STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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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** 47882 Based on observation, interview, and record review, the facility failed to promote dignity and respect for two of three sampled residents (Resident 16 and 80) when: 1. Certified Nursing Assistant (CNA) 1 was observed standing over Resident 16, who was in bed, while feeding resident for breakfast. 2. CNA 3 was observed standing over Resident 80, who was in bed, while feeding resident for breakfast. This deficient practice violated the resident's rights to maintain and enhanced their self-esteem, self-worth, and the right to be treated with dignity and respect. Findings: 1. During a review of Resident 16's, Admission Record (AR), dated 7/10/2024, indicated Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy (damage or disease that affects the brain), Parkinsonism (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and muscle wasting (a weakening, shrinking, and loss of muscle caused by disease or lack of use). A review of Resident 16's History and Physical Examination, dated 4/25/2024, indicated Resident 16 does not have the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 4/30/2024, the MDS indicated Resident 16's cognitive status (the mental process of thinking and understanding) was severely impaired. MDS indicated Resident 16 required substantial/maximal assist (helper does more than half the effort) with eating, oral hygiene, toileting and bathing. 2. During a review of Resident 80's AR, dated 7/10/2024, indicated Resident 80 was admitted on [DATE], with diagnoses including idiopathic peripheral autonomic neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), lack of coordination, and muscle wasting. (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	A review of Resident 80's History and Physical Examination, dated 4/25/2024, indicated Resident 80 had fluctuating capacity to understand and make decisions. A review of Resident 80's MDS dated [DATE], indicated Resident 80 cognitive status was severely impaired. The MDS indicated Resident 80 required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene and required substantial/maximal assist with toileting and bathing. During a concurrent observation and interview on 7/10/2024 at 7:40 AM in Residents 16's and 80's room (roommate's). CNA 1 was observed standing over Resident 16, who was lying with head of bed elevated, while feeding resident for breakfast, also CNA 3 was observed standing over Resident 80, who was lying with head of bed elevated, while feeding resident for breakfast. CNA 1 stated, she should have used a chair and/or at the eye level with Resident 16 while feeding, it violates residents ' rights and dignity. CNA 3 stated, she was just uncomfortable using the chair, but she should be sitting down, and be at the eye level of Resident 80 and not standing over, the resident as it violates the resident ' s rights and dignity. During an interview on 7/10/2024 at 8:50 AM with Registered Nurse (RN) 2, RN 2 stated, CNAs should be assisting the residents to eat while the residents were sitting/lying with head of bead elevated and within eye level of the resident, and not stand over the residents as it violates resident rights and dignity. During an interview on 7/10/2024 at 4:12 PM with the Director of Nurses (DON), DON stated, he expected the CNAs sitting next to the resident to see eye level while feeding the resident, it is more dignified than standing over the resident during the process. A review of the facility's policy and procedure (P&P) titled, Resident Rights - Quality of Care, dated 3/2017, indicated; a) each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect individuality and services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being, b) demeaning practices and standards of care that compromises dignity are prohibited, c) facility staff treats cognitively impaired residents with dignity and sensitivity.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on the observation, interview, and record review, the facility failed to ensure call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for two out of three sampled residents (Resident 357 and Resident 26) as indicated in the facility's policy and procedure. These deficient practices had the potential not to meet the residents' needs, preferences, especially during emergency. Findings: 1. A review of Resident 357's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included major depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act) and aphasia (a language disorder that affects a person ' s ability to communicate), and Parkinsonism (a disorder of the central nervous systems that affects movement). A review of Resident 357's History and Physical Examination (H&P) dated 12/7/2023, indicated Resident 357 does not have the capacity to understand and make decisions. A review of Resident 357's the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/29/2024, indicated Resident 357 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 357 required substantial/maximal assistance (helper does more than half the effort) from staff with oral hygiene, upper body dressing, lower body dressing, and personal hygiene. A review of Resident 357's care plan (CP), titled 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), dated 5/11/2024, indicated Resident 357 has limited mobility, required extensive assistance from staff, and at risk for further ADL decline in function. The (CP), intervention indicated to keep the call light within easy reach for Resident 357 and remind Resident 357 to call for assistance at all times. During a concurrent observation in Resident 357's room and interview with Resident 357 on 7/9/2024 at 10:03 AM, Resident 357's call light was hanging on the right side of the bed and tied to the right bedrail. Resident 357 was lying in bed. Resident 357 pointed at the call light cord which was wrapped on the right bedrail. Resident 357 stated she could not reach the call light cord and was not able to use the call light. During a concurrent observation and interview with Certificated Nursing Assistant 3 (CNA) on 7/9/2024 at 10:31 AM, the CNA 3 stated the call light was hanging on the side of the bed. The call light should be placed closer to Resident 357's hand which was easy for resident to call for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with Director of Nursing (DON) on 7/9/2024 at 4:23 PM, the DON stated it was important to place the call light within easy reach of the resident. Resident could quickly alert staff if they require assistance. 47882 2. During a review of Resident 26's Admission Record, dated 7/10/2024, indicated Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Parkinsonism (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), hypertensive heart disease (abnormally high blood pressure) and diabetes (lifelong condition that causes a person's blood sugar level to become too high). A review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26 cognitive status was severely impaired. The MDS Indicated Resident 26 was dependent (helper does all the effort) with eating and required substantial/maximal assist During a concurrent observation and interview on 7/9/2024 at 9:55 AM with Licensed Vocational Nurse (LVN) 3 in Resident 26 ' s room, Resident 26 made eye contact to surveyor waving his left hand, but unable to move his right hand. Resident 26 ' s call light button was attached at the right upper corner of the bed. LVN 3 stated, Resident 26 does not move his right hand, but can move his left hand, so the call light should be within reach of the left hand. LVN 3 stated, call light should be within reach of Resident 26, who was a fall risk, to call for assistance, especially in case of emergency. A review of Resident 26's CP for potential alteration of ADL (activity of daily living) function, dated 12/22/2021, the CP indicated, Resident 26 required extensive assistance from staff. The CP interventions included to keep call light within easy reach. A review of Resident 26's CP for risk for falls/injuries, dated 12/22/2021, the CP indicated, Resident 26 had communication deficit. The CP interventions included to place call light within reach and answered promptly. A review of Resident 26's Occupational Therapy OT Evaluation & Plan of Treatment, dated 7/30/2023, indicated Resident 26's medical history included right hemiparesis (weakness or the inability to move one side of the body). During an interview on 7/10/2024 at 8:19 AM with Occupational Therapist (OT), OT stated, Resident 26 has right hand hemiparesis, so call light should be within reach of the functional hand which is the left. During an interview on 7/10/2024 at 3:58 PM with the Director of Nurses (DON), DON stated, he expected Resident 26 ' s call light to be within reach to accommodate his needs and in case of emergency. DON stated, Resident 26 had minimal movement on his right hand, so the call light should be within reach of his left hand. A review of facility's policy and procedure (P&P) titled, Communication - Call Light dated 1/1/2012, the P&P indicated, the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. The call cords will be placed within the resident ' s reach in the resident ' s room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to report a significant change in condition to the attending physician (Physician 1) and responsible party for one of three sampled residents (Resident 48), with a redness on both eyes. This failure resulted in a delay in receiving necessary care and treatment to both eyes which could potentially result in worsened eyes condition and/or infection that could lead to blindness. Findings: A review of Resident 48 Admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis that included hypertension (high blood pressure), obesity (overweight) , type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood) with diabetic nephropathy [the deterioration of kidney (a pair of organs in the abdomen which remove waste and extra water from the blood) function], and bilateral age-related cataract (a condition in which the lens of the eye becomes cloudy). A review of Resident 48's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/26/2024 indicated, Resident 48's cognitive skills was severely impaired (difficulty with or unable to make decisions, learn, remember things), and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) in eating and personal hygiene. A review of Resident 48's Order Summary Report (a summary of all currently active physician orders), indicated Physician 1 ordered the facility to obtain an eye health and vision consult for Resident 48 on 5/11/2024. Physician 1 also ordered for Resident 48 to receive an Artificial Tears Ophthalmic Solution (Artificial Tear Solution to keep eyes moist) to instill two drops in both eyes every 6 hours as needed for dry eye relief dated 7/9/2024. A review of Resident 48's Change in Condition Evaluation (CIC), dated 7/9/2024 timed at 6:08 PM, indicated Resident 48's eyes appeared reddened, Resident 48 ' s Primary Physician was notified with order received for lubricant eyedrops. During a concurrent observation and interview on 7/9/2024 at 9:32 AM with Resident 48 in her room, Resident 48 was observed lying in bed, with the right eye ' s sclera (the white layer of the eyes that covers most of the outside of the eyeball) redness, and the left eye ' s sclera was observed slightly red. Resident 48 stated, her eyes had been red since the previous morning, and she needed eye drops. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/9/2024 at 3:55 PM with Resident 48 in her room, Resident 48 was observed sitting on a wheelchair, with both eyes remained reddened. Resident 48 stated, there was no staff that assessed her eyes in the morning, and she had not received any eye drops yet. Resident 48 stated, it bothered her that her eyes were red and believed that her eyes were dry or because she was allergic to something. During a concurrent observation and interview on 7/9/2024 at 4:10 PM with Licensed Vocational Nurse (LVN) 6 in Resident 48's room, Resident 48's eyes were observed. LVN 6 stated, she has noticed Resident 48 ' s eyes were reddened for about two or three days already and LVN 6 believed the eye redness was due to Resident 48 had not been sleeping well at nighttime. LVN 6 stated, Resident 48 liked to eat food in her room, not washing her hands and might scrub her eyes, which could contribute to the resident's eyes redness. LVN 6 stated, she did not report Resident 48's eyes ' redness to the physician because it should have already been reported and there should be a CIC documentation in the resident's chart. During a concurrent interview and record review on 7/11/2024 at 2 PM with LVN 3, Resident 48's records titled CIC was reviewed from the date the resident was readmitted to the facility on [DATE] was reviewed. LVN 3 stated, she could not find any CIC related to Resident 48 ' s eyes condition in her electronic medical chart prior to 7/9/2024. During an interview on 7/11/2024 at 2:02 PM with LVN 3, LVN 3 stated, she was in charge of Resident 48's care on the day shift on 7/9/2024. LVN 3 stated, she did not notice Resident 48's redness on both eyes during her morning shift on 7/9/2024 and did not assess Resident 48's eyes because the assessment should be done weekly, not daily. LVN 3 stated, the Certified Nurse Assistant (CNA) usually report any changes in resident ' s condition because they take care of the residents closely. LVN 3 stated, she did not receive any report related to Resident 48's eyes from any CNA. During an interview on 7/11/2024 at 2:05 PM with Registered Nurse (RN) 2, RN 2 stated, Resident 48 ' s redness on both eyes should have been reported to the physician once the licensed nurse noticed the redness because the eyes needed to be monitored for infection. During an interview on 7/11/2024 at 2:17 PM with the Director of Nurses (DON), the DON stated, LVN 6 should have reported to the physician right after she noticed Resident 48 ' s eyes ' redness. The DON stated, even if LVN 6 believed that the redness on both eyes were normal and caused by the resident ' s inability to sleep at night, LVN 6 should have reported it to the RN supervisor to communicate with the physician for interventions and monitoring needed for the resident. The DON stated, there could be a risk of infection and worsening eyes' condition if not being monitored right away. A review of the facility ' s policy and procedure (P&P) titled, Change in Condition Notification, revised 4/1/2015, indicated Change in Condition related to Attending Physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident ' s condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan.

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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** 47467 Based on observation, interview, and record review, the facility failed to preserve one of twenty-seven sampled residents (Resident 36), dignity when failing to pull the privacy curtain while a certified nurse assistant was cleaning the resident without clothes inside the resident ' s room. This failure resulted in Resident 36's privacy violated and had the potential to impact the resident's self esteem and feel humiliated on 7/9/2024. Findings: A review of Resident 36's Admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included encephalopathy (damage or disease that affects the brain), dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], Type 2 diabetes mellitus ((DM2 - condition that results in too much sugar circulating in the blood), and hypotension (low blood pressure). A review of Resident 36's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/16/2024 indicated, Resident 36's cognitive skills was severely impaired (never/rarely made decisions), and Resident 36 needed substantial/maximal assistance (helper does more than half the effort, healer lifts or holds trunk or limbs and provides more than half the effort) in toileting hygiene (maintain perineal hygiene), shower/bathe self (washing, rising, and drying self), and personal hygiene (combing hair, shaving, washing/drying face and hands). During an observation on 7/9/2024 at 10:55 AM in Resident 36's room, Resident 36 was observed without clothes or covering from the neck down and being cleaned by Certified Nurse Assistant (CNA) 10. During the observation, Resident 36's privacy curtain was wide open and not pulled back to provide privacy to Resident 36. Resident 36's roommate was observed present while Resident 36 was being cleaned. During an interview on 7/9/2024 at 11:12 AM with CNA 10, CNA 10 stated, he was giving Resident 36 a bed bath and changing his gown. CNA 10 stated, he was supposed to pull the curtain around the resident ' s bed to provide privacy while cleaning the resident. CNA 10 stated, he forgot to pull the privacy curtain. During an interview on 7/11/2024 at 2 PM with Registered Nurse (RN) 2, RN 2 stated, before cleaning Resident 36, CNA 10 must pull the privacy curtain to provide privacy even if the resident ' s door was closed because there were other residents residing in the same room. RN 2 stated, Resident 36 could be exposed, and it could affect the resident's dignity. During an interview on 7/11/2024 at 2:09 PM with the Director of Nurses (DON), the DON stated, for all residents including the cognitively impaired residents, privacy must be provided by pulling the curtain to preserve the resident ' s dignity. The DON stated, the resident could feel like I was exposed, I feel humiliated. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Resident Rights - Quality of Life, revised March 2017, indicated the following: -Each resident shall be cared for in a manner that promotes ad enhances the quality of life, dignity, respect. -Facility Staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care. -Facility Staff treats cognitively impaired residents with dignity and sensitivity.

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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** 47467 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan that address the necessary interventions in management and services for two out of 22 total sample residents (Resident 48 and Resident 99), when: 1. Resident 48 was observed with redness of both eyes on 7/9/2024. 2. Resident 99 did not have a care plan for the clinical management of inguinal hernia (condition in which soft tissue bulges through a weak point in the abdominal muscles, causing discomfort and/or pain). These failures had a potential to result in inadequate and incomplete provision of care and result in the residents' decline in wellbeing. Findings: 1. A review of Resident 48 Admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis that included hypertension (high blood pressure), obesity (severely overweight) , type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood) with diabetic nephropathy [the deterioration of kidney (a pair of organs in the abdomen which remove waste and extra water from the blood) function], and bilateral age-related cataract (a condition in which the lens of the eye becomes cloudy). A review of Resident 48's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/26/2024 indicated, Resident 48 ' s cognitive skills was severely impaired (difficulty with or unable to make decisions, learn, remember things), and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) in eating and personal hygiene. A review of Resident 48's Order Summary Report, dated 7/11/2024, indicated Resident 48 had physician orders for eye health and vision consult dated 5/11/2024 and Artificial Tears Ophthalmic Solution (Artificial Tear Solution) to instill two drops in both eyes every 6 hours as needed for Dry eye relief dated 7/9/2024. A review of Resident 48 ' s Change in Condition Evaluation (CIC), dated 7/9/2024 timed at 6:08 PM by Licensed Vocational Nurse (LVN) 6, indicated Resident 48 ' s eyes appeared reddened, Resident 48 ' s Primary Physician was notified with order received for lubricant (solution to keep eyes moist) eyedrops. (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 record review and interview on 7/11/2024 at 2:05 PM with Registered Nurse (RN) 2, Resident 48 ' s Care Plan since readmission on 12/1/2023 was reviewed. RN 2 stated, she could not find any care plan developed that addresses the intervention for Resident 48 with eyes redness. RN 2 stated, with all CIC and new treatment orders, the resident ' s care plan would need to be updated. During an interview on 7/11/2024 at 2:17 PM with the Director of Nurses (DON), the DON stated, regarding Resident 48 ' s eyes redness, a care plan was expected to be developed due to potential risk of infection. The DON stated a care plan was important because it was used to communicate with the care team the interventions needed and to ensure the resident was monitored for the new treatment, and if the eye redness has improved or not. 48854 2. A review of Resident 99's admission record indicated Resident 99 was admitted to the facility on [DATE] with diagnoses that included inguinal hernia and weight loss. A review of Resident 99's History and Physical (H&P), dated 3/14/2024, indicated Resident 99 has the capacity to understand and make medical decisions. The H&P indicated Resident 99 has a history of inguinal hernia and abdominal pain. A review of Resident 99's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/19/2024, indicated Resident 99 has intact cognition (able to make reasonable decisions). During an observation and interview on 7/9/2024 at 9:30 AM, inside Resident 99 ' s room, Resident 99 was sitting on the edge of the bed eating breakfast. Resident 99 stated he was eating slowly because his abdomen was bothering him. Resident 99 stated he has a hernia, and he can only eat slowly. During a concurrent interview and record review on 7/11/2024 at 1:48 PM with Registered Nurse (RN) 1, Resident 99's care plans were reviewed. RN 1 stated there was no care plan for Resident 99 to address the interventions necessary in the care of the resident with inguinal hernia. RN 1 stated Resident 99 has a diagnosis of inguinal hernia and there should be a care plan. RN 1 stated not having a care plan is like not having a plan to address the resident ' s problem. During an interview on 7/12/2024 at 2:15 PM with Director of Nursing (DON), DON stated Resident 99 should have had a care plan for the inguinal hernia. DON stated comprehensive care plans are used by staff to help take care of residents. A review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 11/2018, indicated the facility is to provide person-centered, comprehensive and interdisciplinary care. The P&P also indicated the care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs that will be reviewed and revised at the following times: Onset of new problems; Change of condition; To address changes in behavior and care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48481 Based on observation, interview, and record review, the facility failed to review and revise a resident-centered care plan for one of three sampled residents (Resident 93) to address interventions for occasional bladder incontinence (no control urination) after the removal of the urinary catheter (a flexible tube catheter inserted into the bladder to drain urine from the bladder). As a result of this deficient practice Resident 93 did not receive consitent care and services to regain continence (control) of bladder and prevent urinary tract infection (UTI - an infection in any part of the urinary system, the kidneys, bladder or urethra). Findings: A review of the Admission Record dated 12/07/2023 indicated Resident 93 was admitted to the facility with diagnoses that included dementia (conditions characterized by impairment of at least two brain functions), and psychosis (a mental disorder characterized by a disconnection from reality.) A review of Resident 93's Minimum Data Set (MDS - a comprehensive assessment and care tool) dated 6/18/2024 indicated Resident 93 ' s cognitive (ability to understand and reason) status in elderly residents) was severely impaired cognition) and the urinary function was frequently incontinent. A review of the Comprehensive Care Plan initiated on 12/7/23, revised on 3/15/24, indicated Resident 93 had a urinary catheter due to urinary retention (the inability to empty the bladder completely). The care plan's goal was to ensure Resident 93 did not show signs and symptoms of urinary infection and remain free from trauma related to the catheter use. A review of Baseline Care Plan dated 12/17/23 showed Resident 93 was frequently incontinent. A review of the Progress Note dated 5/9/24 indicated Resident 93 was diagnosed with urinary tract infection and was prescribed antibiotics (medication used to treat infection). During a concurrent interview and record review on 7/11/24 at 10:50 a.m. with the Registered Nurse (RN) 1, RN 1 stated Resident 93's urinary catheter was present when the resident was first admitted to the hospital but was discontinued on the same day. RN 1 stated the licensed nursing staffs were responsible for revising and updating the care plan when there was a change in the resident's condition. RN 1 stated Resident 93's comprehensive care plan should have been revised and updated since the urinary catheter was removed, and should havbe been identified to indicate interventions to care for Residnet 93 who was incontinent. During an interview on 07/12/24 at 2:15 p.m. with Director of Nurses (DON), The DON stated, the licensed staff should have revised and updated the resident's care plan, but it was not done. (continued on next page)

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F 0657 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, Comprehensive Person-Centered Care Planning Policy dated 9/7/23, indicated, Within 7 days from the completion of the comprehensive MDS assessment the comprehensive care plan will be developed. The comprehensive care plan will be periodically reviewed and revised, in addition, at the following times: ii. Change of condition.

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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** 44018 Based on observation, interview, and record review, the facility failed to implement care and services to prevent the development of skin breakdown and/or pressure ulcer (painful wound caused as a result of pressure or friction) for one (1) of three sampled Residents (Resident 15) in accordance with the facility's policy and procedure by failing to ensure the Low Air Loss mattress (LAL, mattress designed to circulate a constant flow of air for the management of pressure ulcer) was based on the resident ' s weight as ordered by the physician. The physician ordered for Resident 15's LAL mattress to be set at #6 (setting for 275 pounds [lbs. unit of mass] body weight), the LAL mattress was observed set at #2 (setting for 150 lbs. body weight) and the mattress was soft. This deficient practice had the potential for the resident to be at risk of developing new pressure ulcer. Findings: A review of Resident 15's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. with diagnoses which included morbid obesity (severely overweight) and hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness) following cerebral infarction (disrupted blood flow to the brain) affecting right dominant side. A review of Resident 15's History and Physical Examination (H&P) dated 2/25/2024, indicated Resident 15 has fluctuating capacity to understand and make decisions. A review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/23/2024, indicated Resident 15 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 15 required substantial/maximal assistance (helper does more than half the effort) from staff for eating, oral hygiene, and toileting hygiene. The MDS also indicated Resident 15 was totally dependent (full staff performance every time) on staff to provide lower body dressing and putting on/taking off footwear. A review of Resident 15's care plan (CP), titled Skin Maintenance, reevaluated on 4/21/2024, indicated to maintain skin integrity of Resident 15, the facility will ensure the LAL mattress was set at #6 (275 millimeters [mm] of mercury [Hg] unit of pressure measurement), repositioning and support of bony prominences. A review of Resident 15's Order Summary Report (a summary of all currently active physician orders), dated 4/21/2024, indicated Resident 15 was ordered to use LAL mattress. Another order dated 4/22/2024, indicated to check and verify LAL mattress functioning and correctly and set at 6 (275 pounds [lbs., unit of mass] every shift). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident 15's room on, 7/9/2023 at 11:51 AM, Resident 15 was observed lying in the LAL mattress that was not fully inflated. Resident 15's LAL mattress setting was set on #2 (150 mmHg). During a concurrent observation in Resident 15's room and interview with the Certified Nursing Assistant (CNA) 1 on 7/10/2024 at 11:58 AM, CNA 1 stated Resident 15's LAL mattress setting was set at 150 mmHg. During a concurrent interview with Director of Staff Development (DSD) in the Resident 15 ' s room on 7/9/24 at 12:13 PM, DSD stated, the Resident 15's LAL mattress setting was set at #2-150 mmHg which was too soft for resident since Resident 15's weight was greater than 200 lbs. DSD stated the LAL mattress setting should be set based on Resident 15 ' s weight. A review of Resident 15's Weights Summary, dated 7/10/2024 at 3:06 PM, indicated Resident 15 weighted 281 lbs. During an interview with Director of Nursing (DON) and record review of Resident 15's Physician order on, 7/10/2024 at 4:24 PM, DON stated the Physician's order dated 4/21/2024, indicated to check and verify LAL mattress is functioning and correctly set on 6 (275 lbs.). The DON stated Resident 15 ' s weight is 281 lbs. based off Resident 15's recorded weight in the Weight Summary dated 7/10/2024. The DON stated Resident 15 ' s LAL mattress was set too soft; it would potentially cause discomfort and would not serve the purpose of preventing skin breakdown. A review of facility's policy and procedure (P&P) titled, Mattresses, date issued on 9/1/2012, P&P indicated, an air mattress is used under the direction of an attending physician ' s order or when the resident ' s clinical condition warrants pressure reducing devices .be sure that mattress is inflating properly, check air mattress routinely to ensure that it is working properly. A review of the undated [NAME] Air Alternating Pressure Redistribution System, indicated on the operation, the pressure of the mattress can be adjusted according to the weight and height of the patient, adjust the pressure setting to the most suitable level without bottoming out using the Comfort Setting buttons (+) and (-).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48481 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 63) who had an indwelling catheter (a flexible tube [a catheter] inserted into the bladder that remains (dwells) there for continuous urinary drainage) was provided with care and services to prevent and urinary tract infection (UTI, an infection of the kidney, ureter, bladder, or urethra) by ensuring the urinary indwelling catheter was secured/ anchored and not touching the floor. This deficient practice placed the resident at risk to have potential accidental dislodgement (removal) of the catheter that may result with a trauma to the urethra (a hollow tube that lets urine leave the body) and urinary tract infection. Findings: During a concurrent observation and interview on 7/10/24 at 8:50 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 63 was in the room with the indwelling that was not secured and anchored and the catheter bag touching the floor. In an interview LVN 1 stated the urinary bag should not be touching the floor, even if the bed was kept low position. During a concurrent observation and interview on 7/11/24 at 10:35 a.m., LVN 5 stated Resident 65 ' a urinary catheter tubing should be anchored (secured) to Resident 63's leg to prevent pulling or dislodgement of the catheter. During an interview on 07/12/24 at 2:30 p.m. with Director of Nurses (DON), The DON stated I understand that, I spoke to the RNs and will make sure they have to come up with the device for securing catheter. As for the urinary bag, they will make sure it ' s kept off the floor. During a review of the facility's policy and procedure titled, Catheter Care- of, dated 6/10/21, indicated, The catheter will be anchored to prevent excessive tension on the catheter, and the catheter tubing, bag, or spigot will be anchored to not touch the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to provide oxygen therapy (treatment that provides supplemental, or extra oxygen) and necessary respiratory care services for two (2) of three (3) sampled residents (Resident 31 and Resident 50) in accordance with the facility's policy and procedure by failing to: 1. Ensure Resident 31 who was using the nasal cannula (a device that delivers extra oxygen through a tube and into your nose) for continuous oxygen therapy was properly placed on her nostrils (two openings in the nose through which air moves when you breathe) and not on the resident's right cheek. This deficient practice had the potential for Resident 31's lung, heart, brain at risk for hypoxemia (low concentration of oxygen in the blood) and can be life-threatening. 2. For Resident 50 with history of pneumonia (a severe lung infection), label Resident 50 ' s nasal cannula (NC- a flexible tubing used to deliver oxygen into the nares) with the date of when the NC was last changed. a. Administer oxygen per physician's order of 2 liters per minutes (LPM, liter-unit of volume, minutes-unit of time). Resident 50 was observed with 4 LPM. b. Assess Resident 50's oxygen saturation (a measurement of how much oxygen that blood is carrying as a percentage of the maximum it could carry) when receiving oxygen therapy and after to ensure the level of oxygen delivered was effective. This failure had a potential for Resident 50 to develop lung infection, receive low oxygen level that does not meet the body ' s oxygen demand, and if prolonged, could result in hypoxia (low oxygen level or saturation in the blood) and lead to difficulty breathing and death. Findings: 1. A review of Resident 31's Admission Record indicated the resident was admitted to the facility on [DATE], readmitted on [DATE], with diagnoses that included bronchitis (an inflammation of the tubes that carry air to and from the lungs.) and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). A review of Resident 31 ' s History and Physical Examination (H&P) dated 2/13/2024, indicated Resident 31 does not have the capacity to understand and make decisions. A review of Resident 31's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/5/2024, indicated Resident 31 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 31 required substantial/maximal assistance (helper does more than half the effort) from staff for eating, oral hygiene, toilet hygiene, and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan for oxygen therapy dated 2/23/2024, indicated the goal was not to have shortness of breath. The intervention indicated to maintain clear airway, to administer oxygen as ordered, and to elevate HOB to 90 degrees. A review of Resident 31's Physician's order dated 2/21/2024, indicated for the resident to receive oxygen at 3 liters per minute (LPM-liters of oxygen should flow into the patient ' s nose in one minute) via nasal cannula continuously to keep oxygen saturation above 90% (normal range 90-100%) secondary to COPD and to keep the resident ' s head of bed (HOB) elevated at all times. During a general observation in Resident 31's room on, 7/9/2024 at 10:42 AM, Resident 31 was lying on the bed, with the nasal cannula on the resident ' s right cheek. During a concurrent observation in Resident 31's room on 7/9/2024 at 10:48 AM, a Certificated Nursing Assistant (CNA) 3 entered Resident 31 ' s room and turned off the call light and exited the room. Resident 31 was lying on the bed with the nasal cannula on her right cheek. During a concurrent observation in Resident 31's room and interview with Licensed Vocational Nurse (LVN) 1 on, 7/9/2024 at 10:52 AM, LVN 1 stated the nasal cannula was on Resident 31's right cheek, it should be placed properly in her nares. LVN 1 was asked to check Resident 31 ' s oxygenation via pulse oximeter (a device use for monitoring oxygen saturation) and Resident 31 ' s oxygen saturation level was 92%. During an interview with Director of Nursing (DON) on 7/9/2024 at 4:23 PM, DON stated when LVN 1 did rounds first thing in the morning and at least every two hours, LVN 1 should have noticed that NC was not properly placed on Resident 31 ' s nose. DON stated Resident 31 would not effectively receive oxygen treatment as physician ordered if the NC was not placed properly. The DON stated the physician order was for the resident to receive oxygen via NC, continuously. 47467 2. A review of Resident 50's Admission Record indicated Resident 50 was admitted to the facility on [DATE], with diagnosis that included severe obesity (overweight), major depressive disorder [a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life with psychotic features (delusions and hallucinations)], acute bronchitis (virus or bacterial infection that causes the lungs to become inflamed), and pneumonia. A review of Resident 50's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/16/2024 indicated, Resident 50 ' s cognitive skills (ability to think, remember, and reason) was moderately impaired, needed substantial/maximal assistance (helper does more than half the effort, healer lifts or holds trunk or limbs and provides more than half the effort) in toileting hygiene (maintain perineal hygiene), shower/bathe self (washing, rising, and drying self), and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 50's Order Summary Report, dated 7/1/2024, indicated the physician ordered on 1/22/2023 to have Resident 50 ' s oxygen tubing changed every Sunday during 7 AM to 3 PM shift, and the physician ordered on 12/27/2023 to have Resident 50 receive on oxygen at 2 liter (unit of volume) per minute (unit of time) via NC as needed to maintain oxygen saturation above 92% for shortness of breath as needed. A review of Resident 50's Care Plan, dated 1/22/2024, indicated Resident 50 was to receiving oxygen as needed via NC if saturation below 92% with the goal for Resident 50 to demonstrate improved gas exchange in the lungs as evidenced by oxygen saturation greater than 92%, and within one hours of nursing interventions, the resident will improve ventilation [the exchange of air between the lungs and the atmosphere so that oxygen can be exchanged for carbon dioxide in the alveoli (the tiny air sacs in the lungs)] and gas exchange as evidenced by oxygen saturation with normal range and respiratory rate greater than 8. The care plan indicated, the interventions included to administer 2 LPM of oxygen through a NC as needed for saturation below 92%, to assess respirations for rate and quality, as well as use of accessory muscles (a muscle that is not primarily responsible for movement but does provide assistance), and to monitor vital signs for oxygen saturation and changes in heart rate, blood pressure, or cardiac rhythm (the rhythm of a beating heart). A review of Resident 50 ' s Weights and Vitals Summary, dated 7/1/2024 to 7/31/2024, indicated, no respiration rate and oxygen saturation documented on 7/9/2024. The record also indicated, the most recent oxygen saturation record prior to 7/9/2024 was documented on 7/4/2024 at 6:59 PM, which indicated Resident 50 ' s oxygen saturation was at 94% on room air. A review of Resident 50 ' s Progress Note, dated 6/1/24 to 7/10/2024, indicated no documented evidence the respiratory rate and oxygen saturation documented on 7/9/2024. During an observation on 7/9/2024 at 9 AM in Resident 50 ' s room, Resident 50 was observed lying in bed with 4 LPM oxygen given via a NC, without the date and name on the NC tubing. During a concurrent observation and interview on 7/9/2024 at 10:40 AM with Licensed Vocational Nurse (LVN) 3, Resident 50 was observed receiving oxygen at 4 LPM oxygen via a NC, without the date and name on the NC tubing. LVN 3 stated, she could not find any label of the date the NC tubing was changed. LVN 3 stated, by looking at the NC, she could not tell the last time the NC tubing was changed because there was no date on it. LVN 3 stated, the NC tubing was supposed to be changed every Sunday and labelled with the change date to keep track of the last time it was changed to prevent infection. 2. During an observation on 7/9/2024 at 2:20 PM in Resident 50 ' s room, Resident 50 was observed being cleaned and assisted with ADL (activates of daily living) by changed by Certified Nurse Assistant (CNA) 2. During a concurrent observation on 7/9/2024 at 2:35 PM in Resident 50 ' s room, Resident 50 was observed not receiving oxygen, with oxygen device set at 2 LPM and the NC tubing was placed on top of Resident 50 ' s personal belongings at bedside drawer on the right side of Resident 50 ' s bed. In a concurrent interview Resident 50 stated, he had pneumonia for the past few days and was short of breath, so he needed the oxygen. Resident 50 was observed touching his nose and became anxious asking the surveyor where his NC tubing was. Resident 50 was observed getting upset and repeatedly stating he needed his oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/9/2024 at 2:40 PM in Resident 50 ' s room with LVN 3, Resident 50 was observed without NC tubing and no oxygen therapy. Resident 50 ' s oxygen saturation was checked by LVN 3, and the result was fluctuating between 90 to 92%. LVN 3 stated, Resident 50 needed oxygen because of his recent short of breath due to pneumonia. LVN 3 was observed asking Resident 50 if he removed his NC by himself, Resident 50 stated, he did not remove his NC because he needed oxygen to breathe. During an interview on 7/9/2024 at 2:55 PM with Registered Nurse (RN) 2, RN 2 stated, when LVN 3 notified her that Resident 50 ' s NC was not labeled with the date the NC was last changed, RN 2 stated when she came to change Resident 50 ' s NC, she noticed that Resident 50 was receiving oxygen at 4 LPM while the physician order was at 2 LPM. RN 2 stated, she lowered the oxygen down to 2 LPM per ordered and did not remove it from the resident. RN 2 stated, she checked Resident 50 ' s oxygen saturation and it was at 98%. During an interview on 7/10/2024 at 3:05 PM with the Infection Control Nurse (IPN), the IPN stated, the oxygen tubing was supposed to be dated with a label when the tubing was changed because it was how they checked if it was changed weekly. If it was not dated, the facility ' s staffs would not know how long the nasal cannula had been there and there could be a risk of the resident ' s contracting infection via breathing route such as pneumonia. During an interview on 7/11/2024 at 3 PM with the Director of Nurses (DON), the DON stated, Resident 50 ' s NC should have a tag with date to track the date to change it regularly to prevent infection. The DON stated, Resident 50 should be given oxygen according to the physician order, which was at 2 LPM, and not 4 LPM. The DON stated, if there was a change that it should be increase to 4 LPM, the physician should have been notified. The DON stated, he did not know why it was at 4 LPM, and it could be because of the oxygen device error. The DON stated, Resident 50 ' s oxygen device did not have a humidifier, so having Resident 50 on oxygen at 4 LPM for a period of time could potentially resulted in dry nose and eventually bleeding in the nose. During a phone interview on 7/11/2024 at 3:22 PM with CNA 2 on a speaker in the presence of the DON, CNA 2 stated, he was cleaning and changing Resident 50 on 7/9/2024 when the Resident 50 was found without oxygen on. CNA 2 stated, he removed Resident 50 NC tubing before he started to assist the resident with ADL because he had to remove Resident 50 ' s gown. CNA 2 stated, it took him 15 minutes to clean and change Resident 50. CNA 2 confirmed that Resident 50 was not receiving oxygen for 15 minutes while the resident was assisted with ADL. During an interview on 7/11/2024 at 3:26 PM with the DON, the DON stated, Resident 50 had a recent pneumonia and with short of breath, which was why he needed oxygen. The DON stated, when CNA 2 was cleaning and changing Resident 50, it would involve in positioning the resident and giving him a work up, which was the same as giving him a physical therapy. The DON stated it could explain why his oxygen saturation went down to 90-92%. The DON stated, CNA 2 should not remove Resident 50 ' s NC and 15 minutes is a long time to remove the resident ' s oxygen. During a concurrent record review and interview on 7/11/2024 at 3:30 PM with the DON, Resident 50 ' s oxygen saturation record on 7/9/2024 was reviewed. The DON stated, he did not see any record that was documented related to desaturation on 7/9/2024. (continued on next page)

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Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 7/11/2024 at 3:36 PM with LVN 3 on speaker in the presence of the DON, LVN 3 confirmed that she checked Resident 50 ' s oxygen saturation when she was notified by the surveyor, and it was at 90-92%. LVN 3 stated, she did not document it in the vital signs or in the progress notes. LVN 3 stated, she should have documented the oxygen saturation so that it could be monitored. During an interview on 7/11/2024 at 3:43 PM with the DON, the DON stated, Resident 50 ' s respiration should have been assessed and documented so that the care team would know and monitor. The DON stated, it was important to know because they could adjust the resident ' s plan of care while he was being changed. A review of facility's policy and procedure (P&P) titled, Oxygen Therapy, date issued on 11/2017, P&P indicated, the purpose of this procedure is to administer oxygen per physician orders. Oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure one of twenty-seven sampled residents (Resident 65), who was observed with pain on 7/9/2024 was assessed for pain and reassessed for effectiveness of pain management and relief interventions as indicated in the facility ' s policy and procedure for pain management. This failure resulted Resident 65 in recieving delayed care and services to relieve pain, which can also potentially affect the resident's ability to maintain the highest practicable level of well-being and healing process. Findings: A review of an Admission Record indicated Resident 65 was admitted to the facility on [DATE], with diagnosis that included arthritis (the swelling and tenderness of one or more joints [places where two bones meet, such as the elbow or knee]) in multiple sites, muscle wasting and atrophy, primary generalized osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wears down), and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities]. A review of Resident 65's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 6/21/2024 indicated, Resident 6's cognitive skills was severely impaired (difficulty with or unable to make decisions, learn, remember things), needed supervision/touching assistance (oversight, encouragement or cueing) in eating, and needed substantial/maximal assistance (helper does more than half the effort, healer lifts or holds trunk or limbs and provides more than half the effort) in toileting hygiene (maintain perineal hygiene), shower/bathe self (washing, rising, and drying self). A review of Resident 65's Order Summary Report, dated 7/1/2024, indicated the physician ordered on 5/30/2024 to assess the resident ' s level of pain every shift with 0 for no pain, 1-4 for mild pain, 5-7 for moderate pain, 8-9 for severe pain, 10 for horrible pain. The report also indicated the physician ordered Resident 65 on 6/25/2024 to administer 500 mg (unit of weight) of Methocarbamol (a type of pain medication) by mouth two times a day for right knee and leg pain. A review of Resident 65's Care Plan, initiated on 7/15/2022 and revised on 6/11/2024, indicated Resident 65 was at risk for pain due to osteoarthritis. The care plan goal indicated for Resident 65 to verbalize or show decreased signs and symptoms of pain, with the interventions that included, Resident 65 will be assessed for level of pain using pain rating scale (1-10) and assess pain medication and treatment for effectiveness. A review of Resident 65 ' s Medication Administration Record (MAR) indicated no documented evidence that Resident 65 was assessed for pain during evening shift (from 3 PM to 11 PM) on 7/9/2024. A review of Resident 65's Progress Notes, dated from 5/1/2024 to 7/10/2024, indicated no documented evidence that a note related to pain assessment was documented on 7/9/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/9/2024 at 3:50 PM in Resident 65 s room, Resident 65 was observed calling help, help, help multiple times and was observed restless, uneasy, rocking back and forth in bed with both hands holding her knees. No staff was observed coming into the resident ' s room to assist Resident 65. During an interview on 7/9/2024 at 4 PM, Resident 65 stated, she had pain in her knees and on the back with a pain level of 10/10 (pain scale from 0-10, 0 means no pain and 10 means the worst pain ever felt). The Surveyor walked out to the Nursing Station and informed Licensed Vocational Nurse (LVN) 6, who was in charge of Resident 65 that Resident 65 was requesting for assistance due to knee and back pain. During a concurrent observation and interview on 7/9/2024 at 4:05 PM in Resident 65's room with LVN 6, Resident 65 was observed restless and informed LVN 6 of having pain on her knees and on her back. LVN 6 stated, Resident 65 had a lot of anxiety and pain, especially in the afternoon when she comes back from the activities. LVN 6 stated, Resident 65 had scheduled evening pain medications due at 5 PM, which included her pain medication. LVN 6 stated, she could not give Resident 65 pain medication early because the evening medications included her psychiatric (related to mental illness and its treatment) pills, which could make Resident 65 felt asleep during her dinner time. During an interview on 7/10/2024 at 4 PM with LVN 6, LVN 6 stated, Resident 65 was scheduled Methocarbamol (pain medication) after she was notified by the surveyor on 7/9/2024. LVN 6 stated, she did not assess Resident 65's pain and reassess after the medication was given. During an interview on 7/11/2024 at 1:50 PM with Registered Nurse (RN) 2, RN 2 stated, regardless of chronic pain, when a resident verbalized pain, licensed nurses were supposed to assess the resident for the location, level and characteristic of pain and document the assessment in the pain assessment or progress notes because the pain could be something new or exacerbation (an increase in severity) of an existing pain that the resident ' s current interventions were no longer effective. RN 2 stated, when a resident had pain, the licensed nurses had to attempt non-pharmacologic methods (therapies that do not involve drugs) like repositioning, breathing technique, and if the methods did not work, they could give pain medications. RN 2 stated, they had to reassess after an hour to make sure their interventions were effective. During an interview on 7/11/2024 at 2:35 PM with the Director of Nurses (DON), the DON stated, Resident 65's scheduled pain medication with psychiatric medications should not be the reason why LVN 6 could not give pain medication to Resident 65 to relieve pain. The DON stated, LVN 6 should have report it to him so it could be easily fixed by adjusting the schedule and updated the care plan so they could give more attention to Resident 65 after she came back from her activities. The DON stated, LVN 6 should have assessed Resident 65 for pain right after she was made aware of Resident 65 ' s pain and reassessed for interventions effectiveness after LVN 6 provided Resident 65 with pain relieve medication. The DON stated, Resident 65 could have suffered from pain if the interventions were not provided right away. A review of the facility's policy and procedure (P&P) titled, Pain Management, dated November 2016, indicated the following information: -Facility Staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident ' s pain to the extent possible. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Licensed Nurse will assess each resident for pain upon admission, quarterly, when there is a new onset of pain, exacerbation of pain, or when there is a significant change in status. -The Licensed Nurse will complete a Pain Assessment for residents identified as having pain. -After medications/interventions are implemented, the licensed nurse will reevaluate the resident ' s level of pain within one hour. -The Licensed Nurse will assess the resident for pain and document results on the MAR each shift using the 0-10 pain scale. The shift pain score will indicate the highest pain level that occurred on that shift. A review of the facility ' s P&P titled, Administration of Pain Medication, dated November 2016, indicated the following information: -Resident who receive around the clock (to be administered at regular time intervals to maintain consistent levels of the drug in the bloodstream) pain medication will be reassessed if the pain is managed, or the breakthrough medications becomes routinely needed in between doses of pain medications. -Assess and document the resident ' s intensity of pain prior to the administration of pain medication. Reassess the intensity of the resident ' s pain one hour after pain medication had been administered. -Document the resident ' s response to and the effectiveness of the pain medication in the resident ' s medical record.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, and record review, the facility failed provide evidence that the Annual Certified Nurse Assistant (CNA) Core Clinical Competencies (ACCC, an assessment and training on the CNAs for the ability to perform clinical nursing care) was completed. In addition, the facility failed to provide evidence that there was a system in place to keep track of the CNA's performance evaluation to ensure eight of eight sampled CNAs (CNA 5, 6, 7, 8, 10, 12, 13, 14) were evaluated for their competencies annually and provided training based on the outcome of the review for each of the CNAs. This failure had a potential to result in the facility's resident ' s population based on the Facility Assessment (an assessment to make decisions about direct care staff needs, as well capabilities to provide services to the residents) not to receive quality care services from CNAs with insufficient skills and competencies. Findings: During an interview on 7/12/2024 at 10 AM with the Director of Nurses (DON), the DON stated, the Director of Staff Development (DSD) had an emergency, so she was off. The DON stated, the DSD usually reported to him and when the DSD was not present in the facility, the DON was responsible to cover. During an interview on 7/12/2024 at 2:48 PM with the DON, the DON stated, the DSD was responsible to complete the ACCC for each of the hired CNA. The DON stated, to keep track of the CNA ' s performance evaluation, there should be a system in place, which should be a spread sheet that listed all active CNAs with their hired date and included their last ACCC date. The DON stated, he had not seen the DSD ' s spread sheet to prove that the annual core competencies had been done and tracked. The DON stated the annual competencies skill check was very important because it was to ensure all CNAs deliver care correctly, safely, and up to current standard. During an interview on 7/12/2024 at 6 PM with CNA 6, CNA 6 stated, she had been working in the facility for about [AGE] years. CNA 6 stated, she could not remember when her last annual skill competencies were evaluated. CNA 6 stated, she remembered the DSD came and asked her Charge Nurse how she took care of the residents and completed her skills check. CNA 6 stated, she did not know what skills there were to be checked annually. During an interview on 7/12/2024 at 6:05 PM with CNA 7, CNA 7 stated, she had been working in the facility for [AGE] years. CNA 7 stated, she did not recall if there was any annual competencies skills check done last year (2023). During an interview on 7/12/2024 at 6:07 PM with CNA 8, CNA 8 stated, he could not recall if he had any annual competencies skills check. CNA 8 stated, he recalled that he received in-services for putting on gowns, and how to clean the residents. A review of the facility's Active Licensed Nurse and CNA list, undated, provided by the DON, indicated the following information: 1. CNA 5 was hired on 12/1/2022. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. CNA 6 was hired on 7/15/2004. 3. CNA 7 was hired on 11/23/2012. 4. CNA 8 was hired on 4/21/2017. 5. CNA 10 was hired on 8/16/1986. 6. CNA 12 was hired on 2/6/2023. 7. CNA 13 was hired on 12/6/2021. 8. CNA 14 was hired on 9/15/2021. During a concurrent record review and interview on 7/12/2024 at 6:15 PM in the DSD ' s office with the DON, the CNAs ' employee files for CNA 5, 6, 7, 8, 10, 12, 13, 14 were reviewed, no ACCC found on their files. The DON stated, he could not locate the CNAs ' ACCC in the DSD ' s office or anywhere else in the facility, including the overflow office. The DON stated, he had evidence for CNAs skills competencies provided for Showering/Bathing, Donning and Doffing gloves. The DON confirmed that the evidence he could provide only account for partial annual skills checks because all skills listed in the ACCC must be completed annually. A review of the facility ' s policy and procedure (P&P) titled, Staff Competency Assessment, dated 3/17/2022, indicated the following information: - Each department manager or supervisor will be responsible to see that staff have competency assessments performed for their respective staff. - The competency assessment will be retained in the employee file or a 3-ring binder, indefinitely for current employees and seven (7) years from the last date of employment for former employees.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 47467 Based on observation, interview and record review, the facility failed to ensure the facility's staffing information was posted in a prominent place readily accessible to residents and visitors on a daily basis for one of three nursing station, residents As a result, the total number of staff and the actual hours worked by the staff was not readily accessible to residents and visitors. Findings: During an interview on 7/12/2024 at 10 AM with the Director of Nurses (DON), the DON stated, the Director of Staff Development (DSD) was responsible to update the facility ' s staffing information daily and post it on the designated area on the wall in the hallway, which was right in front of the DON's office. During a concurrent observation and interview on 7/12/2024 at 10:10 AM with the Administrator (ADM), the facility ' s staffing information was observed dated 7/11/2024. The ADM stated, the DSD informed her that the DSD had updated the staffing information and had a printout copy placed in the DSD ' s office before she left the facility early in the morning. The ADM stated, she forgot to post it. During an interview on 7/12/2024 at 10:15 AM with the DON, the DON stated, the staffing information was supposed to be updated daily and posted before 6 AM, the beginning of the shift, so that all of the facility ' s residents could see. A review of the facility ' s policy and procedure titled, Nursing Department - Staffing, Scheduling, & Posting, revised July 2018, indicated the facility will post the nurse staffing data on a daily basis at the beginning of each shift. Data must be posted in a clear and readable format, in a prominent place readily accessible to residents and visitors.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review, the facility failed to identify the need for medically related social services for one out of 3 sampled residents (Resident 99) and ensure that these services are provided. For Resident 99, the facility failed to follow up on Resident 99's plan for surgery for the diagnosis of inguinal hernia (a condition in which soft tissue bulges through a weak point in the abdominal muscles, causing discomfort and/or pain). This deficient practice had the potential for Resident 99 to suffer complications of inguinal hernia such as abdominal pain and discomfort. Findings: A review of Resident 99's Admission Record indicated Resident 99 was admitted to the facility on [DATE] with diagnoses that included inguinal hernia and weight loss. A review of Resident 99's History and Physical (H&P), dated 3/14/2024, indicated Resident 99 had the capacity to understand and make medical decisions. The H&P indicated Resident 99 had a history of inguinal hernia and abdominal pain. A review of Resident 99's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/19/2024, indicated Resident 99 had intact cognition (able to make reasonable decisions). A review of Resident 99's physician progress notes, dated 5/1/2024, timed at 12:50 PM, indicated Resident 99 would still like to proceed with surgery. The notes also indicated the surgeon is awaiting clearance from oncology. A review of Resident 99's Order Listing Report, dated 7/10/2024, indicated an order for Surgery Consult, dated 3/25/2024. During a review of Resident 99's Progress Notes, from 3/1/2024 to 7/9/2024 (four months), dated 7/11/2024, an entry on 4/17/2024 indicated the facility was awaiting surgeon for date. Further review of the progress notes did not show documented evidence of any attempts of the facility to contact the physician regarding Resident 99 ' s surgery. During an observation and interview on 7/9/2024 at 9:30 AM, inside Resident 99's room, Resident 99 was sitting on the edge of the bed eating breakfast. Resident 99 stated he was eating slowly because his abdomen was bothering him. Resident 99 stated he has a hernia, and he can only eat slowly. Resident 99 stated he wants to have a surgery done for his hernia and that he had already informed the facility staff about it. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/10/2024 at 4:07 PM with Registered Nurse (RN) 1 in Resident 99's room, RN 1 stated Resident 99 ' s lunch tray was untouched, and Resident 99 has not eaten his lunch. Resident 99 stated he did not want to eat yet because he had some abdominal discomfort. Resident 99 stated he wanted to know when he will get the surgery for his inguinal hernia. RN 1 stated the facility was aware of the resident ' s desire to have the surgery. During a concurrent interview and record review on 7/12/2024 at 10:13 AM with RN 1, Resident 99 ' s medical records were reviewed. RN 1 stated the last nurses ' notes pertaining to Resident 99 ' s surgery was entered on 4/17/2024, which indicated that the facility was waiting for the surgery date. RN 1 stated the physician ' s progress notes, dated 5/1/2024, indicated the resident still wanted to have the surgery, and that the surgeon was awaiting for surgery clearance (the process by which the resident ' s overall health and medical condition are evaluated to determine if they are suitable for a specific surgical procedure) from the oncologist (a doctor who has special training in diagnosing and treating cancer [a disease in which abnormal cells divide uncontrollably and destroy body tissue]). RN 1 stated there were no follow up notes after 4/17/2024, that indicated the facility staff made any attempts to follow up with the physician regarding Resident 99 ' s surgery. During a concurrent interview and record review on 7/12/2024 at 11:48 AM with RN 3, Resident 99 ' s medical records were reviewed. RN 3 stated there were no documented evidence that facility staff followed up on Resident 99 ' s surgery, including a clearance from Resident 99 ' s oncologist. RN 3 stated there should be better communication between staff to follow up on the surgery. RN 3 stated if the surgery was not followed up, Resident 99 ' s medical choice would not be honored, and the resident could be suffering further discomfort because of not getting the surgery. During an interview on 7/12/2024 at 2:15 PM with Director of Nursing (DON), the DON stated he was aware of Resident 99 ' s desire to undergo the surgery. The DON stated the surgery cannot be scheduled without getting clearance from the oncologist. A review of the facility ' s Policy and Procedure (P&P) titled, Referral to Outside Services, revised 12/1/2013, indicated the Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the facility. The P&P also indicated for clinical services, a nursing designee will assist the Director of Social Services in locating a provider. A review of the facility ' s P&P titled, Resident Rights, revised 1/1/2012, indicated it is a resident ' s rights to choose a physician and treatment and participate in decisions and care planning. The P&P indicated the facility will promote and promote the residents ' rights.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview, and record review the facility failed to: 1. Ensure to provide the name of medications and their indication (reason for the use of the medication) prior to administration of the medications, affecting one (1) of seven (7) residents observed for medication administration (Resident 23.) 2. Account for six (6) doses of Controlled Substances ([CS]- also known as narcotics are medications which have a potential for abuse and may also lead to physical or psychological dependence) for Residents 13, 45, 57 and 67, in one of two inspected Medication Carts (Station North). These deficient practices violated Resident 23 ' s rights to make decisions regarding their medication regimen, and increased the opportunity for CS diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and risk that Residents 13, 45, 57 and 67 could have delayed medication treatment and continuity of care due to lack of availability of the CS, and accidental exposure to harmful medications, possibly leading to physical and psychosocial harm. Findings: During an observation on 7/10/2024 at 9:44 AM, in Medication Cart Station North, Licensed Vocational Nurse (LVN) 7 was observed administering 11 medications, including two (2) docusate sodium (a laxative type medication used to soften stool [feces]) 100 milligram ([mg]-a unit of measure of mass) tablets orally to Resident 23. LVN 7 did not inform Resident 23 the name of the 11 medications administered and their indications. During the observation, Resident 23 swallowed the medications including the two docusate tablets with a full glass of water and verbalized to LVN 7 that Resident 23 did not want to be given any laxatives that morning. During an interview on 7/10/2024 at 9:46 AM, with LVN 7, LVN 7 stated LVN 7 administered 11 medications including two docusate tablets to Resident 23 at 9:44 AM and failed to inform Resident 23 the names of the medications and their indications prior to the resident swallowing the medications. LVN 7 stated that Resident 23 verbalized Resident 23 did not want laxatives that morning, however, LVN 7 had already administered the docusate tablets. LVN 7 stated that LVN 7 usually informed residents of each medication and the indication prior to administration but forgot to do so this time. LVN 7 stated it was important to follow this process to ensure Resident 23 was informed of their care and treatment and had the opportunity to state their preferences such as not wanting laxatives that morning. During an observation on 7/10/2024 at 10:52 AM, with LVN 7, in Medication Cart Station North, there was a discrepancy in the count between the Individual Narcotic Record accountability log and the amount of medication remaining in the medication bubble pack (a medication packaging system that contains individual doses of medication per bubble) for the following residents: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One dose of oxycodone with acetaminophen (a combination CS used for pain) 7.5-325 milligram ([mg] - a unit of measure of mass) tablet missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 13. The Individual Narcotic Record accountability log for oxycodone with acetaminophen indicated the medication bubble pack should have contained a total of 20 oxycodone with acetaminophen 7.5-325 mg tablets, after the last administration of oxycodone with acetaminophen 7.5-325 mg tablet documented/signed-off on 7/10/2024 at 1 AM. However, the medication bubble pack contained 19 oxycodone with acetaminophen 7.5-325 mg tablets and did not indicate other documentation of subsequent administrations. 2.Three doses (total 60 milliliter ([ml]- a unit of measure of volume) of Lacosamide (a CS used for seizures [bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness,) 10 mg/ml solution was missing from the medication bottle compared to the count indicated on the Individual Narcotic Record accountability log for Resident 45. The Individual Narcotic Record accountability log for Lacosamide indicated the medication bottle should have contained a total of 400 ml Lacosamide solutions, after the last administration of Lacosamide 20 ml solution documented/signed-off on 7/9/2024 at 9 AM. However, the medication bottle contained 340 ml Lacosamide solution and did not indicate other documentation of subsequent administrations. 3. One dose of lorazepam (a CS used for anxiety) 0.5 mg tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 57. The Individual Narcotic Record accountability log for lorazepam indicated the medication bubble pack should have contained a total of 37 lorazepam 0.5 mg tablets, after the last administration of lorazepam 0.5 mg tablet documented/signed-off on 7/9/2024 at 5 PM. However, the medication bubble pack contained 36 lorazepam 0.5 mg tablets and contained no other documentation of subsequent administrations. 4. One dose of clonazepam (a CS used for anxiety) 0.5 mg tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 67. The Individual Narcotic Record accountability log for clonazepam indicated the medication bubble pack should have contained a total of 8 clonazepam 0.5 mg tablets, after the last administration of clonazepam 0.5 mg tablet documented/signed-off on 7/9/2024 at 9 AM. However, the medication bubble pack contained 7 clonazepam 0.5 mg tablets and contained no other documentation of subsequent administrations. During a concurrent interview with LVN 7, LVN 7 stated that LVN 7 administered oxycodone with acetaminophen 7.5-325 mg tablet to Resident 13, Lacosamide 200mg/20ml solution to Resident 45, lorazepam 0.5 mg tablet to Resident 57, and clonzaepam 0.5 mg tablet to Resident 67 that morning and forgot to sign the Individual Narcotic Record accountability log forms for each of the controlled substances. LVN 7 stated LVN 7 failed to follow the facility's policy of signing each CS dose on the accountability log after preparing the dose for the resident. LVN 7 stated LVN 7 understood it was important to sign each dose once administered to ensure accountability, prevention of CS diversion, and accidental exposures of harmful substances to residents. LVN 7 stated if documentation is not accurate then it can lead to medication error if overdosed (administering more than the prescribed dose) causing harm such as sedation, dizziness, leading to respiratory depression for Residents 13, 45, 57 and 67. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with LVN 2, LVN 2 stated that LVN 2 administered Lacosamide 20 ml to Resident 45 on 7/8/2024 and 7/9/2024 and did not document the preparation of both doses on the Individual Narcotic Record accountability forms even though LVN 2 documented both administrations on the Medication Administration Record ([MAR] - a record of mediations administered to residents). LVN 2 stated because of not documenting, the medication bottle indicated to contain less solution than the Individual Narcotic Record accountability form. LVN 2 stated that LVN 2 failed to follow the facility's policy of signing each CS dose on the Individual Narcotic Record accountability log after preparing the dose for Resident 45. LVN 2 stated LVN 2 understood it was important to sign each dose once prepared to ensure accountability of CS, prevent accidental exposure of harmful substances to residents, and overdosing due to improper documentation, potentially causing harm such as sedation, stoppage of breathing and death to Resident 45. During an interview on 7/10/2024 at 12:12 PM, with the Director of Nursing (DON,) the DON stated that LVN 7 should have informed the name of the medications and their indications prior to administering them on 7/10/2024 at 9:44 AM to Resident 23. The DON stated that it was important to follow this process to ensure residents have the right to be informed about their care and make preferences about their treatments. The DON stated not providing this information during medication administrations does not provide the resident the opportunity to exercise that right. During the same interview on 7/10/2024 at 12:12 PM, the DON stated that LVN 2 and 7 failed to follow policy of documenting the preparation of CS ' s on the accountability log immediately after preparation of the dose for Resident 13, 45, 57 and 67. The DON stated not having accurate accountability records can potentially lead to diversion of CS ' s and medication errors for the residents. During a review of Resident 13 ' s Admission Record (a document containing demographic and diagnostic information,) dated 7/10/2024, the Admission Record indicated Resident 13 was originally admitted to the facility on [DATE] with diagnosis including low back pain. During a review of Resident 13 ' s MAR for July 2024, the MAR indicated Resident 13 was prescribed oxycodone with acetaminophen 7.5-325 mg one tablet to be given by mouth every 8 hours as needed for severe pain (pain scale between 8 to 10), starting 4/12/2024. The MAR also indicated that Resident 13 was administered oxycodone-acetaminophen 7.5-325 mg tablet on 7/10/2024 at 10 AM by LVN 7. During a review of Resident 23 ' s Admission Record, dated 7/10/2024, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing) and malnutrition (not eating enough of the rights things.) During a review of Resident 23 ' s MAR for July 2024, the MAR indicated Resident 23 was prescribed docusate 100 mg tablet to give 2 tablets by mouth twice a day for bowel (intestine, gut) management and to hold for loose stool at 9 AM and 5 PM, starting 1/31/2024. During a review of Resident 45 ' s Admission Record dated 7/10/2024, the Admission Record indicated Resident 45 was originally admitted to the facility on [DATE] with diagnosis including epilepsy (brain disorder that causes recurring, unprovoked seizures.) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 45 ' s MAR for July 2024, the MAR indicated Resident 45 was prescribed Lacosamide 10mg/ml to give 20 ml by mouth every morning for seizures at 9 AM, starting 3/25/2024. The MAR also indicated that Resident 45 was administered Lacosamide 20 ml on 7/10/2024 at 9 AM by LVN 7. During a review of Resident 57 ' s Admission Record dated 7/10/2024, the Admission Record indicated Resident 57 was originally admitted to the facility on [DATE] with a diagnosis including epilepsy. During a review of Resident 57 ' s MAR for July 2024, the MAR indicated Resident 57 was prescribed lorazepam 0.5 mg to give one tablet via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) two times a day for anxiety manifested by pulling G-tube during panic attack/frequent seizure at 9 AM and 5 PM, starting 6/17/2024. The MAR also indicated that Resident 57 was administered lorazepam 0.5 mg tablet on 7/10/2024 at 9 AM by LVN 7. During a review of Resident 67 ' s Admission Record dated 7/10/2024, the Admission Record indicated Resident 67 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including anxiety. During a review of Resident 67 ' s MAR for July 2024, the MAR indicated Resident 67 was prescribed clonazepam 0.5 mg one tablet by mouth every morning for anxiety manifested by verbalization of inability to relax/pacing at 9 AM, starting 12/27/2023. The MAR also indicated that Resident 67 was administered clonazepam 0.5 mg tablet on 7/10/2024 at 9 AM by LVN 7. A review of the policy and procedures (P&P), titled Controlled Medications, dated August 2014, the P&P indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. C. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): a. Date and time of administration. b. Amount administered. c. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. A review of the facility ' s P&P, titled Resident Rights, dated 1/1/2012, the P&P indicated that Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights, Resident ' s have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care . I. State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident ' s right to: c. Choose a physician and treatment and participate in decisions and care planning. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s P&P, titled Medication-Administration, dated January 01, 2012, the P&P indicated To ensure the accurate administration of medications for residents in the Facility. VI. Medication rights A. Nursing Staff will keep in mind the seven rights of medication when administering medication. B. The seven rights of medication are: vi. The resident has the right to know what the medication does. vii. The resident has the right to refuse the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Two (2) medication errors out of twenty-four (24) total opportunities contributed to an overall medication error rate of 5.71% affecting two (2) of seven (7) residents observed for medication administration (Resident 20 and 103.) The medication errors were as follows: Resident 20 received a form of calcium (a medication used as a dietary supplement to provide support to bones) that was different than the one ordered by Resident 20's physician. Resident 103 received a form of multivitamin (a medication used as a dietary supplement to provide essential vitamins, minerals, and other nutritional elements, including magnesium) that was different than the one ordered by Resident 103's physician. These failures had the potential to result in Residents 20 and 103 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 20 ' s and 103 ' s health and well-being to be negatively impacted. Findings: During an observation on 7/9/2024 at 9:30 AM, in Medication Cart Station 1 South, Licensed Vocational Nurse (LVN) 1 was observed administering multivitamin with mineral tablet orally to Resident 103. Resident 103 was observed swallowing the multivitamin with mineral tablets with a full glass of water. During an observation on 7/9/2024 at 9:47 AM, in Medication Cart Station 4, LVN 2 was observed administering calcium 250 milligram ([mg]-a unit of measure of mass) with Vitamin D (a medication used as a dietary supplement to provide support to bones and wound healing,) 3.1 microgram ([mcg] - a unit of measure of mass) two tablets orally to Resident 20. Resident 20 was observed swallowing the calcium with Vitamin D tablets with a full glass of water. During an interview on 7/9/2024 at 1:24 PM, with LVN 1, LVN 1 stated that LVN 1 failed to administer the correct multivitamin to Resident 20 during the morning medication administration at 9:30 AM, as prescribed by Resident 103 ' s physician. LVN 1 stated that LVN 1 administered multivitamin with minerals. LVN 1 stated this is considered a medication error. LVN 1 stated LVN 1 will notify the physician for administering the incorrect medication to Resident 103 and obtain additional orders as necessary. During an interview on 7/9/2024 at 1:28 PM, with LVN 2, LVN 2 stated that LVN 2failed to administer the correct form of calcium to Resident 20 during the morning medication administration at 9:47 AM, as prescribed by Resident 20 ' s physician. LVN 2 stated that LVN 2 administered calcium with vitamin D, and that administering additional Vitamin D to Resident 20 may lead to vitamin D toxicity (amount that maybe poisonous if not cleared by the body.) LVN 2 stated this is considered a medication error and that LVN 2 will notify the physician for administering the incorrect medication to Resident 20 and obtain additional orders as necessary. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/2024 at 12:12 PM, with the Director of Nursing (DON), the DON stated that LVN 1 and 2 failed to administer medications as ordered by the physician and should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered to residents. The DON stated that LVN 1 failed to administer multivitamin without minerals to Resident 103, and LVN 2 failed to administer calcium without vitamin D to Resident 20 and that these are considered medication errors. During a review of Resident 20 ' s Admission Record (a document containing demographic and diagnostic information,) dated 7/9/2024, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including weakness and kidney (pair of organs in the abdomen that help remove waste and extra water from the blood and help keep body chemicals in balance) disease (inability to provide normal kidney functions.) During a review of Resident 20 ' s Order Listing Report, dated 7/9/2024, indicated Resident 20 was prescribed calcium 500 mg tablet for hypocalcemia (having low levels of calcium) to be given by mouth once a day, starting 10/24/2023. The clinical record did not indicate that the resident should be given two tablets of calcium 250mg with Vitamin D 3.1 mcg. During a review of Resident 20 ' s ([MAR] - a record of mediations administered to residents), for July 2024, the MAR indicated Resident 20 was prescribed calcium 500 mg tablet to be given by mouth once a day, at 9 AM. During a review of Resident 103 ' s Admission Record, dated 7/9/2024, indicated the resident was originally admitted to the facility on [DATE] with diagnoses including hypomagnesemia (having low levels of magnesium.) During a review of Resident 103 ' s Order Listing Report, dated 7/9/2024, indicated Resident 103 was prescribed multivitamin tablet as supplementation, starting 6/19/2024. The clinical record did not indicate that the resident should be given multivitamin with mineral tablet. During a review of Resident 103 ' s MAR, for July 2024, the MAR indicated Resident 103 was prescribed multivitamin tablet to be given by mouth once a day, at 9 AM. A review of the facility ' s Policy and Procedures (P&P,) titled Medication Administration - General Guidelines, dated October 2017, the P&P indicated that Medications are administered as prescribed . Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. A. Preparation -Prior to administration, the medication and dosage schedule on the resident ' s MAR is compared with the medication label. If the label and MAR are different .the physician ' s orders are checked for the correct dosage schedule. B.Administration 2. Medications are administered in accordance with written orders of the attending physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s P&P, titled Medication-Administration, dated January 01, 2012, the P&P indicated To ensure the accurate administration of medications for residents in the Facility. I. Administration of Medications ii. Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. VI. Medication rights A. Nursing Staff will keep in mind the seven rights of medication when administering medication. B. The seven rights of medication are: i. The right medication. Review of the facility ' s P&P, titled Medication - Errors, dated July 2018, the P&P indicated: II. Medication Error means the administration of medication: C. At the wrong dose; E. Which is not currently prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43455 Based on observation, interview, and record review the facility failed to remove and discard from facility stock unused and expired medications, in accordance with the manufacturer ' s requirements in one of two inspected Medication Rooms (Medication Room Station 1 South West). The medications included the following: 1. One Aplisol (medication used to diagnose tuberculosis [infection in the lungs]) vial, and 2. 15 expired Afluria (an influenza [also known as flu] vaccine [a substance that provides immunity to an infectious disease] used to provide protection against the flu vaccine for the 2023 -2024 flu season) prefilled (already loaded with the medication) syringes These deficient practices increased the risk for residents in the facility to receive medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization . Findings: During an observation, on 7/10/2024 at 11:54 AM, with Licensed Vocational Nurse (LVN) 4, in Medication Room Station 1 South West, the following medications were found expired and stored contrary to facility policies: 1. One open vial of Aplisol for facility stock was found stored in the refrigerator without a label indicating when storage or use began. - According to the manufacturer ' s product storage and labeling, Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 30 days of opening the vial. 2. Fifteen unopened prefilled syringes of Afluria 2023-2024 formula vaccine for facility stock were found stored in the refrigerator. -According to the manufacturer expiration dating, the Afluria prefilled syringes should be stored in the refrigerator and discarded by 06/30/2034. During a concurrent interview, on 7/10/2024 at 11:54 AM, LVN 4 stated that the Aplisol vial in the refrigerator in Medication Room Station 1 South [NAME] was open and did not have a label indicating when the vial was opened. LVN 4 stated without a label indicating when the vial was opened it would be unknown when the Aplisol would expire. LVN 4 stated the vial was considered expired and should be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents. LVN 4 stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to the residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview, on 7/10/2024 at 11:54 AM, LVN 4 stated all 15 prefilled syringes of Afluria vaccine expired on 6/30/2024, needed to be removed from the facility and placed in the expired medication bin to be disposed to not accidentally be used for residents. LVN 4 stated that expired medications remaining in the facility are a concern as they can be accidentally used and not be effective in providing protection to the flu virus for all the residents receiving the flu vaccine in the facility. During an interview, on 7/10/2024 at 12:12 PM, with the Director of Nursing (DON,) the DON stated the Aplisol vial was not labeled with a date indicating when use began. The DON stated multidose (used more than once) products should be labeled with a date open to know when they expire and not to be used beyond that date as the sterility (ability to be free from bacteria or viruses) and potency (strength of the medication) of the medication will be affected. The DON stated using the Aplisol vial beyond the expiration date in error may potentially provide inaccurate results. The DON stated the unopened Afluria prefilled syringe vaccines were expired and needed to be removed from the medication room and be discarded prevent accidental use. The DON stated administering expired Afluria vaccine to residents will not provide protection from the flu. The DON stated several LVN ' s failed to remove expired medications from the refrigerator which can potentially lead to the accidental use of expired medications and harm residents. A review of the facility ' s Policy and Procedures (P&P) titled, Storage of Medications, dated April 2008, indicated that Medications and biologicals ae stored safely, and properly, following manufacturer ' s recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. A review of the facility ' s P&P titled, Discontinued Medications, dated December 2008, the P&P indicated that When medications are expired .the medications are .stored in a separate location and later destroyed. A. If a medication expires .shall be stored in a separate location designated solely for this purpose. B. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed. A review of the facility ' s P&P titled, Vials and Ampules of Injectable Medications, dated April 2008, the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer ' s recommendations or the provider pharmacy ' s directions for storage, use, and disposal. A. The date opened and the initials of the first person to use the vial are recorded on the multi-dose vials (on the vial label or an accessory label affixed for that purpose). F. Medications in multi-dose vials may be used until manufacturer ' s expiration date or 6 months after opening unless otherwise specified.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38740 Based on observation, interview, and record review, the facility failed to ensure one of three kitchen staff, Dishwasher (DW) 1 was routinely trained and evaluated for competency related to their duties when: Dishwasher 1 (DW 1) did not know the proper sanitizer test strip to use for the quaternary ammonium (QUAT-a quaternary ammonium-QUAT, a type of sanitizing solution used to sanitize food contact surfaces) sanitizer. DW 1 did not know the procedure for testing strength of the quaternary ammonium sanitizer. This Deficient practice had the potential to result in unsafe and unsanitary food production and can affect residents who were served food from the facility kitchen. Findings: During an observation in the kitchen on 7/9/2024 at 9:10AM, DW 1 was cleaning the counters using a kitchen cloth stored in a red bucket filled with solution. DW 1 stated the red bucket was filled with sanitizer (a solution used to kill germs) and the cloth was used to clean the counters. DW 1 stated he checks the sanitizer ' s effectiveness before starting to clean the counters. During a concurrent observation and interview with Dietary Supervisor (DS) and DW 1 on 7/9/2024 at 9:20A M, DW 1 was requested to check the sanitizer ' s effectiveness in the red bucket. DW 1 attempted to use the Chlorine (a solutions used to kill germs) sanitizer test strip in a QUAT sanitizer solution. DW 1 immersed the chlorine sanitizer test strip inside the red bucket filled with QUAT sanitizer and the test strip did not changed color. During the same observation, DS stated DW 1 was using the wrong test strip and handed the correct test strip to the DW. DS stated the color should change and then the test strip is compared to the color chart for the strength of the sanitizer. DW 1 immersed the correct QUAT sanitizer test strip inside the red bucket for a quick second and quickly removed the strip. The test strip did not change color. DW 1 stated it should be a quick dip for one second in the solution and it will change color. DS stated DW 1 should count for 10 seconds then remove the test strip for an accurate reading. After DW 1 immersed the test strip and counted for 10 seconds, the strip showed the sanitizer was at 200 parts per million (PPM-unit of concentration measurement). DS stated 200 PPM (reference range 200-400 PPM) would be acceptable for the QUAT sanitizer. During an interview with Registered Dietitian (RD) on 7/9/2024, at 9:30AM, RD stated QUAT solution concentration should be at least 200 PPM. RD stated they have changed sanitizer test strip product, and the previous test strip was a 1 second dip. RD stated staff should know the correct use of the products in the kitchen. A review of the facility Inservice titled (cleaning vs sanitizing) dated 4/8/2024 did not include the procedure on how to test the sanitizer solution and for how long should the test strips be dipped in the sanitizer solution for accurate reading. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Dishwashers job description not dated indicated Principal responsibilities to maintains a safe and sanitary work environment. A review of manufacturers instruction on QUAT Sanitizer test strips testing Instructions indicated, Dip the strip into the sanitizing solution for 10 seconds, then instantly match the result in color with the color chart on the package to determine the concentration, the minimum reading properly diluted sanitizer solution is 200ppm. Acceptable range: 200-400ppm.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure the portion sizes for lunch menu was followed on 7/9/2024 when the facility failed to follow the lunch menu and portion sizes as written for residents on Pureed diet and Mechanical soft diet. During the facility ' s observed Tray Line Service, 12 residents on pureed diet received 4 ounces (oz) of chicken oregano instead of 5 and 1/3 oz. 46 residents on mechanical soft diet received 2 and 2/3 ounces of zucchini instead of 4 oz per the food portion and serving guide. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake, weight loss in residents who received food from the kitchen. Findings: According to the facility ' s lunch menu for puree diet on 7/9/2024, the following items will be served: Pureed Oregano Chicken #6 scoop (5 1/3 ounces (oz)); pureed polenta #8 scoop (4oz); Pureed baked fresh zucchini #12 scoop 1/3 cup; fresh green salad; dressing; pureed frosted cake. And for the mechanical soft menu: Ground oregano chicken #10 scoop 3 oz; polenta #8 scoop (4oz); Baked fresh zucchini soft #8 scoop (4oz or 1/2 cup); fresh green salad chopped; dressing; frosted cake; milk. During an observation of the tray line service for lunch on 7/9/2024, at 11:50AM, residents who were on pureed diet, the cook (Cook 1) served pureed oregano chicken using scoop #8 (4oz), instead of #6 scoop that yields 5 1/3 ounces. During the same observation, [NAME] 2 served baked zucchini using scoop #12 (2 2/3 oz) instead of 4 oz for residents on mechanical soft diet. During an interview with Cooks 1 and 2 on 7/9/2024, at 12:30PM [NAME] 1 stated that pureed meat was always served with scoop #8 (4oz) and not scoop #6. During a concurrent review of the menu spreadsheet (food portion and serving guide), [NAME] 1 and [NAME] 2 stated they made a mistake, and the spreadsheet indicated that they should serve with the larger scoop. [NAME] 1 stated residents on pureed diet received less chicken because she served with a smaller scoop; [NAME] 2 stated he served less zucchini to residents who were on mechanical soft diet. [NAME] 2 stated it was important to serve the correct portions, so residents meet their nutrients and diets. During an interview with RD on 7/9/2024, at 12:45PM, RD stated the Cooks made a mistake and served food using the wrong scoop. RD stated it is importation for cooks to review and follow the menu and spreadsheet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the recipe for Oregano Chicken indicated for pureed diet serve puree scoop #6. Puree following the pureed recipes. A review of the pureed meats recipe indicated complete regular recipe, measure out the total number of portions based on the portion size indicated on the cook ' s spreadsheet. A review of facility policy and procedure titled Menus (revied 4/2014) indicated, ensure that the facility provides meals to residents that meet the requirements of the food and nutrition board of the national research council . Food served should adhere to the written menu.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to implement the facility ' s infection control program to prevent the spread and infections in the facility by failing to: 1. Ensure the shared restroom for Room A had labeled urinal and three rectangle wash basins left on top of the reservoir tank (reserve and hold the correct amount of water require to flush the toilet bowl) of the toilet. 2. Ensure Resident 12 ' s urinal at his bedside table with urine was labeled with the resident ' s name and date on when the urinal was first used. 3. Ensure Resident 20 ' s urinal was observed at his bedside table with urine was labeled with the resident ' s name and date on when the urinal was first used. 4. Ensure staff use the appropriate equipment when Certified Nursing Assistant (CNA) 11 was observed providing care to Resident 102 with a wound on the foot and was not wearing an isolation gown (a disposable down made of paper-like material or plastic that helps in protecting the user ' s clothes). These failures had the potential to cause development and transmission of communicable diseases (one that is spread from one person to another through a variety of ways that include: contact with blood and bodily fluids) and infections. Findings: 1. During a general observation on 7/9/2024 at 9:56 AM, the shared restroom in Room A (with six residents) had an unlabeled urinal and three rectangle wash basins on top of the toilet reservoir tank. During a general observation and interview with a Certified Nursing Assistant 1 (CNA 1), on 7/9/2024 at 10:27 AM, the CNA 1 stated that she did not know to whom the rectangle wash basins belonged to. The CNA stated she emptied Resident 62 ' s urinary catheter drainage bag (a soft tube is held in the bladder to collects urine by attaching to a drainage bag) using the urinal that left on top of the reservoir tank. The CNA 1 stated the wash basins, and the urinal should be dated and labeled with the resident's name. During an interview on 7/9/2024 at 10:50 AM with Infection Prevention Nurse (IPN) with the presence of Surveyor 4, IPN stated, urinals and wash basins should be changed every week, they need to be labeled and dated to ensure they had been changed and were for the right person. IPN stated, labeling, and dating of urinals and wash basins were important for infection prevention and cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 4:12 PM with the Director of Nurses (DON) with the presence of Surveyor 44018, DON stated, the facility does not have a policy for labeling and dating urinals and wash basins, but all the urinals and wash basins should be labeled and it is best to have a date to know whom it belong to and the last time it was changed, it is to prevent infection and prevent cross contamination. During a review of the facility ' s policy and procedure (P&P) titled, Cleaning & Disinfection of Residential Care Equipment, dated 1/1/2012, indicated; a) Residential-care equipment , including reusable items and durable medical equipment is cleaned and disinfected to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard, b) single resident-use items are clean and disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals) During a review of the facility ' s policy and procedure (P&P) titled, Infection Control - Policies and Procedures, dated 1/1/2012, indicated; a) the facility ' s infection control policies and procedures are intended to facilitate and maintaining a safe, sanitary, and comfortable environment and to help manage transmission of diseases and infection, b) prevent, detect investigate and control infections in the facility, c) provide guidelines for the safe cleaning and reprocessing of reusable resident care equipment. 47882 2. During a review of Resident 12 ' s Admission Record, dated 7/10/2024, indicated Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), atrial fibrillation (an irregular heartbeat that causes the heart to beat faster than normal) and acute viral hepatitis (inflammation of the liver, generally meaning inflammation caused by infection). During a review of Resident 12 ' s History and Physical Examination, dated 2/6/2024, indicated Resident 12 had fluctuating capacity to understand and make decisions. During a review of Resident 12 ' s Minimum Data Set (MDS-a standardized assessment and screening tool) dated 4/16/2024, the MDS indicated Resident 12 cognitive status was moderately impaired. MDS indicated Resident 12 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) eating, oral hygiene and toileting. 3. During a review of Resident 20's Admission Record (AR), dated 7/10/2024, the AR indicated Resident 20 was admitted on [DATE], and readmitted on [DATE], with diagnoses including atherosclerotic hear disease (thickening or hardening of the arteries), atrial fibrillation, and chronic kidney disease (a long-term condition where the kidneys do not work as well as they should). A review of Resident 20 ' s History and Physical Examination, dated 10/18/2023, indicated Resident 20 was alert and oriented and follows simple commands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20 ' s, MDS, dated [DATE], the MDS indicated Resident 20 ' s cognitive status was moderately impaired. The MDS indicated Resident 12 required supervision or touching assistance with eating, oral hygiene, and required partial/moderate assistance (helper does less than half the effort) with toileting. During a concurrent observation and interview on 7/9/2024, at 10:30 AM with Certified Nurse Assistant (CNA) 2 in Residents 12' s and 20 ' s room, Resident 12 was in bed with a urinal on the bedside table with urine that had no label of the resident ' s name and date of when the urinal was first used. Resident 20 was also observed in bed with a urinal on the bedside table. that had no label of the resident ' s name and date of when the urinal was first used. CNA 2 stated, he should have emptied the urine from the urinals as soon as possible and it should have been dated and labeled, as it is an infection control issue. During an interview on 7/9/2024 at 10:35 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, Residents 12 ' s and 20 ' s urinal should have been labeled with the resident ' s name and date of when the urinal was first used to know who ' s it for and the last time it was changed. LVN 2 stated, if urinals are not labeled or dated, another resident might use it, that could be old and grow bacteria and spread infection. During an interview on 7/9/2024 at 10:40 AM with Registered Nurse (RN) 2, RN 2 stated, urinals should be labeled and dated, as it is an infection control issue. RN 2 stated, labeling and dating the urinal with the resident ' s name and date of when the urinal was first used could prevent bacterial growth and cross contamination. 48854 4. During a review of Resident 102's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included infection of the skin and ulcer (other word for wound) of the foot. Durin a review of Resident 102's History and Physical (H&P), dated 6/15/2024, indicated the resident has cognitive deficits (inability to make daily decisions for activity of daily living). A review of the H&P indicated the resident has a diabetic right foot ulcer (a serious complication caused by a combination of poor circulation, susceptibility to infection and nerve damage from high blood sugar levels). During a review of Resident 102's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/21/2024, indicated the resident has intact cognition. During an observation on 7/10/2024 at 8:31 AM, inside Resident 102 ' s room, Certified Nursing Assistant (CNA) 11 was observed wearing gloves, but not wearing an isolation gown (a disposable down made of paper-like material or plastic that helps in protecting the user ' s clothes) while providing care to Resident 102. Resident 102 was sitting on the edge of the bed, while CNA 11 was putting a shirt on Resident 102. During an interview on 7/10/2024 at 8:32 AM with CNA 11, CNA 11 stated she should have worn an isolation gown when she provided care to Resident 102. CNA 11 stated she provided direct patient care to Resident 102 because she bathed the resident in the shower and helped the resident put on clothes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 9:45 AM with Infection Preventionist Nurse (IPN), IPN stated Resident 102 has a wound on the foot which places the resident at risk of contracting infections. IPN stated wearing the appropriate equipment, such as an isolation gown, mask, and gloves, help in the prevention of the spread of infection-causing bacteria. IPN stated CNA 11 should have worn an isolation gown, mask, and gloves when CNA 11 provided a shower and dressing Resident 102. During a concurrent interview and record review on 7/11/2024 at 9:45 with IPN, the facility ' s in-service titled, EBP- Enhanced Barrier Precautions, was reviewed. IPN stated EBP is used to reduce the potential for transmission of pathogens (microorganisms that have the potential to cause infections). IPN stated all residents with wounds are placed under EBP. IPN further stated staff must use gown and gloves during high contact resident care activities such as showering and cleaning wounds. During a concurrent interview and record review on 7/12/2024 at 1:00 PM with Registered Nurse (RN) 1, Resident 102 ' s medical records was reviewed. RN 1 stated the facility does not input EBP orders in the residents ' medical records. RN 1 reviewed Resident 102 ' s medical records and stated the resident does not have an order for EBP. RN 1 stated Resident 102 has a wound in the foot and staff should use gowns and gloves when providing care to resident. During a review of the facility ' s policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 6/7/2024, indicated EBP is to be utilized for the duration of the [resident] ' s stay. The P&P indicated the required equipment when employing EBP are gloves and gown prior to the high-contact care activity. The P&P indicated high-contact resident care activities include: 1. Dressing 2. Bathing/showering 3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting 7. Device care or use 8. Wound care During a review of the facility's P&P titled, Enhanced Standard Precautions, revised, 8/22/2019, indicated standard precautions will be used when there is any resident contact regardless of transmission risk. The P&P also indicated standard precautions will include gowns, gloves, mask and face shield when a healthcare worker anticipates their hands, clothes or mucous membranes of the eyes, nose, mouth or skin on their face will be exposed to blood or other body fluids.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview and record review, the facility failed to ensure the resident bedrooms accommodate no more than four residents for eight of 41 rooms (Rooms 2, 19, 23, 26, and 39 with five beds in the room, and rooms [ROOM NUMBER] with six beds in the room) in the facility. This deficient practice had the potential to negatively affect the resident ' s privacy and the quality of care and safety of the residents due to inadequate space for nursing care and emergency services. Findings: During the Recertification Survey Entrance Conference on 7/9/2024 at 9:15 AM, in the presence of the Director of Nursing (DON), the Administrator (ADM) stated the facility has room waivers (a permit approved by Centers for Medicare & Medicaid Services for rooms that did not meet the regulation requirement) with variances (difference in the measurement of what is expected than the actual measurement) and will continue to apply for a room waiver. During a review of the Client Accommodation Analysis submitted by the facility on 7/9/2024 indicated the following rooms did not meet the federal requirement of no more than four beds per resident room in a multiple resident bedroom: On 7/9/2024 to 7/12/2024, during the recertification survey, the following were observed: 1. room [ROOM NUMBER] has five beds with 5 residents. 2. room [ROOM NUMBER] has six beds with 5 residents (1 unoccupied bed) 3. room [ROOM NUMBER] has six beds with 4 residents (2 unoccupied beds) 4. room [ROOM NUMBER] has five beds with 2 resident (3 unoccupied beds) 5. room [ROOM NUMBER] has six beds with 5 residents (1 unoccupied bed) 6. room [ROOM NUMBER] has five beds with 5 residents 7. room [ROOM NUMBER] has five beds with 5 residents 8. room [ROOM NUMBER] has five beds with 5 residents During the survey, multiple observations on 7/9/2024, 7/10/2024, 7/11/2024, and 7/12/2024, were conducted at random times from 7:30 AM to 5:00 PM. The residents in rooms 2, 4, 17, 19, 22, 23, 26, and 39 had enough space for individualized beds, dressers and resident care equipment. (continued on next page)

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During a resident council interview on 7/10/2024 at 10:04 AM in the facility ' s activity room with the resident council, the residents did not report or brought up concerns regarding the room sizes for the residents. During a review of the room waiver letter submitted by ADM on 7/9/2024 indicated Rooms 2, 4, 17, 19, 22, 23, 26, and 39 had adequate space for nursing care and multiple beds per room would not adversely affect the health and safety of the residents.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48854 Based on observation, interview, and record review, the facility failed to ensure the resident care area in multiple resident bedrooms were 80 square feet (sq/ft) per resident as required for 18 of 41 resident rooms. This deficient practice had the potential to negatively affect the quality-of-care delivery and the ability of the nursing care to safely provide care and privacy to the residents. Findings: During the Recertification Survey Entrance Conference on 7/9/2024 at 9:15 AM, in the presence of the Director of Nursing (DON), the Administrator (ADM) stated the facility has room waivers (a permit approved by Centers for Medicare & Medicaid Services for rooms that did not meet the regulation requirement) with variances (difference in the measurement of what is expected than the actual measurement) and will continue to apply for a room waiver. A review of the Client Accommodation Analysis submitted by the facility on 7/9/2024 indicated the following rooms did not meet the required square foot per resident in a multiple resident bedroom: Room: 4 #Capacity: 6 Minimum Capacity: 480 sq/ft Allocated: 51.1 sq/ft Total Room: 307 sq/ft Room: 17 #Capacity: 6 Minimum Capacity: 480 sq/ft Allocated: 71.2 sq/ft Total Room: 427.31 sq/ft Room: 19 #Capacity: 5 Minimum Capacity: 400 sq/ft Allocated: 72.9 sq/ft Total Room: 364.3 sq/ft Room: 22 #Capacity: 6 Minimum Capacity: 480 sq/ft Allocated: 73.4 sq/ft Total Room: 440.5 sq/ft Room: 23 #Capacity: 5 Minimum Capacity: 400 sq/ft Allocated: 75 sq/ft Total Room: 375.31 sq/ft Room: 26 #Capacity: 5 Minimum Capacity: 400 sq/ft Allocated: 68.1 sq/ft Total Room: 340.83 sq/ft Room: 27 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 79.32 sq/ft Total Room: 237.96 sq/ft Room: 28 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.07 sq/ft Total Room: 231.21 sq/ft Room: 30 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.96.32 sq/ft Total Room: 233.90 sq/ft Room: 31 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.96 sq/ft Total Room: 233.90 sq/ft Room: 32 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.07 sq/ft Total Room: 231.21 sq/ft Room: 33 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.88 sq/ft Total Room: 233.64 sq/ft (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Room: 34 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 76.76 sq/ft Total Room: 230.29 sq/ft Room: 35 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 76.76 sq/ft Total Room: 230.29 sq/ft Room: 36 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 76.76 sq/ft Total Room: 230.29 sq/ft Room: 37 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 77.07 sq/ft Total Room: 231.21 sq/ft Room: 38 #Capacity: 3 Minimum Capacity: 240sq/ft Allocated: 75.19 sq/ft Total Room: 225.58 sq/ft Room: 39 #Capacity: 5 Minimum Capacity: 400 sq/ft Allocated: 72.3 sq/ft Total Room: 361.53 sq/ft During multiple observations and tour of the facility on 7/9/2024, 7/10/2024, 7/11/2024, and 7/12/2024, during the observations throughout the survey, the size or the square footage in resident rooms did not interfere with the care and services rendered by staff. The residents were observed to have enough space provided for the resident ' s bed, dresser, and resident care equipment. During group interview on 7/10/2024 at 10:04 AM in the facility ' s activity room with the resident council, no concerns were brought up regarding the room sizes for the residents. A review of the facility ' s Waiver Request Letter, dated 7/9/2024, indicated the rooms have less than the currently required space per unit as noted in the Client Accommodation Analysis form. The arrangement of the rooms provided adequate space for nursing care and does not adversely affect the health and safety of the residents. The facility administrator requested a continuation of the room waiver for the rooms indicated and would be recommended for room waiver approval.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to provide a functioning call light for one of six sampled residents (Resident 357). This deficient practice had the potential to result in the residents not to receive necessary immediate care specially during emergency or delay receiving care to meet the residents needs for toileting, personal hygiene and activities of daily living. Findings: A review of Resident 357 Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included major depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act), aphasia (a language disorder that affects a person ' s ability to communicate), and Parkinsonism (a disorder of the central nervous systems that affects movement). A review of Resident 357 ' s History and Physical Examination (H&P) dated 12/7/2023, indicated Resident 357 did not have the capacity to understand and make decisions. A review of Resident 357 ' s the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/29/2024, indicated Resident 357 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 357 required substantial/maximal assistance (helper does more than half the effort) from staff with oral hygiene, upper body dressing, lower body dressing, and personal hygiene. A review of Resident 357's care plan (CP), titled 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), dated 5/11/2024, indicated Resident 357 has limited mobility that required extensive assistance from staff, and was at risk for further ADL decline in function. The (CP), intervention indicated to call for assistance at all times. During an observation of Resident 357 ' s shared bathroom and a concurrent interview with Resident 357 on 7/9/2024 at 10:05 AM, Resident 357 was in her room, lying in her bed, awake, alert and able to respond to interview. When asked about the call light in the shared bathroom, Resident 357 stated that she did not know the call light was not be working. Resident 357 stated she does not use the bathroom often but it ' s safe to have a working call light in the bathroom in case she needed to call for assistance. During a concurrent observation and interview with Director of Staff Development (DSD) on 7/9/2024 at 10:08 AM, DSD confirmed the call light in the shared bathroom was not functioning. DSD stated call light allowed residents quickly communicate to staff when they needed assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/9/2024 at 10:12 AM, with the MS in Resident 357 ' s shared bathroom, the MS stated he made rounds monthly to check all call lights. MS stated no staff reported defective call lights to him this month. The MS also stated it was important to have a working call light in the bathroom to reduce fall or injury. The MS stated in case an emergency occurred in the bathroom, residents could quickly call for help. A review of the facility's logbook titled Nurse Call System, indicated the last entry was made on 6/28/2024. A review of the facility's policy and procedure (P&P) titled, Communication-Call Light, dated 1/1/2012, indicated the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathroom facilities. The P&P indicated that call bells located within resident bathrooms are considered emergency calls due to the potential for falls and injury. Emergency calls must be answered promptly. The P&P also indicated that if call bell is defective, it will be reported immediately to maintenance and replaced immediately.