE], bread dated [DATE], lettuce dated [DATE] and freezer burned meat. DM stated the food is outdated and should not be stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:16 am with DM, DM stated the food is labeled the dated when it's opened, and the kitchen staff follow the expiration dates and discard food if it is expired. DM further addeduse by date means the date, we have to use the food by. DM stated it is important to discard expired food to prevent food borne illnesses. During an interview on [DATE] at 1:34 pm with the Director of Nursing (DON), DON stated the residents can get food poisoning and stomach sickness if they eat expired food. DON stated food with freezer burns is not acceptable to taste and is advisable to throw away. During a review of the facility's policy and procedures (P&P) titled, Storage Of Food And Supplies, dated 2018, the P&P indicated, No food will be kept longer than the expiration date on the product .Do not store bread in the refrigerator .Food in unlabeled rusty, leaking broken containers or cans with side seams dents, rims dents or swells shall not be retained or used. During a review of the facility's policy and procedures (P&P) titled, Procedure for Refrigerator Storage, dated 2020, the P&P indicated, Food that has been freezer burned must be discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36943 Based on observation, interview, and record review, the facility failed to ensure the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) treatment records for one of nine sample residents (Resident 12) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) was complete for the month of 10/2024. This failure resulted in incomplete RNA records for the provision of passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) for Resident 12. Findings: During a review of Resident 12's Admission Record, the facility admitted Resident 12 on 8/22/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities), and rhabdomyolysis (condition where muscle cells break down and release their contents into the bloodstream). During a review of Resident 12's physician orders, dated 8/28/2024, the physician's order indicated for the RNA to provide PROM to the left leg, five times per week as tolerated. Another physician's order, dated 8/28/2024, indicated for the RNA to provide PROM to the right leg, five times per week as tolerated. During a review of Resident 12's RNA treatment record, dated 10/2024, the RNA treatment record included Restorative Nursing Aide 2's (RNA 2) initials for providing PROM to the left leg, five times per week as tolerated. Resident 12's RNA treatment record was blank (no initials) for RNA to provide PROM to the right leg. During a review of Resident 12's Minimum Data Set ([MDS] a resident assessment tool), dated 12/2/2024, the MDS indicated Resident 12 had clear speech and was significantly impaired for cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 12 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, toileting, bathing, dressing, and rolling to both side while lying in bed. During an observation on 12/19/2024 at 9:53 a.m. with Restorative Nursing Aide 2 (RNA 2) in Resident 12's room, Resident 12 was lying in bed with both hips and knees bent. Both of Resident 12's hips were rotated to the right side. RNA 2 performed PROM to the left hip, knee, and ankle. RNA 2 attempted to perform PROM to the right leg but Resident 12 refused the PROM exercises. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/20/2024 at 10:34 a.m. with RNA 2, Resident 12's RNA treatment record, dated 10/2024, was reviewed. RNA 2 stated she provided PROM to the right leg but did not initial on the RNA treatment record for the entire month. During a concurrent interview and record review on 12/20/2024 at 10:35 a.m. with the Director of Medical Records (DMR), Resident 12's RNA treatment record, dated 10/2024, was reviewed. The DMR stated Resident 12's RNA treatment record was incomplete since the RNA treatment record was blank for the provision of PROM to the right leg for 10/2024. The DMR stated Resident 12 could potentially develop contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) if the RNA treatment record did not indicate the RNA provided PROM to the right leg. During an interview on 12/20/2024at 1:47 p.m. with the Director of Nursing (DON), the DON stated a resident's medical record (in general) was the record of care providing to the resident. The DON stated the facility's Medical Record departments was supposed to check the resident's medical records for accuracy. The DON stated the facility could miss treatments or care provided to residents if the medical record was not accurate. During a review of the facility's undated Policy and Procedure (P&P) titled, Charting and Documentation, the P&P indicated all services provided to the resident shall be documented in the resident's medical record.

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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** 36943 49130 49145 Based on observation, interview, and record review, the facility failed to maintain infection control practices for four of six sampled residents (Resident 20, 27, 54, and 73) by failing to: 1) Ensure the humidifier was changed for Resident 73. 2) Ensure staff wore appropriate Personal Protective Equipment ([PPE] clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment) while providing passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises and applying splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to Resident 20, who had Enhanced Barrier Precautions ([EBP] an approach of targeted gown and glove use during high contact care activities to reduce transmission of infections). 3) Ensure facility staff implemented infection prevention and hand hygiene precautions before administering eye drops to Residents 27 and 54. These failures had the potential to result in the transmission of infectious microorganisms and increase the risk of infection for Residents 20, 27, 54, and 73. Findings: 1.During a review of Resident 73's Admission Record, the Admission Record indicated Resident 73 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease ({COPD}- a chronic lung disease causing difficulty in breathing) and cardiomegaly (heart is larger than normal). During a review of Resident 73's Minimum Data Set ({MDS}- resident assessment tool), dated 11/18/2024, the MDS indicated Resident 73 had moderate cognitive impairment (a noticeable decline in thinking abilities, problem-solving, and judgment). The MDS indicated Resident 73 required partial/moderate assistance (helper does less than half the effort) with toileting, dressing, and transferring. During a concurrent observation and interview on 12/17/2024 at 9:53 a.m., in Resident 73's room, Licensed Vocational Nurse (LVN) 5 stated Resident 73's humidifier was dated 12/8/2024. LVN 5 stated the humidifier should be changed weekly. During an interview on 12/17/2024 at 9:58 a.m. with LVN 2, LVN 2 stated its important to change the humidifier to prevent the resident from getting an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 8:41 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the treatment nurse is responsible for changing the humidifier every Sunday because if the water dries up, it can dry up the resident's nostrils and for infection prevention. During an interview on 12/19/2024 at 3:27 p.m. with the Infection Prevention Nurse (IPN), the IPN stated it's important to change the residents humidifier because if it is not changed, bacteria can form, and the resident could potentially be hospitalized for an infection. During an interview on 12/20/2024 at 1:23 p.m. with the Director of Nursing (DON), the DON stated if the humidifiers are not changed weekly, it could cause an infection for the resident. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Equipment, undated, the P&P indicated, Resident-care equipment is categorized based on the degree of risk for infection involved in the use of the equipment. Semi-critical items are exposed to mucous membranes (i. e. respiratory therapy equipment) or non-intact skin. During a review of the facility's P&P titled, Oxygen Administration, undated, the P&P indicated, Other infection control measures include: change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. 2. b. During a review of Resident 20's Admission Record, the facility admitted Resident 20 on 9/5/2023 with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), parkinsonism (group of conditions with symptoms including slow movements, stiffness, tremors, and balance issues), and attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). During a review of Resident 20's physician orders, dated 9/6/2023 and revised 11/18/2024, the physician's orders indicated a RNA program to provide exercises (unspecified) to both arms, apply both hand rolls or rolled washcloth for five hours, and provide passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) to both legs followed by application of both ankle splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for two hours, five times per week. During an observation on 12/19/2024 at 9:00 a.m. with RNA 1, Resident 20's RNA session was observed. An orange sign titled, Enhanced Barrier Precautions, was observed posted on the wall next to the doorway prior to entering Resident 20's room. The back of the EBP sign indicated Resident 20 was on EBP. RNA 1, who was already wearing a face mask, was observed washing hands and wearing disposable gloves prior to providing PROM to Resident 20's hips and shoulders. RNA 1 placed a rolled hand towel in Resident 20's hands and applied both ankle splints. RNA 1 did not wear a protective gown while providing Resident 20 with PROM exercises and applying the splints. During an interview on 12/19/2024 at 9:32 a.m. with RNA 1, RNA 1 stated Resident 20 was on EBP due to having a G-tube. RNA 1 stated EBP meant staff had to wear a face mask, gloves, and gown while providing care to Resident 20. RNA 1 stated wearing the gown was optional since Resident 20 did not have an active infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 3:28 p.m. with the IPN, the IPN stated residents with any bodily openings, including but not limited to G-tubes, wounds, urinary catheters (a hollow tube inserted into the bladder to drain or collect urine), and surgical sites were on EBP to prevent infections. The IPN stated the facility staff was supposed to perform hand hygiene (washing hands or rubbing hands with an alcohol-based hand sanitizer), wear gloves, and wear a protective gown while providing high contact activities with residents on EBP. The IPN stated performing ROM exercises with a resident on EBP was considered a high contact activity, requiring the use of gloves and a gown. During an interview on 12/20/2024 at 1:47 p.m. with the DON, the DON stated staff was supposed to wear a face mask, glove, and gown when providing care to residents on EBP to prevent infection. During a review of the facility's undated Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, the P&P indicated EBP referred to the use of gown and gloves for use during high-contact resident care activities known to be infected with a multidrug-resistant organism ([MDRO] germ resistant to many antibiotics) and those at increased risk of acquiring MDROs. The P&P indicated residents with wounds and indwelling devices, such as G-tubes, should be on EBP even if the resident was not known to be infected with a MDRO. 3. During a review of Resident 27's Admission Record, dated 12/18/2024, the facility originally admitted Resident 27 on 11/8/2019 and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), hypotension (low blood pressure) and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 27's Order Summary Report (a document containing a summary of all active physician orders), dated 12/19/2024, the order summary report indicated: Artificial Tears (eye drops solution used to relieve burning and irritation in eyes due to dry eyes) Ophthalmic (eye) Solution 1%, instill 1 drop in both eyes three times a day for dry eyes, order date 4/10/2023, start date 10/8/2024. During an observation of medication administration on 12/18/2024 at 8:45 a.m. in Resident 27's room with LVN 1, LVN 1 administered the list of prepared medications below to Resident 27. LVN 1 used a hand sanitizer and wore gloves before entering Resident 27's room. LVN 1 administered oral medications first to Resident 27. LVN 1 was observed touching bedside cart, medication tray, medicine cups and other resident care areas. LVN 1 did not wash hands, perform hand hygiene and/or change gloves prior to administering Artificial Tears eye drops to Resident 27. During a review of Resident 54's Admission Record, dated 12/18/2024, the facility originally admitted Resident 54 on 3/24/2022 and readmitted Resident 54 on 9/18/2024 with diagnoses including hypertensive (a condition described as high blood pressure) heart disease without heart failure (a condition when heart cannot pump enough blood and oxygen to the body's organs) and Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication. (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 Resident 54's Order Summary Report, dated 12/19/2024, the order summary report indicated: Artificial Tears Ophthalmic Solution, instill 1 drop in both eyes two times a day for dry eyes, order date 10/1/2024, start date 10/8/2024 During an observation of medication administration on 12/18/2024 at 9:10 a.m. in Resident 54's room with LVN 1, LVN 1 administered the following prepared medications to Resident 54 while the resident was sitting in her wheelchair. LVN 1 wore gloves before administering oral medications. LVN 1 was observed touching bedside cart, medication tray, medicine cups and other resident care areas. After administering oral medications to Resident 54, LVN 1 administered Artificial Tears eye drops to Resident 54 without performing hand hygiene. 1. One drop of Artificial tears in both eyes During an interview on 12/18/2024 at 12:21 p.m. with LVN 1, LVN 1 stated she should have washed hands before and after administration of artificial tears eye drops to Residents 27 and 54. LVN 1 stated although she washed her hands before starting medication pass, it was important to wash hands as well as change gloves before administering eye drops to prevent infection in eyes. During an interview on 12/19/2024 at 3:39 p.m. with the DON, the DON stated facility staff should wash hands before and after administering eye drops to prevent infection. During a review of the facility's P&P titled, Medication Administration - Eye Drops, dated 5/2016, the P&P indicated, To administer solution into eye in a safe and accurate manner.Procedures: Refer to Section Medication Administration .Perform hand hygiene. During a review of the facility's P&P titled, Handwashing During Medication Administration, undated, the P&P indicated, The facility requires all staff involved in medication administration to adhere to strict hand hygiene practices before, during, and after the process to prevent contamination and ensure resident safety. The P&P indicated, When to perform Handwashing: Before Medication Administration: Wash hands before preparing or administering any medications. Wash hands before touching a resident or any equipment involved in the medication process. After Medication Administration: Wash hands immediately after medication administration for a resident. Wash hands after removing gloves or handling used medication packaging or equipment. The P&P indicated, gloves are not a substitute for hand hygiene. Wash hands before donning gloves and after removing them.