STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056350	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Merritt Healthcare Center LLC	309 MacArthur Boulevard Oakland, CA 94610

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593 Based on interview and record review, the facility failed to follow its Grievance/Complaints, Filing policy and procedure to make prompt efforts to respond and resolve grievances/complaints for two (Resident 5 and 26) sampled residents when; the facility did not follow up with Resident 5 and 26's complaint of missing personal items made during the resident council meeting. This deficient practice had the potential to cause residents emotional distress. Findings: During a review of the facility's record titled, Resident Council Minutes, dated 9/27/24, the document indicated, Resident 5 complained of missing purple colored brassiere with stars symbols and Resident 26 complained of missing two [NAME] spots shirts. During a review of Resident 5's Minimum Data Set (MDS - Resident assessment and care guide tool), dated 9/14/24, the MDS indicated Resident 5's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 13 and indicated intact mental status. The MDS indicated Resident 5 was able to recall the correct year and month. MDS indicated Resident 5 had clear speech, able to express her ideas and wants, and understood what others said to her. During a review of Resident 26's Minimum Data Set (MDS - Resident assessment and care guide tool), dated 8/8/24, the MDS indicated Resident 26's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. The MDS indicated Resident 26 was able to recall the correct year, month and day of the week. The MDS indicated Resident 26 had clear speech, able to express his ideas and wants, and understood what others said to him. During an interview on 10/23/24 at 8:47 a.m. with Resident 26, Resident 26 stated he was missing two [NAME] sport shirts about three months ago. Resident 26 stated he reported to staff and at the resident council meeting. Resident 26 stated no one assisted him to look for the tee shirts. Resident 26 said he would like to have his shirts back. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 9:01 a.m. with Activity Director (AD), AD stated Resident 26 complained of missing two [NAME] shirts and Resident 5 missing purple colored brassiere during resident council meeting that was held on 9/27/24. AD stated she informed staff with a referral for response form but they have not returned it. AD stated she left referral for response in the social services mailbox. During an interview on 10/23/24 at 9:53 a.m. with Social Services (SW), SW stated she was not informed of residents missing items and had not followed up with Resident 5 and 26 complaints. SW stated she did not received referral related to missing items in her mail box. During an interview on 10/23/24 at 12:43 p.m. with Administrator (Admin), Admin stated he was not aware of Resident 5 and 26 complaints/ grievances regarding missing personal items. Admin stated that he will follow up with AD. Admin stated the expectation was for complaints/grievance from resident council meetings to go to appropriate department and completed in a week. Admin stated he reviewed for completion. Admin said he will follow up with September 2024 complaints/grievances from resident council meeting. During a review of the facility's policy and procedure (P&P) titled, Grievances/Complaints, Filing, revised April 2017, the P&P indicated, Residents and their representatives have the rights to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representatives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36593 51692 Based on observation, interview, and record review, the facility failed to ensure a system to perform ongoing repairs and maintenance work when three of three sampled areas of the facility were affected by the following: 1. Floor tiles in resident care hallway were broken and coming off. 2. a. Baseboard on the walls for Room A and Room B was missing and broken at places, with broken dry wall and plaster pieces sticking out of the wall. b. The overbed tables for Resident 42 and Resident 31 were chipped and unfurnished with rough edges, posing a potential risk for them getting scratched and hurting themselves. c. Screen door for Room A shared among Residents 42, 31 and 17 was broken and off the track. d. Electric cable cord for the television and Resident 37's call light cord in Room B were taped to the wall. e. The wall clock in Room B displayed an inaccurate time, with a potential to cause confusion and disorientation of time. f. Shared bathroom between two residents' rooms (Room A and Room B) did not have soap for more than two consecutive days. 3. Smoking patio had broken, rusty metallic table and chairs with sharp edges coming out placing the residents visiting that area at risk of hurting themselves. Findings: 1. During an observation on 10/21/24 at 12:23 p.m. in the hallways, there were several cracked, broken, opened floor tiles in disrepair opposite residents' activity/dining room. During an interview on 10/23/24 at 9:56 a.m. with Administrator (Admin), Admin stated the opened floor tile located next to residents' activity/dining room had been there for sometime. Admin stated facility planned to make over all the floors in the residents' care area hallways. 2. a. During a concurrent observation and interview with Maintenance Supervisor (MS) on 10/22/24 at 11:06 a.m., two adjacent rooms (Room A and Room B) were observed. MS stated baseboard in Room A and Room B were broken, the dry wall and plaster was off and sticking out. MS stated he conducted room rounds every Friday; however, he did not notice the damaged baseboards on Friday, 10/18/24. When asked if it looked like a new damage to the baseboards, MS stated no. MS stated both rooms needed new baseboards because facility was old and constructions was done long time ago. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an observation and interview on 10/21/24 at 9:37 a.m. Resident 42 was sitting at the edge of the bed with his overbed table in front of him. The overbed table had rough and chipped all four sides of the top tray. Resident 42 stated facility staff was aware, and they could see his damaged overbed table. Resident 42 stated it made him feel that staff did not care about his damaged overbed table. During a concurrent observation and interview on 10/22/24 at 11:08 a.m. with MS, Resident 31 and Resident 42's overbed tables were observed. MS stated both tables had chipped and rough edges, and the rubber that goes around all four sides of the top tray that protects the residents from hurting themselves, was completely off. MS stated the top tray was made of compression wood and residents could easily stick their fingers/hands and could get splinters and hurt themselves easily. MS stated he did not identify need to repair/replace the overbed tables for Resident 31 and 42 on 10/18/24 during his room rounds. MS stated both tables needed to be replaced. c. During an observation and interview with MS on 10/22/24 at 11:10 a.m., Room A's screen door was half open, off the track, not latching, and MS was not able to close it all the way. MS stated he was aware that the screen door for Room A needed a replacement for last three weeks. MS stated he called a company from Google one week ago but was unable to provide the details. MS stated it was important to replace the screen door in a timely manner to prevent animals and bugs coming into the room. d. During an observation on 10/21/24 at 10:24 a.m., electrical cord for the television was taped with a blue scotch tape to the wall; and Resident 37's call light cord was taped with a yellow-colored scotch tape to the call light outlet. During an observation and interview with MS on 10/22/24 at 11:12 a.m., in Room B, two back colored television cords were taped onto the wall, additionally the call light cord for Resident 37 was taped to the call light outlet. MS stated he noticed the cable cords taped up to the walls on Friday 10/18/24, during his rounds but he did not remove the tape. MS stated taping the electric cords was not safe and he needed to staple the cords to affix them to the walls. MS stated he did not have a staple in the facility and needed to buy one. e. During an observation on interview on 10/22/24 at 11:12 a.m. with MS, the wall clock in Room B was off. MS stated the clock displayed 9:05 at that time. MS stated he was responsible for changing the battery for the clock. During another observation and interview on 10/23/24 at 12:32 p.m., the wall clock in Room B still displayed 9:05. Resident 37 was lying in the bed and stated the time on the clock made him confused because his cell phone and wall clock in the room did not match. During an interview and record review with MS on 10/22/24 at 11:21 a.m. at nursing station, facility's maintenance logbook from 7/2024 through 10/2024 was reviewed. MS stated staff used the maintenance logbook to report the need of repairs and maintenance in the facility/resident care areas. MS stated he was unable to find above issues being reported in the logbook. f. During an observation on 10/21/24 at 10:04 a.m. in shared bathroom between Room A and Room B, there was no soap in the soap dispenser. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/21/24 at 10:20 a.m., Resident 42 used the bathroom, walked out of the bathroom, when asked if there was any soap, Resident 42 stated what can you do? During a concurrent observation and interview on 10/21/24 at 10:26 a.m., Regional Registered Nurse 3 (RN 3) entered the shared bathroom between Room A and Room B. RN 3 turned the tap on to wash his hands and stated there was no soap in the liquid soap dispenser. RN 3 stated it was unusual to not have soap in residents' bathroom. During a concurrent observation and interview on 10/21/24 at 10:35 a.m. Janitor 1 walked into the shared bathroom and started refilling the soap dispenser. Janitor 1 stated housekeeping staff 1 (HSKP 1) told him around 1:30 pm on 10/18/24 that this bathroom needed soap replacement, but he forgot to replace it at that time, indicating the bathroom was out of soap for more than two (2) consecutive days. During an interview with HSKP 1 on 10/22/24 at 8:47 a.m. in hallway outside Room A and Room B, HSKP 1 stated she told Janitor 1 to replace the soap in the bathroom on 10/18/24 because she did not have the keys to the supply room where liquid soap supply was kept in the facility. 3.During a concurrent observation and interview with Director of Staff Development (DSD) on 10/22/24 at 9:09 a.m., in facility's smoking patio, a white colored round metal table and two white metal chairs were worn out. The DSD stated the furniture was rusty and had rough edges and sharp metallic meshy edges were coming out on the table and chairs. The DSD stated that area was dedicated for smoking residents, and they could cut their hands and get injured if they ever used that furniture. During an interview with Maintenance Supervisor (MS) on 10/22/24 at 11:06 a.m., MS stated he had to threw away the broken and rusty furniture that was kept in the smoking patio as it was not good anymore. During a review of facility's policy and procedure (P&P) titled Maintenance Service revised 12/2009, the P&P indicated, The Maintenance Department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times . 39939

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on interview and record review, the facility failed to ensure two of two sampled resident's (Resident 44 and 37) Preadmission Screening and Resident Review (PASRR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.) was completed and referred to the appropriate state mental authority for Level II evaluation and determination when: 1. Resident 44's PASRR Level 1 Screening was not resubmitted when Resident 44 remained in the facility longer than 30 days. 2. Resident 37 PASRR Level 1 Screening completed inaccurately. This failure placed Resident 44 and 37 at risk for inappropriate placement in the facility and prevent Resident 44 and 37 from receiving appropriate required mental health services. Findings: 1. During a review of Resident 44's undated Admission Record, printed on 10/21/24, the Admission Record indicated, Resident 44 was admitted to the facility on [DATE]. The record also indicated; Resident 44 had diagnoses that included Unspecified Dementia with Psychotic Disturbance (a medical condition that can include psychotic symptoms like hallucinations, delusions, paranoia, and suspiciousness), Anxiety Disorder (a mental health condition that involves persistent and uncontrollable feelings of fear and anxiety that can significantly impact a person's life), Paranoid Personality Disorder (a psychiatric disorder distinguished by a pervasive pattern of distrust and suspiciousness of others, leading to impairments in psychosocial functioning), Depression (a mental health condition that causes a long-lasting low mood and a loss of interest in activities that used to be enjoyable) and Auditory Hallucinations (hear voices or noises that don't exist in reality). During a review of Resident 44's Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 5/8/24, The MDS indicated the PASRR was coded zero-meaning, Resident 44 was not considered by the State Level II PASRR process to have a serious mental illness. However, Resident 44's diagnoses included Unspecified Dementia with Psychotic Disturbance, Anxiety Disorder, Paranoid Personality Disorder, Depression and Auditory Hallucinations. During a concurrent interview and record review on 10/24/24 at 8:17 a.m. with the DON, Resident 44's PASRR Level I Screening, dated 4/30/24 was reviewed. The PASRR Level 1 Screening indicated, Resident 44's PASRR Level 1 screening was completed at the acute care hospital prior to admission to the facility. The DON stated PASRR Level I Screening doesn't need to be completed again once it was done. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 44's Department of Health Care Services letter, dated 4/30/24, the Department of Health Care Services letter indicated, Resident 44's PASRR Level 1 Screening did not identify Resident 44 as an individual with suspected mental illness. The letter also indicated; Resident 44 does not require a Level II mental health evaluation. The letter further indicated; the facility should resubmit a new Level 1 Screening for individuals remaining in the nursing facility longer than 30 days. During a review of the facility's policy and procedure (P&P) titled, Pre-Admission Screening and Resident Review (PASRR), dated 12/17, the P&P indicated, If the individual's facility stay lasts longer than thirty (30) days, a Level 1 Screening must be performed within forty (40) days of admission. 2. During a record review of Resident 37's Admission Record printed on 10/22/24, the record indicated Resident 37 was admitted to the facility on [DATE]. During a review of Resident 37's physician orders dated 3/4/24, the order indicated Resident 37 was receiving Trazadone, a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior; psychotropic drugs include, but are not limited to the following categories: anti-depressants, anti-anxiety, and hypnotics) HCl 50 milligrams (mg) for Depression (a state with persistent depressed mood or loss of interest in activities causing impairment in daily life) manifested by inability to sleep. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 9/9/24, the assessment indicated Resident 37 had an active diagnosis of Depression and Schizophrenia (a mental condition which makes it difficult to think clearly, have normal emotional responses, act normally in social situations, and tell the difference between what is real and what is not real). During a review of Resident 37's Preadmission Screening and Resident Review (PASARR) Level 1 screening assessment dated [DATE], the assessment indicated it was marked as No to Question 10. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder . Schizophrenia/Schizoaffective mental disorder .? and No for Question 12. [if] the individual has been prescribed psychotropic medications for mental illness. The assessment indicated Resident 37 did not require further Level II mental health evaluation. During a concurrent interview and record review with Director of Nursing (DON) on 10/23/24 at 9:32 a.m., Resident 37's PASARR assessment dated [DATE] was reviewed. The DON stated she did not think the assessment was inaccurate because even though Resident 37 had Schizophrenia, but he was not receiving any medications for that disorder. The DON also stated Trazadone medication was not a psychotropic medication and did not need to be reflected on Resident 37's PASARR. During a concurrent interview and record review with MDS Coordinator (MDSC) on 10/23/24 at 9:54 a.m., Resident 37's PASARR assessment dated [DATE] was reviewed. The MDSC stated Resident 37's PASARR assessment was inaccurate in terms of reflecting the mental illness and use of psychotropic medications. The MDSC stated even though Acute Care Hospitals were responsible for completing the PASARR assessment prior to the facility admitting the residents, it was facility's responsibility to review the assessment for accuracy. The MDSC stated accurate completion of Level 1 screening could have prompted Resident 37 to receive mental/behavior health help such as psyche referrals. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another interview and record review with MDSC on 10/23/24 at 10:23 a.m., the MDSC stated she was unable to find any records for psyche referrals or consults in Resident 37's electronic or paper chart. 49498

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 36593 Based on observation, interview and record review, the facility failed to ensure staff attempted to use appropriate measures to communicate with one of three sampled non-English speaking residents (Resident 43) when; Resident 43's communication tool/binder was not used. This failure placed Resident 43 at risk for not feeling understood, unmet needs and decline in health. Findings: During a review of Resident 43's Admission-Minimum Data Set (MDS - Resident assessment and care guide tool), dated 7/10/24, the MDS indicated Resident 43's preferred language was Chinese. MDS indicated Resident 43 needed and wanted an interpreter to communicate with doctor or health care staff. Resident 43's diagnoses included Depression (a mental health condition that causes a persitent low mood and loss of interest in activities). During a concurrent observation and interview on 10/23/24 at 8:36 a.m. with CNA 5, Resident 43's laid in bed in her room, Resident 43 spoke in her native language. A communication binder laid on Resident 43's bedside table. CNA 5 stated she could only communicate with Resident 43 through gestures and pointing. CNA 5 stated she did not know that Resident 43 had a communication binder. During an interview on 10/23/24 at 10:09 a.m. with Director of Staff Development (DSD), DSD stated the expectation was for CNAs to use communication binder for non English speaking residents. DSD stated she had not provided CNAs in-service training about use of communication tools for non English speaking residents. During an interview on 10/23/24 at 2:26 p.m. through a language line interpreter (ITP), via telephone, Resident 43 stated she spoke cantoneese. Resident 43 stated facility staff did not understand her native language. Resident 43 stated it appeared there was missing messages. Resident 43 stated she did not understand staff when they communicate with her. Resident 43 stated she would like to transfer to a place where residents spoke Resident 43's native language. During an interview on 10/23/24 at 10:54 a.m. with Admininistrator (Admin), Admin stated facility did not have an interpreter access phone line. Admin stated facility was working on getting a translator phone line and staff could use google to translate. During a review of the facility's policy and procedure (P&P) titled Translation and/ or Interpretation of Facility Services, revised November 2020, the P&P indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. 51692

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview, and record review the facility failed to provide an ongoing and effective activity program to meet resident activity preferences, physical and psychosocial goals for one of 15 sampled residents (Resident 37). This failure placed Resident 37 at risk for mental and psychosocial decline. Findings: During a record review of Resident 37's Admission Record printed on 10/22/24, the record indicated Resident 37 was admitted to the facility on [DATE] A review of Resident 37's Admission Minimum Data Set (MDS, an assessment used to plan care) dated 3/10/24 indicated, it was very important for Resident 37 to do his favorite activities. During a record review of Resident 37's discharge planning review completed on 9/16/24, the assessment indicated Resident 37 enjoys activities including drawing and painting. During a record review of Resident 37's activity care plan dated 03/2024, the care plan indicated to, allow resident choices and provide resident with outdoor activities. During an observation on 10/21/24 at 11:00 a.m. Resident 37 was lying in the bed with both legs flexed, with a linen on top of his legs. Resident 37 stated he was mostly just lying in bed because he did not have a proper wheelchair to go around the facility. (Cross Reference F684). Resident 37 stated he enjoyed drawing and painting, but facility did not provide him enough materials like paper for him to do his activity. During an observation on 10/23/24 at 11:14 a.m., Resident 37 was lying in his bed, not engaged in any activity. During an observation and interview on 10/24/24 at 9:22 a.m. Resident 37 was lying in bed and stated he felt worthless sitting in bed all day. During interview on 10/22/24 at 10:48 a.m. with activity assistant (AA), the AA stated Resident 37 received three visits per week for art and games at bedside. AA stated Resident 37 was given some art supplies but he had requested more frequent visits to meet his activity needs. AA stated Resident 37 comes to the activity room only twice a month. During a concurrent interview and record review with AA on 10/22/24 at 11:00 a.m. Resident 37's Activity participation logs were reviewed. AA stated activities staff was supposed to use the log to indicate date, type of activity and residents' response to activity on the log for each visit. AA stated she was unable to find any documentation of one-on-one activity participation in activity log since 07/07/2024. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's Policy and Procedure (P&P) titled Activity Programs revised 6/2018, the P&P indicated, Activity programs are designed to meet the interests of and support the physical, mental and psychological well-being of each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview and record review, the facility failed to assess and provide an appropriate wheelchair to one of 15 sampled residents (Resident 37), for seven months, since admission to the facility. This deficiency placed Resident 37 at risk for physical decline and resulted in Resident 37 feeling worthless, and hopeless about his personal goals of discharge from the facility. Findings: During a record review of Resident 37's Admission Record printed on 10/22/24, the record indicated Resident 37 was admitted to the facility on [DATE] with left hip contracture (a medical condition with hardening of muscles leading to deformity and rigidity in joints). During a record review of Resident 37's contracture care plan, initiated on 3/4/24, the care plan indicated to, use assistive device as/if ordered. During a record review of Resident 37's discharge planning review dated 6/25/24 and 9/16/24, the assessments indicated Resident 37's goal was to go back to the community with home health services. During observation and concurrent interview on 10/21/24 at 11:54 a.m. Resident 37 was lying in bed with linen covers on his both legs. Resident 37 stated he needed help with wheelchair as he stayed in bed most of the time. Resident 37 stated he got out of bed once or twice a week using a Geri-chair (a large, padded, reclining wheelchair with adjustable back). Resident 37 stated he needed a bigger wheelchair appropriate for his size. During an interview on 10/21/24 at 12:04 p.m. with Licensed vocational nurse (LVN 1) stated Resident 37, does fit in geri-chair, but was unaware of geri-chair weight limit. LVN 1 stated facility had only one geri-chair and residents took turns to use it. During an observation and interview with the Social Worker (SW) on 10/21/24 at 12:28 p.m. in Resident 37's room, Resident 37 was lying SW stated Resident 37 was bedbound and she had never seen him up in a wheelchair. During an interview and concurrent observation on 10/21/24 at 12:46 p.m. in Resident 37's room, a black colored manual wheelchair was observed at Resident 37's bedside. Social worker (SW) stated manual wheelchair at Resident 37's bedside was not suitable in size and had no working brakes. During an observation on 10/22/24 at 11:46 a.m. Resident 37 requested to leave resident council meeting in the middle of it. Resident 37 stated geri-chair he was using was too small and uncomfortable to sit in. During an interview on 10/24/24 at 11:03 a.m. with Regional Social Services Director (RSS) stated Rehab Department was responsible for evaluating the need of medical equipment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 10/22/24 12:03 p.m. with Director of Rehab (ST 1), Resident 37's therapy progress notes were reviewed. ST 1 stated therapist was responsible for completing the wheelchair evaluation upon admission, at the facility. ST 1 stated there was no documentation of wheelchair evaluation in Resident 37's therapy treatment records since his admission to the facility. During another observation on 10/23/24 at 8:32 a.m. Resident 37 stated geri-chair was too small and made his knees hurt. During observation and concurrent interview on 10/24/24 at 9:22 a.m. Resident 37 was found lying on right side in his bed. Resident 37 stated staying in bed most of the time, made him feel like he was never going home and never getting his children back. Resident 37 stated him and his family were very sad about him missing the birth of first grandchild. Resident 37 stated he felt worthless in bed all day and he felt so separated from his whole family. Resident 37 stated It was important for him to be able to get into a car when discharged from the facility, but he was often left in the bed. During a review of facility's Policy and Procedure (P&P) dated Quality of Life-Dignity revised 8/2009, the P&P indicated, Each resident shall be care for in a manner that promotes and enhances quality of life .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593 Based on observation, interview and record review, the facility failed to follow it's smoking policy and procedure to prevent accidents hazards, complete smoking/safety evaluation, develop and implement care plan that promote smoking safety for three (Resident 19, 37 and 41) of three sampled residents when: 1. Resident 19 with amputated fingers, bilateral hands and non-compliance with smoking policy and procedure kept cigarettes and lighter in her possession. 2.Facility did not assess and complete a care plan for Resident 41 for safe smoking practices. Resident 41's charge nurses were unaware if Resident 41 smoked cigarettes, when direct care staff including Certified Nursing Assistants (CNA 1 and CNA 3) were aware that Resident 41 had always smoked at the facility. 3. Resident 37 did not receive smoking aprons, and cigarette holder per plan of care during smoking. 4. Facility staff (Janitor 1) smoked in the smoking patio when door to all rooms adjacent to smoking patio were left open with residents in the rooms. 5. Multiple smoking buds were disposed off in the flower planters instead of designated ash holders kept the smoking patio. This failure had the potential to cause residents to suffer accidents and injuries. Findings: 1. During a review of Resident 19's Annual-Minimum Data Set (MDS - Resident assessment and care guide tool), dated 5/24/24, the MDS indicated Resident 19's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. MDS indicated Resident 19 was able to recall the correct year, month and day of the week. Resident 19 had clear speech, able to express her ideas and wants, and understood what others said to her. Resident 19 needed substantial maximal assistance with personal hygiene, helpers lifts or holds trunk or limbs more than half the effort. Resident 19 currently used tobacco. Resident 19 diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a concurrent observation and interview on 10/22/24 at 10:15 a.m. with Resident 19 in her room, Resident 19 was seated up in wheelchair, amputated fingers on right hand, left hand bandaged. Resident 19 stated she had been smoking at the facility for 5 years with no problems. Resident 19 stated she had cigarette and lighter in her possession. Resident 19 stated facility staff had not checked her for safety for many years. Resident 19 stated she did not smoke in her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Admission Record (AR), the AR indicated, Resident 19 initial admitted to the facility on [DATE]. During a concurrent interview and record review on 10/23/24 9:29 a.m. with MDS coordinator (MDS)1, Resident 19's Smoking and Safetyevaluation dated 7/3/24 was reviewed. The smoking and safety evaluation indicated Resident 19 was non compliance (failing to act in accordance with a wish or command). Further review of Resident 19's Smoking and Safety evaluation dated 10/22/24, indicated Resident 19 had balance problems while sitting or standing. Resident 19 had limited or no ROM range of motion in arms or hands. Resident 19 had insufficient fine motor skills needed to securely hold tobacco. Resident 19 unable to light, hold and extinguish tobacco safely. During a review of Resident 19's 'Tobacco Use care plan, dated 7/10/24, the care plan indicated, Resident 19 was non adherence with smoking policy, refused to wear smoking apron, does not smoke in designated smoking area, does not follow smoking schedule, refused to be supervised by staff. Resident 19 kept smoking paraphernalia. During an interview on 10/24/24 at 3:23 p.m. with Activity Assistant (AA), AA stated Resident 19's sister sent money to facility. AA stated when Resident 19 request store run for cigarette AA said she goes as requested and bought cigarette for Resident 19. AA said Resident 19 keep her cigarette and lighter on herself. During an interview on 10/24/24 at 3:45 p.m. with Licensed Vocational Nurse (LVN4), LVN 4 stated Resident 19 was a long term resident at the facility. LVN 4 stated Resident 19 keeps her cigarette and lighter on herself. LVN 4 stated Resident 19 goes out to smoke by her self. LVN 4 stated Resident 19 will not give up her cigarette and lighter. LVN 4 stated resident was non compliance with smoking policy. During an interview on 10/24/24 at 4:05 p.m. with MDS 1, MDS 1 stated resident was assessed as unable to light, hold and extinguish tobacco and need to be supervised when smoking. 2. During a record review of Resident 41's Admission Record printed on 10/23/24, the record indicated Resident 41 was admitted to the facility on [DATE]. During an observation on 10/23/24 at 11:14 a.m., Room B (shared room between Resident 37 and Resident 41, adjacent to the smoking patio) had smell of cigarette smoke. Resident 41 was outside in the smoking patio by himself, sitting in a wheelchair, smoking a cigarette, without any staff's supervision. During an observation and interview on 10/23/24 at 12:31 p.m. in Resident 41's room, Resident 41 was sitting at the edge of the bed. Resident 41 stated he had always smoked since he had been there, though he was in process of quitting smoking. Resident 41 stated he kept the cigarettes with him, pointing at the pouch on his nightstand. Resident 41 stated staff did not supervise him, but they assisted to take him to the smoking patio. Resident 41stated Certified Nursing Assistant 1 (CNA 1) assisted him to go outside by opening the door to the smoking patio earlier that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA 1 on 10/23/24 at 12:39 p.m. outside the activity room, CNA 1 stated she was the assigned nursing assistant for Resident 41 that day and knew that he was a smoker since his admission to the facility. CNA 1 stated she was aware that he kept the cigarettes with himself but borrowed the lighter from the charge nurses. CNA 1 stated staff did not need to stay with Resident 41 when he smoked because he was alert and oriented. CNA 1 stated Resident 41's family brought his smoking supplies. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 10/23/24 at 12:26 p.m., Resident 41's Smoking Evaluation dated 9/2/24 was reviewed. LVN 1 stated she had been working with Resident 41 since his admission to the facility, but she was not aware if he was a smoker. LVN 1 stated she had not seen him smoking. LVN 1 stated the smoking assessment dated [DATE] indicated Resident 41 was a nonsmoker. During an interview with Minimum Data Set Coordinator (MDSC), accompanied by CNA 1 on 10/23/24 at 12:51 p.m., MDSC stated she did not know if Resident 41 was a smoker; while CNA 1 stated Resident 41 smoked at least two cigarettes during her morning shift (usual time- 7:00 am till 3:00 pm). During an interview with Certified Nursing Assistant 3 (CNA 3) on 10/24/24 at 3:23 p.m., CNA 3 stated she had observed Resident 41 smoking cigarettes in the smoking patio sometime last week. During a concurrent interview and record review with Licensed Vocational Nurse 2 (LVN 2) on 10/24/24 at 3:25 p.m., Resident 41's Smoking Evaluation and Smoking Care Plan dated 10/23/24 was reviewed. LVN 2 stated she assessed Resident 41 for smoking safety on 10/23/24 after facility's management discovered that Resident 41 was a Smoker. LVN 2 stated she did not review smoking policy, and/or share facility's smoking schedule with Resident 41. LVN 2 stated Resident 41's smoking evaluation indicated Resident 41 used Tobacco. The evaluation had following areas to assess: Poor vision or blindness, balance problems while sitting or standing, limited or no [Range of Motion] in arms or hands, insufficient fine motor skills needed to securely hold tobacco .lethargic/falls asleep easily during tasks or activities; Burned skin, clothing, furniture or other; Drops ashes on self; Follows the facility's policy on location and time of smoking. LVN 2 stated she marked 'yes' for balance problems while sitting or standing as she knew the resident, but she did not assess all other areas. LVN 2 also stated she did not assess Resident 41 if he was unable to light, hold, extinguish tobacco, and use ashtray safely. LVN 2 stated she did not alert Resident 41's attending physician and/or all direct care staff who took care of Resident 41, that he was a smoker. LVN 2 further stated the Registered Nurse who created the Non-Compliance with smoking policies and procedures care plan for Resident 41 on 10/23/24, was not even a nurse who worked at this facility, rather she was a director of nursing at a sister facility, indicating no actual oversight and/or knowledge of Resident 41. During an interview on 10/24/24 at 3:54 p.m., Registered Nurse 1 (RN 1) stated she worked with Resident 41 on 10/23/24 evening but was not made aware of him being a smoker. 3. During a record review of Resident 37's Admission Record printed on 10/22/24, the record indicated Resident 37 was admitted to the facility on [DATE]. During a review of Resident 37's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 3/10/24, the assessment indicated Resident 37 used Tobacco; and had diagnosis of Schizophrenia and opioid dependence, in remission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's Smoking Evaluation dated 10/21/24, the assessment indicated Resident 37 used Tobacco, had balance problems while sitting or standing; Resident 37 was to use Cigarette holder, and a smoking apron while smoking. During a concurrent interview and record review with MDS Coordinator (MDSC) on 10/23/24 at 12:24 p.m., Resident 37's Smoking Evaluations in electronic and paper chart were reviewed. MDSC stated Resident 37 was not assessed for safe smoking until 10/21/24. MDSC stated facility should conduct smoking evaluation upon admission. During an observation with Director of Staff Development (DSD) on 10/22/24 at 9:09 a.m., in facility's smoking patio, there were no smoking aprons observed in the smoking patio at that time. During an observation on 10/23/24 at 11:14 a.m., in facility's smoking patio, there were no smoking aprons. During an interview with Resident 37 on 10/23/24 at 12:56 p.m., Resident 37 stated he had never used a smoking apron and/or a cigarette holder and was unsure of what they looked like. During an interview with Certified Nursing Assistant 3 (CNA 3) on 10/24/24 at 3:47 p.m., CNA 3 stated she had seen a smoking apron one time in the past eight months. CNA 3 stated she was aware that Resident 37 was a smoker, however he never used a smoking apron and/or a cigarette holder. During an interview with Registered Nurse 1 (RN 1) on 10/24/24 at 3:54 p.m., RN 1 stated she was aware that Resident 37 was a smoker but had never seen a smoking apron in the facility. RN 1 stated she was not aware where to find smoking aprons in the facility. During an observation of the smoking patio on 10/24/24 at 4:10 p.m., there were still no smoking aprons available for use. During a review of facility's policy and procedures (P&P) titled Smoking Policy- Residents titled 07/2017, the P&P indicated, This facility shall establish and maintain safe resident smoking practices .6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If smoker, the evaluation will include a. Current level of tobacco consumption; b. Method of tobacco consumption; c. Desire to quit smoking, if a current smoker; and d. Ability to smoke safely with or without supervision .7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation 14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision . During an observation on 10/22/24 at 11:31 a.m. in Room A, with Registered Nurse 2 (RN 2) screen door was open and the room had smell of cigarette smoke. RN 2 peeked through the door and stated it was Janitor 1 smoking in the smoking patio. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Janitor 1, accompanied by RN 2 on 10/22/24 at 11:35 a.m. Janitor 1 standing in the smoking patio, actively smoking a cigarette. Janitor 1 stated he smoked in that patio sometimes indicating it was not the first time he was smoking there. Glass door to all six adjacent rooms to the smoking patio were open with residents in the rooms. Janitor 1 stated he did not pay attention to residents' rooms being open while he smoked in the patio because residents wanted the doors to be left open. Janitor 1 stated when I see the smoke going to the side, I know where the wind is blowing. RN 2 stated residents rooms' doors adjacent to the smoking patio should be closed when staff/residents smoked in the patio. RN 2 stated secondhand smoke was not good for residents; or some residents did not want to smell the smoke; the smoke could get into their respiratory track; could cause upto and including lung cancer. RN 2 stated secondhand smoke was more serious than firsthand smoke. 5. During an observation with Director of Staff Development (DSD) on 10/22/24 at 9:09 a.m., in facility's smoking patio, there were multiple smoking butts were in large sized flower planter next to stand-alone ash holder. The DSD stated cigarette butts should not be disposed off in the flower planters as it posed a risk for fire and hurt vulnerable residents at the facility. 39939

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39939 Based on observation, interview, and record review, the facility failed to complete performance review and maintain competency/skills records for three of three sampled licensed nurses (LVN 1, RN 2, and RN 4). A Licensed Nurse is a healthcare professional who has met requirements by state board of nursing to practice nursing skills within defined scope. This failure placed facility to be unaware and address training needs for LVN 1, RN 2 and RN 4 and placed all residents receiving care from LVN 1, RN 2 and RN 4 for receiving care from incompetent licensed nurses. Findings: During an interview and record review with Director of Staff Development (DSD) and Licensed Vocational Nurse 1 (LVN 1) on 10/24/24 at 9:36 a.m., personnel file for LVN 1 was reviewed. The DSD stated LVN 1 was hired on 6/17/24 and she was only able to find background information, hiring application etc. in LVN 1's file. LVN 1 stated she never received an orientation/ training and/or a competency evaluation upon hire and/or after hire. During an interview and record review with the DSD on 10/23/24 at 2:40 p.m. a documented titled Licensed Nurse Clinical Checklist was reviewed. The DSD stated facility utilized this checklist to assess licensed nurses' competency upon orientation and on an annual basis. The checklist indicated to add S for satisfactory and U for unsatisfactory performance. The checklist indicated to assess licensed nurses in: 1. Comprehensive assessment 2. Resident plan of care 3. Validation of care 4. Resident outcome/delivery of care 5. Medication administration 6. Medication security 7. Nursing environment 8. Routine treatments 9. Feeding tubes 10. [Intravenous] therapy 11. Nursing management 12. Supervision role .in a. communicates resident status to [certified nursing assistants] & other staff b. coaches and praises for work performance and work habits c. conducts performance evaluations when applicable d. takes progressive disciplinary action when applicable. [13]. Discard used materials, dispose equipment used to appropriate trash bin, according to facility's policy, perform handwashing, clean/disinfect medical equipment used for the procedure using appropriate/ germicidal wipe. [14] Sign and document medication administration procedure accordingly. The checklist indicated to add licensed nurses' signature, title, date and Reviewer's signature, title and date. During an interview and concurrent record review with the DSD on 10/23/24 at 2:41 p.m. Registered Nurse 2 (RN 2)'s personnel file was reviewed. The DSD stated RN 2 was hired on 5/5/23, and she was unable to find any documentation to indicate if she received a competency evaluation since hire. (Cross Reference F880 and F755) During an interview and concurrent record review with the DSD on 10/23/24 at 2:47 p.m. Registered Nurse 4 (RN 4)'s personnel file was reviewed. DSD stated RN 4 was hired on 8/23/23, but did not have any documentation of training or competency evaluations. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 2:51 p.m. the DSD stated skills and competency evaluations were needed to ensure resident safety, prevent resident harm, reduce errors in providing care, prevent falls and injury, risk of wrong treatment, decline in skin health etc. DSD stated she was unsure of how to anticipate staff's training needs. The DSD stated the Director of Nursing (DON) was responsible for conducting licensed nurses' competency/skills evaluations because DSD herself was an LVN. DSD stated if licensed nurses received competency/skills evaluations, they must be kept and maintained in their personnel files. During an interview on 10/24/24 at 9:17 a.m., the DON stated she was responsible for competency evaluations for licensed nurses, however she had not completed any since she started working at the facility. The DON stated it was important to evaluate nurses' performance to best nursing practices in proving residents' care. During an interview on 10/24/24 at 9:53 a.m. at facility's nursing station, the Administrator (ADM) stated the DON was responsible for evaluated performance for licensed nurses working at the facility, however to knowledge this task was probably not happening. The ADM stated there was an issue with this requirement during previous annual recertification survey as well. During a record review of the Competency of Nursing staff policy and procedure (P&P) revised 05/2019, the P&P indicated , facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment, and The staff development and training program . is designed to train nursing staff to deliver individualized, safe, quality care and services for residents.

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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. 39939 Based on interview and record review facility failed to complete an annual performance review, commonly known as competency/skills checks for one of three sampled Certified Nursing Assistants (CNA 7). Facility did not complete and maintain records for competency/skills checks completed upon hire/orientation for two of three sampled CNAs (CNA 4 and CNA 6). CNA is an unlicensed health professional providing nursing or nursing-related services to residents in the facility. This failure placed facility's residents residing at the facility at risk for not receiving need-based care, compromised safety, and receiving care from incompetent CNAs. Findings: During a review of facility's undated and untitled Staff list, the list indicated CNA 4 was an active, on-call CNA since 5/3/24; CNA 6 was an active, full-time CNA since 1/26/24 ; and CNA 7 was facility's active and full-time employee as a CNA since 11/1/20. During an interview and record review on 10/23/24 at 3:27 p.m. with Director of Staff Development (DSD), in DSD's office, an electronic Excel spreadsheet with facility's staff names was reviewed. The DSD stated she created the spreadsheet for all staff to track their annual competency reviews, however she did not start using it yet. The DSD stated she was responsible for completing the orientation and annual performance reviews for CNAs. The DSD stated she did not complete anyone's competency/skills checks in the past two months, since she started working as a DSD. During an interview and record review on 10/23/24 at 3:30 p.m. with DSD, CNA 4's personnel file was reviewed. CNA 4's personnel file had a document titled Nursing Assistant Orientation and Competency Evaluation dated 5/3/24 with CNA 4's name written on it. The document indicated to fill in the Date and Result of skills check next to each Skills column, Comments section and Evaluator's signature section. The DSD stated document was not completed at all by anyone. The DSD then pulled another undated document titled Performance Evaluation with CNA's name and title written on it. The DSD stated facility used this document to evaluate CNA's performance during probation, quarterly and on an annual basis. The document had following sections: Goals, Specific areas of improvement needs, Comments, Date performance was discussed on; Employee and Supervisors' name, title, and signatures. The DSD stated CNA 4's performance evaluation document was left blank and only had CNA's printed name and signatures. During an interview and record review on 10/23/24 at 3:33 p.m. with DSD, personnel file for CNA 6 was reviewed. DSD stated CNA 6's file had a document titled Competency Evaluation and Performance Satisfactory Completion for Turning and Repositioning dated 2/1/24 signed by CNA 6 and the Evaluator indicated, there were no results documented if CNA 6 was competent or incompetent for that task. DSD stated rest of the competency/skills checks documents for adult brief application, Ambulation with Assistance, Hair and Scalp care, Gait belt application, Foot Care, Fingernail Care, Filling Liquid Oxygen, feeding a Resident, Emptying Urinary Drainage Bags, dressing a Resident, Perineal care, Blood Pressure, and Bed making had CNA 6's name written on them. DSD stated she was unable to find any documentation if CNA 6 was ever trained and/or evaluated for above skills. (continued on next page)

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 10/23/24 at 3:37 p.m. with DSD, CNA 7's personnel file was reviewed. The DSD stated the file had a document undated titled CNA Core Clinical Competencies which indicated CNA 7 had an annual performance review completed on 6/20/23 and 6/23/23. The DSD stated she was unable to find any other/annual performance review for CNA 7 after 6/23/23. The DSD stated training, orientation to required procedures and annual performance reviews must be conducted to ensure residents' safety, to prevent harm, reduce errors in providing care, prevent falls, injuries, decline in residents' skin health. The DSD stated she was unsure how to anticipate staff's training needs. During an interview on 10/24/24 at 9:53 a.m. at facility's nursing station, the Administrator (ADM) stated all CNA's working at the facility needed to go through standard orientation upon hire. The ADM stated it was facility's policy that the DSD was responsible to assess CNA's competency upon hire, after 90 days of their date of hire and then on an annual basis, however, it was probably not happening. The ADM stated once DSD completed the competency evaluation for CNA's, he received a copy of the evaluation for review; however, he had not been receiving any evaluations for almost a year. The ADM stated they were in non-compliance with this requirement during previous annual recertification survey as well. During a review of facility's policy and procedure (P&P) titled Competency of Nursing Staff revised 05/2019, the P&P indicated, Competency in skills and techniques necessary to care for residents needs includes but is not limited to competencies in areas such as: Preventing abuse, neglect and exploitation of resident property; Dementia management; Resident rights; Person centered care . Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49498 Based on observation, interview and record review, the facility failed to administer medication as ordered by the physician for one of five sampled residents (Resident 20) when Registered Nurse (RN) 2 thought Resident 20's eye drop medication was not available. This failure had the potential for Resident 20 to experience adverse effect from missed eye drop dose. Findings: During a concurrent medication administration and interview on 10/22/24 at 8:31 a.m. with RN 2, RN 2 took out Resident 20's one eye drop bottle labeled Simbrinza (a combination eye drop containing two medications: brinzolamide and brimonidine, a medication used to treat glaucoma and high pressure in the eye) and one eye drop bottle labeled Artificial Tears (eye drops used to lubricate dry eyes and help keep moisture on the outer surface of your eyes) from the first left medication drawer of the medication cart. RN 2 stated Resident 20 had an order for Brinzolamide (medication used to treat glaucoma and high pressure in the eye) eye drop but the eye drop bottle was not inside the medication cart after looking. RN 2 stated she doesn't know how long the Brinzolamide eye drop was not available but will re-order from the pharmacy. RN 2 proceeded to administer Resident 20's Artificial Tears eye drops. During a review of Resident 20's Order Summary Report, dated 10/27/23, the Order Summary Report indicated, Resident 20 had an order for Artificial Tears one drop to both eyes three times a day for dry eyes and Brinzolamide-Brimonidine Tartrate 0.2% one drop in left eye three times a day for Glaucoma (group of eye diseases that can damage the optic nerve and lead to vision loss or blindness). During a review of Resident 20's Progress Notes, dated 10/22/24, the Progress Notes indicated, RN 2 documented the Brinzolamide eye drop will be administered once available. During a review of Resident 20's Visual Function Care Plan, dated 5/4/21, the Visual Function Care Plan indicated, Resident 20 had a diagnosis of Glaucoma and one of the plan of care was to instill eye medicine as ordered. During an observation and interview on 10/23/24 at 12:49 a.m. with RN 2, RN 2 took out Resident 20's two eye drop bottle of Simbrinza from the medication cart drawer. RN 2 stated one eye drop bottle of Simbrinza was the old supply and the other one eye drop bottle of Simbrinza was refilled by the pharmacy. RN 2 stated she thought the Simbrinza and Brinzolamide were two different eye drops. RN 2 stated the Brinzolamide eye drop was in the medication cart drawer all along. During a review of facility's policy and procedure (P&P) titled, Administering Medication, dated 12/12, the P&P indicated, Medications shall be administered as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39939 Based on observation, interview, and record review the facility failed to ensure proper medication storage for one of one sampled medication room and one of one sampled resident (Resident 31) when: 1. An unauthorized staff had access to the medication room. 2. Unlabeled, undated medication cup filled with white creamy substance was left unattended on top of Resident 31's overhead light fixture for over 24 hours. This failure had the potential for loss or diversion of medications and residents' accidental access to unknown substance. Findings: 1. During a concurrent observation and interview on 10/23/24 at 8:36 a.m. with the CSS, the CSS unlocked the medication room door with a key from a set of keys he was holding. The CSS stated the key to the medication room was given when he started working at the facility. The CSS stated he ordered over the counter medication for the facility and stored in the medication room. During an interview on 10/23/24 at 10:16 a.m. with the DON, the DON stated, the CSS can open the medication room to access over the counter medication even without a nurse. During a follow up interview on 10/23/24 at 12:59 p.m. with the DON, the DON stated, the CSS was not a person authorized to prepare and administer medication. During a review of the facility's policy and procedure (P&P) titled, Storage of medication, dated 4/07, the P&P indicated, Only persons authorized to prepare and administer medications shall have access to the medication room. 2. During an observation on 10/21/24 at 9:53 a.m., a clear plastic 30 milliliter (ml) medication cup, filled with white creamy substance was on the overhead light fixture for Resident 31, while Resident 31 was lying in bed. The medication cup was unlabeled and undated. During an observation on 10/22/24 at 8:30 a.m., the unlabeled and undated medication cup with white creamy substance was still on top of the overhead light fixture for Resident 31. During an observation and interview on 10/22/24 at 11:40 a.m. with Registered Nurse 2 (RN 2), in Resident 31's room, the medication cup with white creamy substance was on top of Resident 31's overhead light fixture. RN 2 stated based on the texture of the substance, she thought it was Eucerin (a moisturizer) cream in the medication cup, however she was not sure because cup was not labeled. RN 2 stated medication cups must be discarded after use. RN 2 stated facility had confused and ambulatory residents who could easily access the medication cup and eat the creamy substance. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49498

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 36593 Based on interview and record review, the facility failed to ensure that when it did not hire a full-time registered dietitian, the person designated to serve as the director of food and nutrition services met both the federal and/or state educational qualifications for the position. The lack of full-time, competent oversight of food and nutrition staff placed residents who received food from the kitchen at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) and/or decreased nutrient intake which had the potential to result in death and/or nutritional related medical complications Finding: During an interview on 10/21/24 at 1:45 p.m. with Dietary Manager (DM), DM stated she worked full time. DM stated she was not a certified director of food and nutrition. DM stated she was still in school. DM said facility has a Registered Dietician (RD) that visit weekly to complete new admission assessment of residents. During an interview on 10/21/24 at 1:17 p.m. with Registered Dietician (RD), RD stated she visited weekly to support facility with assessment and evaluation of residents. During an interview on 10/24/24 at 9:06 a.m. with Administrator (Admin), Admin stated he was aware DM did not have the educational qualification for the position of director of food and nutrition services. Admin said DM was in school.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36593 Based on observation, interview, and record review the facility failed to store and prepare foods in a sanitary manner that prevented foodborne illness when: - One bag of sliced ham unlabeled and undated was stored in the refrigerator. - Kitchen vents, fans and window screens with dusty areas. These failures had the potential for residents to be exposed to food borne illness. Findings: During the initial tour of the kitchen on 10/21/24 at 9:22 a.m. accompanied by Dietary Aide (DA) and Dietary Manager (DM) one opened bag of sliced ham not labeled with use-by date was observed in the refrigerator. During a concurrent observation and interview on 10/22/24 at 8:47 a.m. with Maintenance Supervisor (MS) and DM in the Kitchen, vents, fans and window screens were dusty. MS stated he cleaned monthly. MS stated he did not have a record or documentation of the cleaning. During an interview on 10/22/24 at 9:02 a.m. with DA, DA stated she received training on labeling and dating food items. DA stated it was important to label with use-by date food items stored in the refrigerators. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised July 2014, the P&P indicated, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, The Maintenance Department will assist Food & Nutrition Services as necessary in maintaining equipment and in doing janitorial duties which the food & nutrition services employees cannot do and maintain maintenance records on all equipment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39939 Based on observation, interview, and record review the facility failed to accurately complete functional status in discharge planning assessment (an evaluation of residents' clinical and functional condition to arrange resources to help them prepare for a smooth discharge from the facility) for one of 15 sampled residents (Resident 37). This failure resulted in an inaccurate reflection of Resident 37's clinical condition, and placed him at risk for receiving inappropriate care upon discharge from the facility. Findings: During a record review of Resident 37's Admission Record printed on 10/22/24, the record indicated Resident 37 was admitted to the facility on [DATE]. During a review of Resident 37's Minimum Data Set (MDS, an assessment used to plan care) dated 9/9/24, the assessment indicated Resident 37 was able to understand others and was able to make his needs known. The assessment indicated Resident 37 was dependent on staff for toilet hygiene, shower/bathing, lower body dressing, personal hygiene, and wheelchair mobility. During an observation on 10/21/24 at 11:00 a.m. Resident 37 was lying in the bed with both legs flexed, with a linen on top of his legs. Resident 37 was unable to fully extend both his legs. During an observation and interview with the Social Worker (SW) on 10/21/24 at 12:28 p.m. in Resident 37's room, SW stated Resident 37 was bedbound with amputation of both legs. SW asked Resident 37 which leg is amputated? Resident 37 stated I don't have no amputation. SW removed the linen from Resident 37's legs and stated since she always seen Resident 37 with the cover on his legs, she thought he had amputations done. SW stated she talked to Resident 37 when she completed his discharge assessments. During an interview and record review on 10/22/24 at 12:36 p.m. with SW and Regional Social Services Director (RSS), Resident 37's discharge planning review dated 6/25/24 and 9/16/24 were reviewed. SW stated she completed Resident 37's initial and ongoing discharge planning reviews using her observations, interviews with the staff and clinical chart review. SW stated the discharge planning review indicated Resident 37's goal was to go back to the community with home health services. SW stated the review indicated Resident 37 was independent in using wheelchair, however she had never observed Resident 37 using a wheelchair. SW stated assessment indicated Resident 37 was independent for bathing, dressing, preparing meals. SW stated however, she never observed and/or consulted with Resident 37's direct care staff to evaluate these activities and used her assumptions to complete the assessment. RSS stated she had trained SW to conduct these assessments and get an input from all disciplines working with the residents. RSS stated using assumptions to complete the discharge planning reviews could adversely affect in reflection of residents' actual clinical condition, psychosocial and overall health and could cause delays in provide care and services to meet residents' needs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 1 on 10/23/24 at 12:39 p.m. CNA 1 stated Resident 37 was totally dependent on staff for activities of daily living since his admission to the facility. During a record review of facility's Policy and Procedure (P&P) titled Charting and Documentation revised 7/2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 36593 Based on interview and record review, the facility failed to follow a written hospice agreement that included joint responsibilities to develop and implement a coordinated plan of care (POC) for one sampled resident (Resident 3) admitted into hospice program, when Resident 3's hospice POC did not reflect the participation of facility staff, Resident 3 and Resident 3's representative (FM 1). {POC means a written plan of care established, maintained, reviewed, and modified as necessary, for an individual that reflects the participation of hospice, facility, the patient and patient's family, as appropriate and complies applicable to federal and state laws and regulations}. {Hospice- a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease}. Findings: During a review of Resident 3's Significant change in status-Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 10/1/24, MDS indicated Resident 3 was on hospice care. Resident 3's diagnoses included Non-Alzheimer's Dementia (a group of diseases characterized by progressive deficits in behavior, executive function or language). MDS indicated Resident 3 had short-term and long-term memory problem. Resident 3 had a clear speech, usually understood and understood others. During a review of Resident 3's order summary report dated 9/15/24, order report indicated, the physician admitted Resident 3 into hospice for senile degeneration of the brain. During a telephone interview on 10/21/24 at 10: 38 a.m. with Resident 3's daughter/responsible party (FM 1), FM 1 stated Resident 3's family had not had a care plan conference with the facility and hospice agency. FM 1 stated Resident 3 had dementia and was forgetful. FM 1 stated facility had not invited Resident 3 and FM 1 to participate in Resident 3's hospice POC. FM 1 stated Resident 3's family had not had a coordinated POC between the facility, hospice agency and Resident 3. During an interview on 10/22/24 at 11:21 a.m. with Director of Nursing (DON), DON stated she was hired in October 2024 and was not aware whether care plan conference with Resident 3, family and hospice agency had taken place . DON stated the Social Services and her self are designated contacts for hospice care. During an interview on 10/24/24 at 10:45 a.m. with Registered Nurse/Hospice Nurse (HN), HN stated she was assigned to care for Resident 3 . HN stated facility had not met with Hospice Agency to coordinate and collaborate with Resident 3 and family representatives for care planning conference. During an interview on 10/22/24 at 2:55 p.m. with MDS coordinator/Licensed Vocational Nurse (MDS) MDS stated she participated in care planning conference for residents on hospice care. MDS stated facility had not met with Resident 3, FM 1 and hospice agency for a care planning conference. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/22/24 at 1:52 p.m. with Regional Social Services Director (RSS), Resident 3's Multidisciplinary Care Conference (interdisciplinary team) care conferences records dated 10/16/24 was reviewed. RSS stated social services was designated to coordinated care plan conference with hospice agency and Resident 3's family members. RSS stated Resident 3 and FM 1 had not been invited to participate in development of Resident 3's hospice care plan in collaboration with hospice agency. {IDT/Interdisciplinary team is a group of people with different functional expertise working collaboratively with a common purpose, to set goals, make decisions and share responsibilities}. During a review of Resident 3's The Nursing Facility Services Agreement (Agreement), dated 3rd of September 2024, the Agreement indicated, Plan of Care means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by IDT. The plan of care must reflect Hospice patient and family goals and interventions based on the problems identified in hospice patient assessments. The plan of care will reflect the participation of hospice, facility and hospice patient and family to the extent possible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49498 Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices when: 1. Registered Nurse (RN) 2 did not perform hand hygiene during medication administration. 2. Nutritional feeding pole in Resident 33's had multiple dried light brown stains. These failures had the potential for cross contamination and spread of infections among residents at the facility. Findings: 1. During medication preparation observation on 10/22/24 at 8:21 a.m. with RN 2, RN 2 was preparing Resident 17's nine medications, poured the tablets and capsule in a medication cup and mixed the laxative powder with 4 ounces (oz) of orange juice in a plastic cup. During medication administration observation on 10/22/24 at 8:28 a.m. with RN 2 in Resident 17's room, RN 2 handed Resident 17 the medication cup and the 4 oz of orange juice placed on the medication tray, Resident 17 poured the tablets and capsules into his mouth and drank the 4 oz of orange juice. RN 2 took the empty medication cup and 4 oz plastic cup from Resident 17's hands and discarded the cups in the garbage can attached to the left lower side of the medication cart located by Resident 17's room door. RN 2 donned a pair of gloves without performing hand hygiene and sanitized the medication tray. During medication preparation observation on 10/22/24 at 8:31 a.m. with RN 2, RN 2 took out Resident 20's one bottle of eye drops from the first left medication drawer of the medication cart. RN 2 donned a pair of gloves without performing hand hygiene and pushed in the medication cart lock with her right gloved hand. During medication administration observation on 10/22/24 at 8:35 a.m. with RN 2 in Resident 20's room, RN 2 pulled Resident 20's left and right lower eyelids with the same gloved hands to administer the eye drops. RN 2 proceeded to screw the white eye drop cap into the bottle with the same gloved hands. RN 2 removed and discarded the gloves in the garbage can and returned the eye drops bottled inside the first left medication drawer of the medication cart. During medication preparation observation on 10/22/24 at 8:39 a.m. with RN 2, RN 2 prepared Resident 302's inhaler medication. RN 2 donned a pair of gloves without performing hand hygiene, pushed in the medication cart lock and proceeded to walk into Resident 302's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During medication administration observation on 10/22/24 at 8:41 a.m. with RN 2 in Resident 302's room, RN 2 handed Resident 302's inhaler medication, Resident 302 shook the inhaler and inhaled two puffs. Resident 302 rinsed his mouth after inhaling the medication. RN 2 took the inhaler from Resident 302's hand and took the medication cart key from her pocket with the same gloved hands. RN 2 returned Resident 302's inhaler in the medication drawer while wearing the gloves. RN 2 then pulled the bottom medication drawer and took disinfecting wipes and disinfected the medication tray using the same gloved hands. During an interview on 10/22/24 at 8:44 a.m. with RN 2, RN 2 stated hand hygiene should be performed before and after glove use to prevent the transfer of bacteria and virus to other residents. During an interview on 10/23/24 at 10:52 a.m. with the Infection Preventionist (IP), the IP stated, gloves should be removed before leaving resident's room and hand hygiene should be performed after removing gloves to prevent transmission of infections among residents and staff. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 8/19, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of infections . Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after direct contact with residents; Before preparing or handling medications; After contact with resident's intact skin; After contact with objects in the immediate vicinity of the resident; After removing gloves. 2. During an observation on 10/21/24 at 10:46 a.m. in Resident 33's room, the IV pole (a medical device that holds bags of fluids or medicine in place while they are administered to a patient) where Resident 33's nutritional feeding machine was attached was observed with multiple dried light brown stains. During a concurrent observation and interview on 10/21/24 at 10:48 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 33's room, the IV pole in Resident 33's had multiple dried light brown stains. LVN 1 stated the IV pole was cleaned daily by the IP. LVN 1 stated the IV pole needed to be cleaned and doesn't look like it had been cleaned daily. During a concurrent observation and interview on 10/21/24 at 10:56 a.m. with the IP in Resident 33's room, the IV pole in Resident 33's had multiple dried light brown stains. The IP stated the IV pole was cleaned either by her or the housekeeping. The IP stated there was no documentation of when the IV pole was cleaned. The IP stated the IV pole doesn't look like it had been cleaned daily. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, dated 6/09, the P&P indicated, Environmental surfaces will be cleaned and disinfected according to current Center for Disease Control and Prevention) CDC recommendation for disinfection of healthcare facilities .Non-critical surfaces will be disinfected with an Environmental Protection Agency (EPA - protects people and the environment from significant health risks, sponsors and conducts research, and develops and enforces environmental regulations)-registered disinfectant according to the label's safety precautions and use direction. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of an online publication by the CDC titled, Environmental Cleaning Procedures, dated 3/24, indicated, Common high-touch surfaces included IV poles . Portable or stationary noncritical patient care equipment incudes IV poles. (https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Merritt Healthcare Center LLC	309 MacArthur Boulevard Oakland, CA 94610

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on observation, interview and record review, the facility had seven resident rooms (Rooms 8, 9, 12, 14, 15, 16, 21) with multiple beds that provide less than 80 square feet (sq. ft.) per resident who occupy these rooms. The deficient practice had the potential to result in inadequate space for the delivery of care to each of the residents in each room or for storage of the residents' belongings. Findings: room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 238 and 79.33 sq. ft. per bed. During random observations of care and services from 10/21/24 through 10/24/24, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with resident care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/ or safety concerns in the seven rooms. Granting of room size waiver recommended.