STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056316	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue Pasadena, CA 91103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview and record review, the facility failed to treat the resident with respect and dignity and maintain privacy for one (1) of 17 sampled residents (Resident 37) in accordance with the facility policy. This deficient practice had the potential to negatively affect Resident 37's self-worth, self-esteem and psychosocial (pertaining to the influence of social factors on an individual's mind or behavior) well-being. Findings: During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia [a thin, fibrous connective tissue that surrounds and supports all the structures in the body, including muscles, organs, bones, and nerves], muscle, tendon, ligament, cartilage or bone in the ulcer. Slough [moist, yellow or white, and stringy or thick necrotic tissue] and/or eschar [dry, hard, leathery, and often black or brown necrotic tissue] may be visible on some parts of the wound bed. epibole [rolled edges], undermining [tissue destruction beneath the wound edges, creating a pocket-like space] and/or tunneling [a narrow, track-like passageway extending from the wound into deeper tissues] often occur. Depth varies by anatomical location) of the sacral region sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]. During a review of Resident 37's Minimum Data Set (MDS- resident assessment tool) dated 1/31/2025, the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 37's undated care plan (CP), Resident 37 has limited physical mobility related to weakness, intervention indicated, provide privacy and dignity during care at all times. During an observation in Resident 37's room on 3/4/2025 at 9:42 AM, Certified Nursing Assistant 3 (CNA 3) was observed performing sponge bath (a bath in which someone or something is not placed in water but is cleaned with a wet, soapy sponge or cloth) to Resident 37. Resident 37 was laying naked on the bed with the privacy curtain (used in healthcare setting is a curtain/ dividing cloth that provides private enclosure for residents ensuring confidentiality and a comfortable environment) opened. Resident 37 was visible to the resident's roommate on the right side (Bed B) and the resident's door was left open. During an interview with CNA 3 on 3/5/2025 at 2:37 PM, CNA 3 stated, CNA 3 forgot to close Resident 37's privacy curtain all the way to cover Resident 37 during bed bath when the CNA 3 was proving care for the resident today around 9:42 AM. CNA 3 stated the curtain must be closed to all the way, because we have to respect the Resident 37's privacy and dignity During a review of the facility's Policy & Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated staff will promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to ensure one of 17 sampled residents (Residents 12) were given sufficient notice prior to the last coverage day for Medicare Part A (hospital insurance) services. This deficient practice had the potential to cause stress to the residents and not be able to make adequate arrangements for charges that may incur. Findings: During a review of Resident 12's Admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone). During a review of Resident 12's Minimum Data Set (MDS- resident assessment tool), dated 1/9/2025, indicated Resident 12's cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was moderately impaired. The MDS indicated Resident 12 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of Resident 12's Notice of Medicare Non-coverage (NOMNC- a notice that indicates when your care is set to end from skill nursing facility [SNF].) dated 11/29/2024 indicated that the effective date coverage of the current services would end on 12/2/2024. The NOMNC did not indicate Resident 12's or the resident's representative's signature. During a review of Resident 12's Skilled Nursing Facility Advance Beneficiary Notice, a Centers for Medicare & Medicaid Services (CMS) form regarding the Medicare Part A services (SNFABN) dated on 11/29/2024, indicated that the resident would be responsible for out-of-pocket care if they did not have other insurance that would cover the costs beginning on 12/3/2024. The form did not indicate an estimated cost and signature of Resident 12 or the resident's authorized representative was left blank. During an interview and review Resident 12's SNFABN with the Social Services Director (SSD) and the Business Office Manager (BOM) on 3/7/2025 at 12:09 PM, Resident 12's SNFABN dated 11/29/2024 was reviewed. the BOM stated she did not know that she had to complete the SNFABN to include the estimated cost. The BOM also stated that Resident 12's NOMNC was not signed and there was the SSD's documentation indicating the SNFABN was sent via phone to resident's representative. The BOM stated that the resident or resident's representative would be notified in writing why the services may not be covered. The BOM stated that it was not facility's practice to send SNFABN via phone. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated Policy and Procedure (P&P) titled, Medicare Advance Beneficiary Notice, indicated that upon admission or during the resident's stay, Medicare (Part A of the fee for Service Medicare Program) will not pay for an otherwise covered skilled services, the resident (or representative) is notified in writing why the services may not be covered and of the resident's potential liability for payment of the non-covered services. The P&P indicated if the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Service (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons) A review of the facility's adopted guideline titled, Form Instructions SNFABN Form CMS-1055 (2018), indicated that the facility must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). Under the Estimated Cost section, the facility should enter an estimated total cost or a daily, per item, or per service cost estimate. The guideline also indicated the facility must make a good faith effort to insert a reasonable cost estimate for the care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) for one of 17 sampled residents (Resident 219) when Resident 219's medical records were left exposed by leaving the computer unattended and not turning off the computer screen on 3/5/2025. This deficient practice violated Resident 219's right to privacy and confidentiality. Findings: During a review of Resident 219's Admission Record, the Admission Record indicated Resident 219 was admitted to the facility on [DATE] with diagnoses that included sepsis (a life-threatening blood infection), degeneration of nervous system due to alcohol (damage to the nerves and brain caused by too much alcohol consumption, potentially leading to memory loss and motor skill difficulties), and essential hypertension (HTN- high blood pressure). During a review of Resident 219's Admission Assessment, dated 3/4/2025, the Admission Assessment indicated Resident 219 was alert and oriented to person, place, time, and situation. Resident 219 was verbally appropriate (words spoken in a way that is suitable, respectful, and effective for the context, audience, and purpose of the communication) and able to make needs known. During a concurrent observation in the Nurse Station 1 (NS 1), and interview on 3/5/2025, at 8:53 AM, with Registered Nurse Supervisor 1 (RNS 1), Computer 1 (COM 1) was observed unattended with Resident 219's information on the computer screen. RNS 1 stated she did not know who left the computer screen on. RNS 1 stated the computer screen should not have been left on exposing resident's medical records and unattended. During an interview with Minimum Data Set Nurse 1 (MDSN 1), on 3/6/2025, at 9:47 AM, MDSN 1 stated Resident 219's records are confidential (intended for or restricted to the use of a particular person or group) and anyone in the facility would be able to read and/ or access Resident 219's medical records if the computer was left on and unattended. MDSN 1 stated, facility staff are required to turn off or log out (to disconnect or stop using the computer system or program so no other individual can access it) of the computer before walking away from the computer. During an interview with the Director of Nursing (DON) on 3/7/2025, at 12:29 PM, the DON stated Resident 219's medical records were confidential. The DON stated anyone could access Resident 219's information if the computer screen is left on and unattended. The DON stated facility staff need to log off the computer or turn off the screen before walking away from the computer. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled, Confidentiality of Information and Personal Privacy, revised on 10/2017, the P&P indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The P&P indicated access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45456 Based on observation, interview and record review, the facility failed to provide a safe, clean, and homelike environment for two (2) of 17 sampled residents (Resident 36 and 37) when facility failed to: 1. Ensure Resident 36 and Resident 37's room did not have used gloves left on the floor. 2. Ensure Resident 36 and Resident 37's trashcan in the room was not overflowing with used disposable gowns. These deficient practices resulted in unsanitary conditions placing Resident 36 and 37 at risk for infection and uncomfortable living. Findings 1. a) During a review of Resident 36's Admission Record, the Admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE], chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), traumatic brain injury (results from a violent blow or jolt to the head) and pneumonia (a lung infection). During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool) dated 1/31/2025, the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. 1. b) During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE], chronic respiratory failure, quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and Stage 4 pressure ulcer of the sacral region sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]) During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 37 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. During an observation on 3/5/2025 at 2:25 PM inside Resident 36 and 37's room, the small trashcan in the room was overflowing with a used gown, and used glove on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/5/2025 at 2:31 PM with Housekeeping Manager (HKM) inside Resident 36 and 37's room, HKM stated it was not appropriate to have resident's trashcan overflowing. HKM stated that staff should dispose used items, such as gown and gloves, properly for infection control. During an interview on 3/7/2025 at 11:18 AM with Infection Prevention Nurse (IPN), IPN stated the staff should not use the small trashcan in the residents' room, and should use the bigger trash can with a lid for proper disposal of used Personal Protective Equipment (PPE, is specialized clothing or equipment worn by an employee for protection against infectious materials, such as gowns, gloves, masks, and goggles). IPN stated if the staff were not disposing the PPE properly, they can spread germs or bacteria that was attached onto the PPE, and could potentially transfer germs/bacteria to the residents in the room. During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, revised 8/2019, the P&P indicated, Housekeeping Surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. During a review of the facility's P&P titled, Homelike Environment, revised 2/2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. The characteristics include a) clean, sanitary, and orderly environment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview and record review the facility failed to ensure that two (2) out of 4 sampled residents (Resident 28 and 49) were reviewed for the use of physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to his body) by failing to: 1. Document the monitoring of Resident 28's hand mittens (a soft, padded glove-like device used to prevent patients from pulling out medical lines or tubes, or from self-harm, when they are restless, confused, or unaware of the need to keep tubes in place) every 2 hours according to the physician's orders dated 1/18/2025. 2. Implement Physician orders to release Resident 28's hand mitten every 2 hours to check for skin integrity (state of the skin and its ability to function properly) and circulation (the continuous movement of blood throughout the body). 3. Document the monitoring of Resident 49's hand mittens and soft elbow splint (a medical device used to prevent of limit elbow flexion [bending] while allowing some arm movement, typically made of soft, padded materials, and secured with straps or Velcro) every 2 hours and re-apply after 15 minutes to check for skin integrity (state of the skin and its ability to function properly) and circulation (the continuous movement of blood throughout the body) according to physician ordered dated 11/24/2024. 4. Implement Physician orders to release Resident 49's hand mitten and soft elbow splint every 2 hours to check for skin integrity and circulation This deficient practice had the potential for Resident 28 and 49 to not be monitored adequately and inhibiting the freedom of movement while using physical restraints. Findings: 1. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis of chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), seizure (a sudden, uncontrolled burst of electrical activity in the brain) and quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool) dated 1/24/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 28 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 28's physician's order dated 1/18/2025, the physician's orders indicated, Bilateral hand mittens secondary to pulling out invasive tubing. Release every 2 hours and reapply after 15 minutes to check for skin integrity and circulation every shift. During an observation on 3/4/2025 at 9:08 AM, in Resident 28's room, Resident 28 was observed lying in bed and wearing bilateral hand mittens (cover the hands to prevent pulling out any lines or tubes that are being used to give them medication, fluids or nutrition). During a concurrent interview and record review on 3/6/2025 at 2:15 PM, with Registered Nurse 3, Resident 28's physician's order dated 1/18/2025 was reviewed. The physician's order indicated Bilateral hand mitten secondary to pulling out invasive tubing's. Release every 2 hours and reapply after 15 minutes to check for skin integrity and circulation every shift. RNS 3 stated, the charge nurses were the ones to releases the hand mittens and wait 15 minutes to watch Resident 28, because Resident 28 pulls the tube for the ventilator (a type of breathing apparatus), and gastrotomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach). The staff should be charting the release time in the MAR by the nurses. During a concurrent interview and record review on 3/6/2025 at 2:17 PM, with RNS 3, Resident 28's informed consent dated 1/18/2025 was reviewed. The informed consent did not indicate the following information: 1. Resident or Resident's Responsible party information. 2. Date when the medical provider signed the consent. 3. Resident or Resident's Responsible party signature 4. Verification that consent was obtained via verbal, person, telephone, fax or email RNS 3 stated the informed consent was incomplete since there was no date indicated of when the physician signed the consent form RNS 3 stated ff a consent was obtained via telephone, 2 nurses were required to sign and date the consent form. RNS 3 stated there was no indication on the consent form indicating when which responsible party (RP) was notified, when the RP was notified, and which RP consented for Resident 28's bilateral hand mittens. During a concurrent interview and record review on 3/6/2025 at 2:20 PM, with RNS 3, Resident 28's informed consent dated 1/18/2025 was reviewed. RNS 3 stated the informed consent was incomplete since the consent did not indicate the resident/RP information, the date the physician signed the consent, a signature from the resident/RP, and did not indicate how the consent form was obtained (verbal, fax, in person, phone or electronic mail). RNS 3 stated, the consent form was incomplete. RNS 3 stated if the informed consent was incomplete, it means it is not valid and we do not have informed consent for the use of hand mittens for Resident 28. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/6/2025 at 2:24 PM, with Registered Nurse 1 (RN 1), Resident 28's Medication Administration Record (MAR) dated 3/1//2025-3/6/2025 was reviewed. RN 1 stated, the physician's order was not transferred correctly in the MAR, there was no other form of documentation for monitoring the use of hand mittens for Resident 28. But we are aware about the release of Resident 28's hand mittens, we follow the doctor's order to release it. We do it visually, we just do not document. During a concurrent interview and record review on 3/7/2025 at 2:24PM, with Minimum Data Set Nurse 1 (MDSN 1), Resident 28's informed consent dated 1/18/2025 was reviewed. MDSN 1 stated the informed consent for Resident 28's hand mittens were incomplete. MDSN 1 stated incomplete consent forms indicated there was no consent for using the hand mittens for Resident 28. During a concurrent interview and record review on 3/7/2025 at 12:31 PM, with MDSN 1, Resident 28's MAR dated 1/1/2025-1/31/2025 was reviewed. MDSN 1 stated the nursing staff were only documenting the hand mittens monitoring every shift and not every 2 hours as ordered. MDSN 1 stated, Resident 28's hand mittens should be documented in the MAR for the nurses to monitor and that the MAR was the only place for licensed nurses to document Resident 28's hand mitten monitoring. During a concurrent interview and record review on 3/7/2025 at 12:37 PM, with MDSN 1, Resident 28's MAR dated 2/1/2025-2/28/2025 was reviewed. MDSN 1 stated, the nurses documented every shift and not every 2 hours in the MAR as indicated on Resident 28's physician orders. MDSN 1 stated there was no way to know if Resident 28's hand mittens were released every 2 hours because it was not documented in the MAR. During a concurrent interview and record review on 3/7/2025 at 12:38 PM, with MDSN 1, Resident 28's MAR dated 3/1//2025-3/6/2025 was reviewed. Resident 28's MAR indicated nurses did not document that Resident 28's hand mittens were release every 2 hours. MDSN 1 stated, we should have document in the MAR that Resident 28's hand mittens were released every 2 hours. If there was no documentation, it means it was not done. During a concurrent interview and record review on 3/7/2025 at 12:43 PM with MDSN, the facility's Policy and Procedure (P&P) titled Physical Restraint Application revised 10/2010 were reviewed. The P&P indicated, document each time the device is released for resident exercise, toileting, and position change. MDSN stated, we did not follow the hand mitten monitoring documentation based on the policy. During a review of the facility's Policy and Procedure (P&P) titled, Physical Restraint Application revised 10/2010, the P&P indicated, the following information should be recorded in the resident's medical record: 1. The date and time the restraint was applied. 5. The length of time the restraint will be used. 6. Each time the device is released for Resident exercise, toileting, and position change. 7. Each time the resident is monitored, facility policy. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. All assessment data (e.g., bruises, rashes, sores, etc.) observed during the procedure. During a review of the undated facility's P&P titled, Informed Consent Policy, the P&P indicated, all consents must be properly documented, including the date and signatures of the resident or their representative, and the healthcare provider. If a resident lacks capacity, a legally authorized representative (e.g., guardian, conservator, or health proxy) can make decisions on their behalf. Procedures for Obtaining Informed Consent indicated under Documentation to obtain the resident's signature or the signature of their authorized representative on the consent form, along with the date and signatures of witnesses. The P&P indicated under Ongoing Review to regularly review the consent to ensure it remains valid and appropriate. 46919 2. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic respiratory failure, anemia (a condition where the body does not have enough health red blood cells), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 was assessed having severely impaired (never/rarely made decisions) cognitive skills for daily decision making. Resident 49 was dependent with oral hygiene, shoer/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 49 was dependent with sit to lying, chair/bed-to-chair transfer, and tub/shower transfer. During a review of Resident 49's physician's order dated 11/24/2024, the physician's order indicated an order for left hand mitten secondary to pulling out invasive lines/tracheostomy tubes (a curved tube inserted into a surgically created opening in the windpipe to maintain an open airway an facilitate breathing) or G-tube, release every two hours and reapply after 15 minutes to check for skin integrity and circulation. During a review of Resident 49's physician's order dated 11/24/2024, the physician's order indicated an order for left soft elbow splint secondary to pulling out invasive lines/tracheostomy tube, release every two hours and reapply after 15 minutes to check for skin integrity and circulation. During a review of Resident 49's care plan, dated 11/24/2024, the care plan indicated Resident 49 had a hand mitten on the left hand due to risk for injury secondary to tendency to pull out life sustaining tubes tracheostomy tube, G-tube, trach tie). Resident 49's care plan intervention included to assess for proper placement and adequate circulation of upper extremities during care time and to assess skin condition during care and notify physician for any skin condition or breakdown. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's care plan, dated 11/24/2024, the care plan indicated Resident 49 uses physical restraints left soft elbow secondary to pulling out invasive lines/tracheostomy tube. Resident 49's care plan intervention included to monitor/document/report as needed (PRN) any changes regarding effectiveness of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in activities of daily living (adl- basic self-care tasks essential for daily life such as bathing, dressing, eating, toileting) self-performance, decline in cognitive ability or communication, contracture (fixed tightening of muscle, tendons, ligaments, or skin) formation, skin breakdown, signs and symptoms (s/sx) of delirium (confused thinking and a lack of awareness of someone's surroundings, falls/accidents/injuries, agitation, weakness. During an observation on 3/4/2025 at 11:28 AM, in Resident 49's room, Resident 49 was observed asleep in bed. Resident 49 had a hand mitten on his left hand and a soft elbow splint on his left arm. During an interview on 3/5/2025 at 9:34 AM, with Registered Nurse Supervisor 3 (RNS 3), RNS 3 stated Resident 49 had a left hand mitten and left arm soft elbow splint to prevent him from pulling his tracheostomy tube. During a concurrent interview and record review on 3/6/2025 at 2:08 PM, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated it was important that Resident 49's left soft elbow splint and left hand mitten restraints were released every 2 hours to check Resident 49's arm circulation and skin integrity. LVN 4 stated she released Resident 49's left elbow splint and hand mitten during her shift, but did not document the removal onto the MAR. LVN 4 stated there was no documentation in Resident 49's chart or MAR indicating Resident 49's left elbow splint and left hand mitten were released and monitored since 11/24/2024. During an interview on 3/7/2025 at 12:21 PM, the DON stated it was important to monitor Resident 49's left arm for circulation since restraints, such as Resident 49's left elbow splint and left hand mitten can impede the circulation and cause cyanosis (a bluish discoloration of the skin resulting from poor circulation), skin breakdown, and harm. The DON stated the release and reapplication of Resident 49's left soft elbow splint and left hand mitten every two hours, to assess the left arm circulation should be documented in Resident 49's MAR. The DON stated the licensed nurses did not document the monitoring. The DON stated if the release and reapplication of Resident 49's left soft elbow and left hand mitten restraints were documented then it was considered not done. The DON stated Resident 49's physician order for restraint and the facility's policy and procedure (P&P) for use of restraints were not followed. During a review of the facility's P&P, titled, Use of Restraints, revised on 4/2017, the P&P indicated when the use of restraints is indicated, The following safety guidelines shall be implemented and documented while a resident is in restraints: a resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. The P&P further indicated, documentation regarding the use of restraints shall include observation, range of motion and repositioning flow sheets. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled, Physical Restraint Application, revised on 10/2010, the P&P indicated: The following information should be recorded in the resident's medical record: each time the device is released for resident exercise, toileting, and position change; Each time the resident is monitored, per facility policy; and all assessment date (bruises, rashes, sores, etc.) observed during the procedure.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure the assessment entry on the Minimum Data Set (MDS- a resident assessment tool) was accurately documented to reflect the restraint (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to his body) that was used one of four sampled residents (Resident 49) assessed for restraints. This deficient practice had the potential to negatively affect Resident 49's plan of care and deliver of necessary care and services. Findings: During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), anemia (a condition where the body does not have enough health red blood cells), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 49's Minimum Data Set (MDS- a resident assessment tool), dated 2/4/2025, the MDS indicated Resident 49 was assessed having severely impaired (never/rarely made decisions) cognitive skills for daily decision making. Resident 49 was dependent (helper does all of the effort) with oral hygiene, shoer/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 49 was dependent with sit to lying, chair/bed-to-chair transfer, and tub/shower transfer. During a review of Resident 49's Order Summary Report, dated 3/6/2025, the Order Summary Report indicated a physician order, with a start date of 11/24/2024 for left hand mitten secondary to pulling out invasive lines/tracheostomy tubes (a curved tube inserted into a surgically created opening in the windpipe to maintain an open airway an facilitate breathing) or gastrostomy tube (G-tube -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), release every (q) two hours and reapply after 15 minutes to check for skin integrity and circulation. During a review of Resident 49's Order Summary Report, dated 3/6/2025, the Order Summary Report indicated a physician order, with a start date of 11/24/2024 for left soft elbow splint secondary to pulling out invasive lines/tracheostomy tube, release every (q) two hours and reapply after 15 minutes to check for skin integrity and circulation. During an observation on 3/4/2025, at 11:28 AM, in Resident 49's room, Resident 49 was observed asleep in bed. Resident 49 had a left-hand mitten on his left hand and a soft elbow splint on the resident's left arm. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/2025, at 9:34 AM, with Registered Nurse Supervisor 3 (RNS 3), RNS 3 stated Resident 49 wore a left- hand mitten and left arm soft elbow splint to prevent the resident from pulling out the resident's tracheostomy tube. During a concurrent interview and record review on 3/7/2025, at 12:03 PM, with Minimum Data Set Nurse 1 (MDSN 1), Resident 49's MDS, dated [DATE] was reviewed. MDSN 1 stated Resident 49's MDS assessment, dated 2/4/2025, indicated Resident 49 did not use a limb restraint in bed, in chair, of out of bed. MDSN 1 stated Resident 49 was ordered for left hand mitten and left arm soft elbow splint on 11/24/2024. MDSN 1 stated Resident 49's restraints (left hand mitten and left arm soft elbow splint) were not included in the Resident 49's MDS and MDSN1 stated he was not able to include it when he completed Resident 49's MDS on 2/4/2025. MDSN 1 stated it was important to capture Resident 49's well-being including the use of restraints during the assessment and to document it in the resident's MDS to be able to provide the right care to the resident. During an interview on 3/7/2025, at 12:32 PM, with the Director of Nursing (DON), the DON stated the MDS needed to be accurate because it was an assessment of the resident. The DON stated the resident's plan of care was based on the MDS assessment. The DON stated Resident's plan of care will not have a holistic approach if the MDS assessment was inaccurate or incomplete. During a record review of the facility's undated MDS Coordinator Job Description, the Job Description indicated the following essential functions of the MDS Coordinator: Facilitates the accurate completion and timeliness of MDS 3.0/Resident Assessment Instrument (RAI- a standardized comprehensive assessment and care planning process used in long term care facilities to ensure residents receive quality care and maintain their highest level of well-being) process as required by law. Assures that MDS/RAI and all support documentation is an accurate representation of the Resident and meets regulatory requirements. During a record review of the facility's policy and procedure (P&P), titled, Resident Assessments revised on 11/2019, the P&P indicated a comprehensive assessment of every resident's needs is made at intervals designated by Omnibus Budget Reconciliation Act (OBRA-Nursing Home reform Act of 1987) and PPS (a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount) requirements.

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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** 46919 Based on observation, interview, and record review, the facility failed to develop a care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) with individualized approaches for communicating for one of 17 sampled residents (Resident 52). This deficient practice had the potential to result in a delay or lack of delivery of care and services for Resident 52. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), cognitive (mental action or process of acquiring knowledge and understanding) communication deficit (impairment in the ability to communicate), and unspecified bilateral (affecting both sides) hearing loss. During a review of Resident 52's Interdisciplinary Team (IDT- a group of healthcare professionals who work together to help people receive the care they need) Care Conference Record, dated 8/19/2024, the IDT Care Conference Record under Activity: Resident preference and response indicated Resident 52 was hard of hearing and notes (written notes) and physical signs (pictures) were ineffective. During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 52 was assessed having moderately impaired cognitive skills for daily decision making. Resident 52 had highly impaired (absence of useful hearing) hearing. Resident 52 required partial/moderate assistance (helper does less than half the effort) with oral/toileting hygiene, shower/bathe self, personal hygiene, sit to lying, and sit to stand. During an observation on 3/4/2025, at 11:59 AM, in Resident 52's room, Resident 52 sat on her wheelchair next to the door. Resident 52 made eye contact with the Surveyor but did not answer the questions she was asked. Resident 52's roommate (unable to identify) yelled, she cannot hear you after numerous attempts were made to speak with Resident 52. During an interview on 3/5/2025, at 3:10 PM, with Social Services Director (SSD), SSD stated Resident 52 was admitted with unspecified hearing loss. SSD stated Resident 52's hearing loss got worst after the resident's cancer treatment in 2024. During an interview on 3/5/2025, at 3:20 PM, with Activities Director (AD), AD stated Resident 52 liked to participate in activities in the Activity Room. AD stated Resident 52 was hard of hearing and facility staff had to speak louder to Resident 52. AD stated the activity staff also wrote on a piece of paper or notebook to communicate with Resident 52. AD stated she did not know which ear Resident 52 could hear more from. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/2025, at 9:43 AM, with Minimum Data Set Nurse 1 (MDSN 1), Resident 52's care plan with focus on Resident 52's communication problem related to (r/t) hearing deficit, dated 8/23/2024 was reviewed. The care plan interventions were reviewed and did not specifically indicate how to be able to effectively communicate with Resident 52. MDSN 1 stated Resident 52's care plan for communication was created on 8/23/2024 and it should be resident-centered (patient-centered - an approach to providing health care where the treatment plan is driven by the needs, preferences, and life-long habits of the resident) and comprehensive (complete). MDSN 1 stated interventions regarding the specific ways Resident 52 communicated should be included in Resident 52's care plan for communication. MDSN 1 stated Resident 52's care plan for communication was not resident-centered and comprehensive because Resident 52's care plan did not indicate that facility staff was able to effectively communicate with Resident 52 by writing on a piece of paper or notebook and/ or must speak to the resident louder until MDSN 1 learned about it on 3/5/2025. During an interview on 3/6/2025, at 10:04 AM, with Registered Nurse Supervisor 2 (RNS 2), RNS 2 stated a care plan for communication was used to inform staff how to effectively communicate with a resident. RNS 2 stated it was important for the care plan to include specific interventions for communication/ communication style that the resident prefers' is effective for the resident so the staff could provide better care. During a review of the facility's policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, revised on 12/2016, the P&P indicated the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (having to do with mental, emotional, social, and spiritual effects of a disease) and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44018 Based on observation, interview, and record review, the facility failed to ensure three (3) out of 3 residents (Resident 27, 36 and 37) reviewed for Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) were provided care and services to maintain good grooming and personal hygiene. 1. Resident 27's fingernails on both contracted hands (a condition where the fingers or palm of the hand become permanently bent or curled) were long and untrimmed. 2. Resident 36's nails on both hands were long and had brownish discolorations. 3. Resident 37's nails on both contracted hands were long and untrimmed. These deficient practices had the potential for Resident 27, 36 and 37 to develop infection and skin breakdown which could result in the decline of the residents' wellbeing. Findings: 1. During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE], seizure (uncontrolled jerking, loss of consciousness, bank stare, or other symptoms caused by abnormal electrical activity in the brain), traumatic brain injury (results from a violent blow or jolt to the head) and hypertension (high blood pressure). During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 27 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing. During an observation on 3/4/2025 at 10:32 AM inside Resident 27'S room, Resident 27 was awake and laying on his bed. Resident 27's both hands are contracted. Resident 27's fingernails on both hands were long, untrimmed and were pressing on the resident's palms. During an observation and interview with Certified Nursing Assistant 1 (CNA 1) on 3/5/2025 at 10:44 AM in Resident 27's room, Resident 27 was laying on his bed. CNA 1 confirmed Resident 27's fingernails on both hands were long, untrimmed, and pressing on the resident's skin/ palms. CNA 1 stated fingernails care is part of resident's daily grooming/ hygiene. CNA 1 stated long fingernails touching/ pressing on Resident 27's palm could cause skin tear, and long fingernails could harbor bacteria. 45456 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 36's Admission Record, the Admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE], chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), traumatic brain injury (results from a violent blow or jolt to the head) and pneumonia (a lung infection). During a review of Resident 36's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. During an observation on 3/4/2025 at 9:46 AM inside Resident 36'S room, Resident 36 was awake and laying on his bed. Resident 36 both hands were positioned across on his chest, all the fingernails on the resident's both hands were long and untrimmed. During an observation on 3/6/2025 at 9:58 AM inside Resident 36'S room, Resident 36 was sleeping on his bed. Resident 36 both hands were positioned across on his chest, all the fingernails on the resident's both hands were long and untrimmed. During a concurrent observation and interview on 3/6/2025 at 10:04 AM with Certified Nurse Assistant 1 (CNA 1) inside Resident 36's room, Resident 36 fingernails on both his hands were long. CNA 1 stated the facility staff should cut Resident 36's fingernails as needed, or usually every 2 to 3 weeks. CNA 1 stated the nursing staff cuts the fingernails to maintain cleanliness, so residents' do not catch infection with the dirty fingernails. 3. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE], chronic respiratory failure, quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and Stage 4 pressure ulcer of the sacral region sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]) During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 37 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. During an observation on 3/4/2025 at 9:51 AM in Resident 37's room, Resident 37 was laying on his bed. Resident 37's both hands are contracted on the chest and all the fingernails were long and untrimmed. During an observation on 3/6/2025 at 9:44 AM in Resident 37's room, Resident 37 was laying on his bed. Resident 37's both hands are contracted on the chest and all the fingernails were long and untrimmed. During a concurrent observation and interview on 3/6/2025 at 10:06 AM with Treatment Nurse 1 (TN 1) inside Resident 37's room. Resident 37's fingernails were long and both hands were contracted. TN 1 stated, we should cut Resident 37's fingernails. It was necessary to keep the fingernails short because we do not want the residents to scratch themselves and we want to prevent injuries because Resident 37 was contracted, and he can develop wounds in his hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue Pasadena, CA 91103

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/2025 at 11:21 AM with Infection Prevention Nurse (IPN), IPN stated the staff should keep all the residents' fingernails clean, and short, especially for the residents with hand contractures because it can cause skin breakdown. IPN stated long nails were habitat for germs/bacteria that can introduce infection to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 8/2019, the P&P indicated, appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to implement treatment for the prevention of pressure ulcer (painful wound caused as a result of pressure or friction) by failing to ensure that the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings for one (1) of two sampled residents (Residents 37), reviewed for pressure ulcer in accordance with the facility's policy and procedure. This deficient practice had the potential for Resident 37 to have worsening Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia [a thin, fibrous connective tissue that surrounds and supports all the structures in the body, including muscles, organs, bones, and nerves], muscle, tendon, ligament, cartilage or bone in the ulcer. Slough [moist, yellow or white, and stringy or thick necrotic tissue] and/or eschar [dry, hard, leathery, and often black or brown necrotic tissue] may be visible on some parts of the wound bed. epibole [rolled edges], undermining [tissue destruction beneath the wound edges, creating a pocket-like space] and/or tunneling [a narrow, track-like passageway extending from the wound into deeper tissues] often occur. Depth varies by anatomical location) of the sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]) Findings: During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE], chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and Stage 4 pressure ulcer of the sacral region. During a review of Resident 37's Braden Scale (is a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries), dated 11/1/2024, indicated Resident 37 has total score of 13, (Scoring 13-14= moderate risk) which indicated Resident 37 was at risk for skin breakdown. During a review of Resident 37's Minimum Data Set (MDS- resident assessment tool), dated 1/31/2025, the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. During a review of Resident 37's Monthly Weights dated on 3/3/2025, the monthly weight indicated, Resident 37's weight was 132 pounds (lbs., unit of measurement). During a review of Resident 37's Physician's Order dated 3/4/2025, indicated the following: 1. Low Air Loss bed setting for skin management ever day shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Low Air Loss bed setting for skin management ever shift. During a record review of Resident 37's undated care plan (CP), Resident 37 has sacrococcyx pressure ulcer during admission; at risk for complication, intervention indicated, low air loss mattress for skin integrity management. During an observation on 3/4/2025 at 9:51 AM, in Resident 37's room, Resident 37 was observed in bed with the LAL set on 120 millimeters of mercury (mmHg, unit of pressure). During an observation on 3/05/2025 at 2:24 PM, in Resident 37's room, Resident 37 was observed in bed with the LAL set on 80 mmHg. During a concurrent observation and interview on 3/5/2025 at 02:28 PM with Licensed Vocational Nurse 2 (LVN 2) in Resident 37's room, Resident 37's LAL was set on 80 mmHg. LVN 2 stated that LAL was supposed to be on 132 mmHg based on Resident 37's weight. LVN 2 stated, We use the LAL to prevent pressure ulcer. Resident 37's LAL was used for decubitus (a skin wound caused by sustained pressure on an area of the body) management. If the LAL was in the incorrect setting, we are not providing the correct setting, Resident 37's pressure ulcers might get worse. We should be checking the LAL setting every shift. During a review of the facility's Policy and Procedure (P&P) titled, Support Surfaces Guidelines, revise date 9/2013, indicated, to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for resident at risk for skin breakdown. The P&P indicated interventions indicated, monitor for other pressure ulcer risk factors and provide interventions as indicated. During a review of the Operation Manual titled, Brand 1 Alternating Pressure Low Air Loss Mattress Replacement System, revised date 3/22/2021, indicated, in the operating instructions, determine the resident's weight and set the control knob to that weight setting on the control unit.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to one of four sampled residents (Resident 218) with limited range of motion (ROM- the extent of movement of a joint) and limited mobility to prevent further decrease in ROM and maintain or improve mobility as indicated in the facility's policy and procedure (P&P). This deficient practice had the potential to place Resident 218 at risk for further ROM decline and contracture (a condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity or rigidity of joints). Findings: During a review of Resident 218's Admission Record, the Admission Record indicated Resident 218 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hemiplegia unspecified affecting right dominant side (paralysis or severe weakness on one side of the body, specifically the right side, that is the dominant side for the resident), aphasia (a disorder that makes it difficult to speak), and essential hypertension (HTN- high blood pressure). During a review of Resident 218's Minimum Data Set (MDS- a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 218 was assessed with moderately impaired (decisions poor, cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 218 had functional limitation in ROM on both sides of his upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). Resident 218 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, upper/lower body dressing, personal hygiene, sit to lying, and tub/shower transfer. During a review of the Order Summary Report, dated 2/1/2025, the Order Summary Report indicated a physician order on hold with a start date of 11/9/2023, for RNA (nursing interventions focused on helping individuals maintain of regain their highest level of function and independence, often after a period of illness or injury, through ongoing care and activities) for passive range of motion (PROM- when someone else, or a machine moves a joint through its range of motion, without the patient actively contracting the muscle) to right upper extremity (RUE- right upper body parts) and right lower extremity (RLE- right lower body parts) every day (qd) five times a week as tolerated every day shift was on hold. During an observation on 3/4/2025, at 11 AM, in Resident 218's room, Resident 218 was observed awake in bed. Resident 218 moved his head from left to right when asked if he was able to move his right hand. Resident 218 moved his head from left to right and mumbled, No when asked if facility staff assisted him with exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/2025, at 9:37 AM, with Restorative Nurse Assistant 1 (RNA 1), RNA 1 stated Resident 218 received RNA services before he was admitted to the General Acute Care Hospital (GACH) last month. RNA 1 stated Resident 218 was not ordered RNA services when he returned from the GACH. RNA 1 stated it was important for Resident 218 to continue with RNA exercises to improve his mobility (ability to move or be moved freely and easily) and prevent contractions (when a muscle becomes shorter and tighter). During an interview on 3/6/2025, at 12:06 PM, with Registered Nurse Supervisor 4 (RNS 4), RNS 4 stated Resident 218 had right sided weakness. RNS 4 stated Resident 218 received RNA services prior to his hospitalization last month. RNS 4 stated Resident 218 should have been evaluated by the physical therapist for RNA services after his readmission from GACH last month and should have continued RNA services. RNS 4 stated RNA services was important for Resident 218 to maintain muscle strength, exercise, gain movement, and prevent decline. RNS 4 stated Resident 218 last received RNA services on 2/17/2025. During an interview on 3/6/2025, at 12:20 PM, with the Director of Nursing (DON), the DON stated Resident 218 should have been assessed by the Rehab Department within 24 hours of re-admission. The DON stated RNA services were started after the Rehab Department assesses the Resident. The DON stated RNA services was important to prevent contractures and improve mobility. During an interview on 3/6/2025, at 1:52 PM with the Director of Rehabilitation (DOR), the DOR stated Resident 218 was on RNA services for a long time before he was admitted to GACH. The DOR stated Resident 218 should have been evaluated to determine if therapy or RNA services was needed after his readmission to the facility. The DOR stated a physician's order for therapy or RNA services was written based on the evaluation of the physical therapist. The DOR stated Resident 218 was not screened by the physical therapist after his readmission back to the facility last month. The DOR stated Resident 218 did not have an active order for RNA services. The DOR stated Resident 218 had not received RNA services for three weeks. During a review of the facility's policy and procedure (P&P), titled, Resident Mobility and Range of Motion, revised on 7/2017, the P&P indicated, Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P further indicated, Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. During a review of the facility's P&P, titled, Restorative Nursing Services, revised on 7/2017, the P&P indicated, residents will receive restorative nursing care as needed to help promote optimal safety and independence. The P&P further indicated, residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to ensure one of three sampled Residents (Resident 46) was informed and understood the concept of the proposed binding arbitration (Arbitration is a procedure in which a dispute is submitted, by agreement of the parties) and the right to rescind (take back or cancel) the agreement within 30 calendar days of signing the agreement, before having Resident 46 enter into a binding arbitration agreement. The deficient practice had the potential resulted in Resident 46 unknowingly giving up their right to resolve any disputes with the facility through a court of law before a jury. Findings: A review of Resident 46's Admission Record indicated the resident was admitted to the facility on [DATE], indicated diagnoses including hemiplegia and hemiparesis (loss of strength on one side of the body) following cerebral infarction (a condition in which a disrupted blood flow to the brain due to problems with the blood vessels that supply it), transient cerebral ischemia (a condition in which a blockage in an artery restricts the delivery of oxygen-rich blood to the brain resulting in damage to brain tissue.), and hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood). A review of Resident 46's Minimum Data Set (MDS-a federally mandated assessment tool), dated 3/5/2025, indicated Resident 46 had cognitively (a mental process of acquiring knowledge and understanding) intact. The MDS indicated Resident 46 was assessed needing walker/ wheelchair for mobility device and has no impairment on his functional limitation in range of motion on his upper and lower extremities. During a concurrent interview and record review of Resident 46's arbitration agreement signed on 12/1/2024, the Resident 46 stated, facility staff left a stack of papers on Resident 46's nightstand and asked Resident 46 to sign the documents. Resident 46 stated not remembering all that entails on the documents since all the documents were not all explained to Resident 46. Resident 46 stated he did not know one of the papers he signed was the arbitration agreement. Resident 46 stated, facility staff did not explain the what the arbitration agreement was, or that Resident 46 had 30 days to make changes to the agreement. During an interview with the Admission Coordinator (AC) on 3/7/2025 at 3:26 PM, AC stated, in the event of a malpractice, (Malpractice occurs when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient) or if a resident would have a case filed against the facility, the case could be resolved faster through an arbitration. AC stated that during admission the admission coordinator was responsible for explaining the arbitration agreement to the resident and this would be the time for the resident to review and sign the agreement. AC stated the facility was responsible for explaining to the resident/ responsible party the arbitration agreement. The facility was also responsible for informing the residents/responsible party that they can rescind their request for arbitration before 30 days upon signing the arbitration agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Arbitration Agreement Form revised 10/5/2020, indicated BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. Rescission indicated, this arbitration agreement may be rescinded by written notice from either party, including the Resident's Legal Representative and/or Agent, if any, and as appropriate, to the other party within thirty (30) days of signature. Execution indicated, The parties to the Arbitration Agreement hereby acknowledge and agree that, upon execution, any and all disputes or claims as to medical malpractice (that is, whether any medical services rendered during the Resident's admission were unnecessary or unauthorized or were improperly, negligently or incompetently rendered or not rendered) will be determined by submission to neutral arbitration, and not by a lawsuit or court process, except as California law provides for judicial review of arbitration proceedings. Such arbitration will be governed by this Arbitration Agreement. By signing this arbitration agreement below, the parties agree to be bound by the provisions of this Arbitration Agreement. Further the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) acknowledges that: (A) the agreement has been explained to the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) by a representative of the Facility in a form and manner that the Resident understands, including in a language that the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) understands; and (B) the Resident (or Resident's Legal Representative or Agent on behalf of Resident) understands this agreement.

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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** 45456 Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for four (5) of 8 sampled resident (Resident 57, 122, 9, 11 and 120) for the infection control care areas in accordance with the facility's policy and procedure when: 1. Resident 57's foley catheter drainage bag (a urine collection bag) was observed touching the floor on 3/6/2025. 2. Licensed Vocational Nurse 3 (LVN 3) failed to change gloves and perform hand hygiene in between task during medication administration to Resident 122. 3. LVN 4 failed to change gloves and perform hand hygiene in between task during medication administration to Resident 9. 4. Registered Nurse 1 (RN 1) failed to change gloves and perform hand hygiene in between task during medication administration to Resident 11. 5. Facility failed to ensure Resident 120's feeding pump (a device that delivers liquid nutrition and/or medications to a patient's digestive tract via a feeding tube) was clean without any visible stains. These deficient practices have a potential to contaminate clean items and can place the residents at risk for infection. Findings: 1. During a review of Resident 57's Admission Record, the Admission Record indicated Resident 57 was admitted to the facility on [DATE], with diagnosis of cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning), urinary tract infection (UTI, occurs when bacteria enter the urinary tract and multiply, causing inflammation and infection) and hypertension (high blood pressure) During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool) dated 11/29/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 57 needs substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) for toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and chair/ bed- to -chair transfer. During an observation on 3/6/2025 at 11:07 AM in Resident 57's room, Resident 57 was laying on his bed and foley catheter drainage bag hanging on the side of the bed was touching the floor. (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 concurrent observation and interview on 3/6/2025 at 11:15 AM, with Registered Nurse Supervisor 2 (RNS 2) in Resident 57's room, Resident 57's foley catheter drainage bag was touching the floor. RNS 2 stated, Resident 57's foley catheter drainage bag was touching floor, it was not supposed to touch the floor. Resident 57's foley catheter drainage bag can get contaminated with bacteria and the resident can get sick. During an interview on 3/7/2025 at 11:15 AM with Infection Prevention Nurse (IPN), IPN stated the foley catheter drainage bag should not be touching the floor because it was a break of infection control, and it can become a nosocomial infection (an infection that develops while a person is in a healthcare facility) because it can contaminate Resident 57's foley catheter. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary revised on 4/2019, the P&P indicated infection control includes ensuring the catheter tubing and drainage bag are kept off the floor. 2.) During a review of Resident 122's Admission Record, the Admission Record indicated Resident 122 was admitted to the facility on [DATE], with diagnosis of acute respiratory failure (occurs when you do not have enough oxygen in your blood) with hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and hypertension. During a review of Resident 122's MDS dated [DATE], the MDS indicated Resident 122 has intact cognitive skills for daily decision making. The MDS indicated Resident 122 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) for toileting hygiene, lower body dressing, putting on/ taking off footwear, lying to sitting, sit to stand, chair/ bed- to -chair transfer and walk 10 feet. During an observation on 3/6/2025 at 8:33 AM with LVN 3 inside Resident's 122's room, LVN 3 assisted Resident 122 from the restroom back to the resident's bed. LVN 3 did not remove her gloves, and did not perform hand hygiene before putting the oxygen cannula on Resident 122's nostrils. LVN 3 did not remove her gloves and did not perform hand hygiene after fixing Resident 122's oxygen cannula. During a concurrent observation and interview on 3/6/2025 at 8:34 AM with LVN 3 in Resident 122's room, LVN 3 did not change her gloves (same gloves from when LVN 3 assisted the resident from the restroom) and started administering medications to Resident 122. LVN 3 stated, LVN 3 should have changed my gloves and performed hand hygiene after putting and fixing the oxygen cannula on Resident 122 nostrils, and before administering Resident 122's medications. LVN 3 stated Resident 122 might get infected with bacterial or viral infection thru her respiratory system (organs/ structures in the body that allows you to breath such as lungs) 3. During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] and readmitted [DATE] with diagnosis of acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). (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 9's MDS dated [DATE], the MDS indicated Resident 9 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 9 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed- to -chair transfer, toilet transfer and tub/ shower transfer. During an observation during medication administration on 3/6/2025 at 1:28 PM with LVN 4 in Resident 9's room, LVN 4 was donning Personal Protective Equipment (PPE, is specialized clothing or equipment worn by an employee for protection against infectious materials, such as gowns, gloves, masks, and goggles) then pulled Resident 9's privacy curtains with her gloved hand then touched Resident 9's gown and then connected the flush syringe (a cylindrical, hollow tube, or barrel of a syringe which is medical devise used to inject or withdraw fluids) on Resident 9's gastrostomy tube (GT, is a tube inserted through the belly that brings nutrition directly to the stomach) without changing LVN 4's gloves. During an observation during medication administration on 3/6/2025 at 1:33 PM with LVN 4 in Resident 9's room, LVN 4 with gloved hand (same gloves observed on 3/6/2025 at 1:28 PM) checked the patency (to check if there is any obstruction) of Resident 9's GT by auscultation (listening to the internal sounds of the body, usually using a stethoscope [a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a piece placed upon the area to be examined]) using LVN 4's stethoscope. LVN 4 then stirred the crushed Reisdent 9's medications in the medicine cup with plastic spoon without removing LVN 4's r gloves and performing hand hygiene. During an observation during medication administration and interview on 3/6/2025 at 1:38 PM with LVN 4 in Resident 9's room, LVN 4 touched Resident 9's linens using the same gloves LVN 4 was using since 1:28 PM (when LVN 4 closed the privacy curtain), LVN 4 then started administering medications to Resident 9 via GT. LVN 4 stated, LVN 4 should be changing her gloves in between tasks from when touching the privacy curtain, up to administering Resident 9's medications. because of infection control. 4. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis of acute respiratory failure with hypoxia, quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures[are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]) During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 11 was dependent for oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, chair/ bed- to -chair transfer, and tub/ shower transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056316	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue Pasadena, CA 91103

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on medication administration on 3/6/2025 at 1:58 PM with RN 1 in Resident 11's room, RN 1 pulled the privacy curtain with her gloved hands and touched Resident11's linen and removed Resident 11's gown to uncover the resident's GT and connected the flushed syringe while wearing the same gloves. During the same observation on medication administration on 3/6/2025 2:01 PM with RN 1, RN 1 checked the patency of Resident 11's GT by auscultation with RN 1's stethoscope. RN 1 used her gloved hand and removed the stethoscope and put it on her neck then checked the residual by aspirating the flush syringe without changing her gloves then started administering Resident 11's medications via GT. During an observation on medication administration on 3/6/2025 2:04 PM with RN 1, RN 1 after administering Resident 11's medications via G-tube with her gloves on, RN 1 touched Resident 11's gown and linens without changing RN 1's gloves and without performing hand hygiene. During an interview on 3/6/2025 at 2:09 PM with RN 1, RN 1 stated, I should be changing gloves when I touched the privacy curtain or linen and after I removed my stethoscope because I could have touched my hair. Resident 11 has a GT, there is possibility of cross contamination while doing the medication administration. During a review of the facility's P&P titled Administering Medications revised on 4/2019, the P&P indicated Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 44018 5. During a review of Resident 120's Admission Record, the Admission Record indicated Resident 120 was admitted to the facility on [DATE], with diagnosis including encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.), encephalopathy (a condition where the brain does not function properly.), and sepsis (infection of the blood) During a review of Resident 120's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was impaired. The MDS indicated Resident 120 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, and tub/shower transfer. The MDS also indicated that Resident 120 had feeding tube (a flexible plastic tube placed into your stomach or bowel to help you get nutrition when you're unable to eat.) During an observation in Resident 120's room on 3/4/2025 at 9:45 AM, Resident 120's feeding pump was observed with brown/yellow substance on the pump. (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 concurrent observation and interview on 3/5/2025 at 1 PM with Certified Nursing Assistant 1 (CNA 1) in Resident 120's room, CNA 1 stated the feeding pump was dirty and stained with brown/yellow substance/ dried up milk (formula from the feeding tube). CNA 1 stated she did not know when it was last cleaned. During an interview with the Infection Preventive Nurse (IPN) on 3/5/2025 at 11:12 AM, the IPN stated cleaning and disinfection of medical equipment/devices were essential for preventing the spread of infections and ensuring safety of the residents. A review of Facility's policy and procedure (P&P) titled, Cleaning & Disinfection of Resident Care Equipment, revised dated on 6/1/2017, indicated that reusable items (equipment that is designed reusable by more than one resident) are cleaned and disinfected or sterilized between residents.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to ensure the antibiotic stewardship program protocols for prescribing the appropriate antibiotics (medication used to treat or prevent some types of bacterial infection) was completed in its entirety for two (2) of three (3) sampled residents (Resident 6 and Resident 218) prior to the administration of their antibiotic therapy. This deficient practice had the potential to result in the development of antibiotic-resistant organisms (not effective to treat infection), from unnecessary or inappropriate use. Findings: During a review of Resident 6's Admission Records, the Admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), and muscle weakness. During a review of Resident 6's Minimum Data Set (MDS- resident assessment tool), dated 12/12/2024, the MDS indicated Resident 6's cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was moderately impaired. The MDS indicated Resident 6 was partial/moderate assistant (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of Resident 6's Physician Order, dated 2/12/2025, the order indicated Resident 6 was prescribed Ciprofloxacin HCL (used to treat bacterial infections in many different parts of the body) oral tablet 500 milligram (mg, a unit of measurement), give 1 tablet (tab) by mouth (PO) two times a day for pneumonia (infection that inflames air sacs in one or both lungs) for 10 days. During a review of Resident 6's Surveillance Data Collection Form, the form indicated the onset of symptoms was on 2/11/2025, and the McGeer Criteria (provides specific criteria for infection surveillance [the ongoing and systematic collection of routine data which are then analyzed, interpreted, and acted upon.]) was incomplete since the symptoms were left blank (unchecked). During a review of Resident 218's Admission Records, the Admission Record indicated Resident 218 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia (severe or complete loss of strength on one side of the body) affecting right dominant side, hypertension (high blood pressure), and hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood). During a review of Resident 218's MDS, dated [DATE], the MDS indicated Resident 218 was cognitively impairment. The MDS indicated Resident 218 was totally dependent on staff for transfer, dressing, toilet use, and personal hygiene. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 218's Physician Order, dated 2/17/2025, the Order indicated Resident 218 was prescribed Amoxicillin-Pot Clavulanate (used to treat bacterial infection.) tablet 875-125 mg, give 1 tab via G-tube (a medical device that delivers liquid nutrition directly to stomach or small intestine through a surgically created opening in the abdominal wall) every 12 hours for pneumonia for 7 days. During a review of Resident 218's Surveillance Data Collection Form, the Form indicated the onset of symptoms was on 2/12/2025, and the McGeer Criteria was incomplete since the symptoms were left blank. During a concurrent interview and record review with Infection Preventive Nurse (IPN) on 3/7/2025 at 3:13 PM, IPN stated the Mc Geer's surveillance criteria was incomplete, since the criteria did not indicate any symptoms checked off for Resident 6 and Resident 218, prior to them receiving antibiotics, in the month of February 2025. The IPN stated, the Mc Greer's surveillance criteria should have been completed. IPN stated it was important to complete the criteria to indicate whether a resident truly requires antibiotics. A review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship revised on December 2016, indicated that antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The P&P indicated that the purpose of antibiotic stewardship program was to monitor the use of antibiotics in facility's residents. The P&P also indicated that when a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the signs and symptoms available and when symptoms were first observed. According to the Centers for Disease Control and Prevention (CDC), there are identified core elements/actions a nursing home should ensure to prevent antibiotic resistance (occurs when bacteria develop the ability to evade the effects of antibiotics, making it difficult or impossible to treat infections.). Among them are: 1. Educate their providers on the potential harm of antibiotics. 2. Document the dose, duration, and indication of the antibiotics, making this information accessible helps ensure that antibiotics can be modified as needed based on additional laboratory and clinical data and/or discontinued in a timely manner to reduce unnecessary antibiotic exposure and improve resident outcomes. https://www.cdc.gov/longtermcare/pdfs/core-elements-antibiotic-stewardship-appendix-a.pdf