STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056363	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Valley Health Care Center	13524 Sherman Way Van Nuys, CA 91405

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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** 49947 Based on observation, interview, and record review, the facility failed to provide reasonable services and accommodations for two of three sampled residents (Resident 16 and Resident 28) by failing to: 1. Ensure Resident 16's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach while in bed. 2. Ensure Resident 28 was provided a call light that was adaptive to the resident's needs. These deficient practices had the potential to delay the provision of services and residents' needs not being met. Findings: 1. During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 5/20/2024, with diagnoses including, but not limited to chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it difficult to breathe), dysphagia (difficulty swallowing) following cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked) and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 16's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 5/22/2024, the H&P indicated the resident can make needs known but cannot make medical decision. During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool), dated 9/21/2024, the MDS indicated the resident needed substantial assistance with activities including eating, hygiene, toileting, dressing, and bathing. During a review of Resident 16's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) titled, Activities of Daily Living (ADL- activities related to personal care) Functional/Rehabilitating Potential, dated 8/27/24, the care plan indicated the call light must be within easy reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/4/2024 at 8:46 a.m., with Resident 16 in Resident 16's room, observed Resident 16 lying in bed with their call light hanging behind Resident 16's bed and out of Resident 16's reach. Resident 16 stated he did not know where the call light was. During a concurrent observation and interview on 11/4/2024 at 8:49 a.m., in Resident 16's room with Certified Nursing Assistant 1 (CNA 1), observed Resident 16's call light hanging behind Resident 16's bed and out of reach. CNA 1 stated the call light must always be in reach of the resident so they can have a way to call for assistance if there is an emergency. During an interview on 11/4/2024 at 11:05 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 16's and all residents' call lights must always be within reach or there could be a delay in care. 2. During a review of Resident 28's Admission Record, the Admission Record indicated the facility readmitted the resident on 7/26/2024, with diagnoses including, but not limited to osteomyelitis (a serious bone infection that causes inflammation and swelling in the bone) of vertebra (bones in the spine), type two (2) diabetes mellitus (when sugar level is too high in the blood) with diabetic neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), congestive heart failure (heart is not pumping as well as it should be), and abnormalities of gait (walking) and mobility (movement). During a review of Resident 28's H&P, dated 7/29/2024, the H&P indicated the resident is alert and oriented times three (knows who they are, the time/date, and where they are) and had the capacity to understand and make decisions. During a review of Resident 28's MDS dated [DATE], the MDS indicated the resident had impairment on both sides of the upper extremities (shoulder, elbows, wrists, hands) and was dependent on staff for ADLs including eating, hygiene, toileting, dressing, and bathing. During a concurrent observation and interview on 11/4/2024 at 9:30 a.m., with Resident 28 in Resident 28's room, observed Resident 28 lying in bed with a push button call light on his lap. Resident 28's right wrist was contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) with the right hand hyper-extended (when a joint is forced past its normal range of motion typically in the direction opposite to how it naturally bends) backwards towards the left and his left hand contracted with his hand in a mostly closed position. Resident 28 stated he was unable to freely move his arms, wrists and hands or press the button to the call light the facility provided. Resident 28 stated he had to yell out for help to get staff's attention. During a concurrent observation and interview on 11/4/2024 at 9:45 a.m., in Resident 28's room with Treatment Nurse 1 (TN 1), observed Resident 28's upper extremities and TN 1 confirmed by stating Resident 28 was unable to move his arms without assistance and not able to push the call light button. TN 1 stated Resident 28 could have an emergency and is unable to call for help, causing a delay in care. During an interview on 11/4/24 at 10:35 a.m., with Registered Nurse 1 (RN 1), RN 1 confirmed by stating Resident 28 needs an adaptive call light and is unable to use the one that Resident 28 currently has, causing a delay in care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/2024 at 11:05 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the call light Resident 28 currently had was inadequate to Resident 28's needs because Resident 28 was unable to call for assistance, causing a delay in care. The ADON further explained Resident 28 needs to be assessed properly in order to provide the equipment for his limited range of motion. During a review of the facility's policy and procedure titled, Call Lights, last reviewed on 8/15/2024, the policy indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. It further indicated the resident should be able to return demonstrate how to use the call light.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 38469 Based on interview and record review, the facility failed to ensure that an advance directive (AD-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was discussed and written information was provided to the resident and/or responsible parties for one of two sampled resident (Resident 6). This deficient practice violated the resident's and/or the representative's right to be fully informed of the option to formulate an advanced directive and had the potential to cause conflict with health care wishes. Findings: During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 9/11/2024 with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe) and muscle weakness. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 9/17/2024, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. During a concurrent interview and record review on 11/5/2024 at 3:38 p.m., with the Assistant Director of Nursing (ADON), reviewed a form titled Patient Self-Determination Act of 1990. The review indicated that the Patient Self-Determination Act of 1990 form contained information regarding the resident rights, including the right to formulate an advance directive. The ADON confirmed by stating that Resident 6's Patient Self-Determination Act of 1990 form did not contain Resident 6's signature or resident representative's signature indicating the resident was not informed of their right to formulate an advance directive. The ADON stated the purpose of the form is to inform the residents of their right to formulate an advance directive and if the resident chooses to formulate an advance directive, then their healthcare wishes would be honored as contained in the advance directive. The ADON stated that if there is no signature of the resident acknowledging receipt of the Patient Self-Determination Act of 1990 form with the information regarding their right to formulate an advance directive, then it is a violation of their right and their healthcare wishes may not be upheld or honored. During a review of the facility's policy and procedure titled, Advance Directives, last reviewed on 8/15/2024, the policy indicated, It is the policy of this facility to promote a resident's right to accept or refuse medical or surgical treatment, and the right to formulate an Advance Directive .upon admission, all residents and their representative are presented with written information about their rights to accept or refuse medical or surgical treatment and their right to formulate and advance directive (if the resident has the capacity to do so). This information is found in the resident rights portion of the admission packet and Preferred Intensity of Care and Advance Directive Acknowledgement forms .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47883 Based on observation, interview, and record review, the facility failed to maintain a safe and comfortable temperature level for one of four sampled residents (Resident 30). This deficient practice had the potential to result in loss of body heat and risk of hypothermia (dangerously low body temperature) for Resident 30. Findings: During a review of Resident 30's Admission Record, the Admission Record indicated that the facility initially admitted Resident 30 on 2/22/2024 and readmitted the resident on 8/30/2024 with diagnoses including acute embolism and thrombosis of deep veins of the right lower extremity (a clinical condition in which blood clots [a gel-like clump of blood] are forming and affecting the veins and arteries in the right lower extremity), degenerative disease of nervous system (a condition where the nerves or brain gradually break down or stop working properly over time), and repeated falls. During a review of Resident 30's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 2/23/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 10/17/2024, the MDS indicated that the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated that Resident 30 was dependent on the assistance of two or more helpers for showering, and required maximal assistance for toileting, personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During a concurrent observation and interview on 11/4/2024 at 9:42 a.m., in Resident 30's room, Resident 30 was observed laying down in his bed, covered with a blanket and stated that he is cold in his room. During a concurrent observation and interview on 11/4/2024 at 9:51 a.m., with the Maintenance Supervisor Assistant (MSA) in Resident 30's room, the MSA took the temperature of Resident 30's room. The MSA stated Resident 30's room temperature was 68 degrees Fahrenheit (unit of measurement of temperature). The MSA stated that the temperature should between 70-75 degrees Fahrenheit. During an interview on 11/7/2024 at 10:15 a.m., with the Maintenance Supervisor (MS), the MS stated that there was an open window in the bathroom, which was why the temperature in Resident 30's room was below 70 degrees Fahrenheit. The MS stated that temperature should be maintained in a safe and comfortable range between 70-75 degrees Fahrenheit. During an interview on 11/7/2024 at 12:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that the temperature in the residents' rooms has to be at a safe and comfortable level for all residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Comfortable Environment, last reviewed on 8/15/2024, the policy indicated, The facility will maintain the temperature at a comfortable level for residents, which is generally 70-75 degrees Fahrenheit, or it can be adjusted to whatever they feel is comfortable level.

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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 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** 49947 Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a written document that summarizes a resident's needs, goals, and care/treatment) for two of three sampled residents (Resident 28 and 50) by failing to: 1. Develop a care plan addressing Resident 28's range of motion (ROM - the amount of movement that a particular joint or series of joints can achieve in a specific direction) limitations. 2. Develop a care plan addressing Resident 50's bowel and bladder incontinence (a problem holding in urine or stool). These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: a. During a review of Resident 28's Admission Record, the Admission Record indicated the facility readmitted the resident on 7/26/2024, with diagnoses including, but not limited to osteomyelitis (a serious bone infection that causes inflammation and swelling in the bone) of vertebra (bones in the spine), type two (2) diabetes mellitus (when sugar level is too high in the blood) with diabetic neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), congestive heart failure (heart is not pumping as well as it should be), and abnormalities of gait (walking) and mobility (movement). During a review of Resident 28's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 7/29/2024, the H&P indicated the resident is alert and oriented times three (knows who they are, the time/date, and where they are) and had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 9/21/2024, the MDS indicated the resident had impairment on both sides of the upper extremities (shoulder, elbows, wrists, hands) and was dependent on staff for Activities of Daily Living (ADLs- activities related to personal care) including eating, hygiene, toileting, dressing, and bathing. During a concurrent observation and interview on 11/4/2024 at 9:30 a.m., with Resident 28 in Resident 28's room, observed Resident 28 lying in bed with a push button call light on his lap. Resident 28's right wrist was contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) with the right hand hyper-extended (when a joint is forced past its normal range of motion typically in the direction opposite to how it naturally bends) backwards towards the left and his left hand contracted with his hand in a mostly closed position. Resident 28 stated he was unable to freely move his arms, wrists and hands or press the button to the call light the facility provided. Resident 28 stated he had to yell out for help to get staff's attention. (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 observation and interview on 11/4/2024 at 9:45 a.m., in Resident 28's room with Treatment Nurse 1 (TN 1), observed Resident 28's upper extremities and TN 1 confirmed by stating Resident 28 was unable to move his arms without assistance and not able to push the call light button. TN 1 stated Resident 28 could have an emergency and is unable to call for help, causing a delay in care. During a concurrent interview and record review on 11/4/2024 at 10:35 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 28's care plans from 7/26/2024 to 11/4/2024 and Resident 28's Initial Nursing History and Assessment form dated 7/26/2024. RN 1 stated there was no care plan to address Resident 28's upper extremity ROM limitations. RN 1 stated she assessed Resident 28 when he was readmitted to the facility on [DATE] and missed notating Resident 28's upper extremity ROM limitations on the Initial Nursing History and Assessment form. During an interview on 11/4/2024 at 11:05 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 28 should have an ADL care plan that accurately reflects the resident's ROM limitations. During a review of the facility's policy and procedure titled, Comprehensive Care Planning, last reviewed on 8/15/2024, the policy indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan is based upon the resident assessment and choices and must be reviewed and revised at least quarterly on an ongoing basis to reflect any changes in the resident. 38469 b. During a review of Resident 50's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/8/2022 and readmitted the resident on 6/18/2023, with diagnoses that included but not limited to, gastroesophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and dysphagia (difficulty swallowing). During a review of Resident 50's MDS dated [DATE], the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required moderate assistance from staff for toileting, shower, dressing and personal hygiene. The MDS also indicated that the resident is frequently incontinent of bowel and bladder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/6/2024 at 10:00 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 50's MDS dated [DATE] and care plans dated 10/8/2022 to 11/6/2024. Section H of Resident 50's MDS indicated Resident 50 is frequently incontinent of bowel and bladder. RN 2 stated there was no care plan for Resident 50's bowel and bladder incontinence and stated there should be a care plan. RN 2 stated that a care plan would clearly identify the incontinence problem, set a goal and a timeframe in resolving the problem, and come up with interventions to attain the goals. RN stated the care plan would also include an evaluation date to review the effectiveness of the care plan and if not then revise the care plan with additional interventions to meet the goals of treatment. RN 2 stated that in the absence of a care plan for bowel and bladder incontinence, the care needs of the resident may not be provided which could result in skin breakdown or impairment due to uncontrolled passage of urine and stool. During a review of the facility's policy and procedure titled, Comprehensive Care Planning, last reviewed on 8/15/2024, the policy indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan is based upon the resident assessment and choices and must be reviewed and revised at least quarterly on an ongoing basis to reflect any changes in the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to: a. Ensure the Interdisciplinary Team (IDT-a group of experts from various disciplines working together to treat your ailment, injury, or chronic health condition) involve the resident on two quarterly IDT Care Conference for one of one resident (Resident 50) investigated under Care Planning. This deficient practice deprived the resident's right to be included in developing a resident-centered care plan (a treatment plan that is based on the needs, preferences, and habits of each resident) which had the potential to result in failure to deliver the necessary care and services. b. Revise the care plan for burning sensation during urination when the resident's symptoms resolved after three days of monitoring for one of three sampled residents (Resident 30). This deficient practice had the potential for Resident 30 to receive inappropriate care and services. Findings: a. During a review of Resident 50's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/08/2022 and readmitted on [DATE], with diagnoses including gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining) and dysphagia (difficulty swallowing). During a review of Resident 50`s Minimum Data Set (MDS - a resident assessment tool), dated 10/10/2024, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and required moderate assistance from staff for toileting, shower, dressing and personal hygiene. The MDS also indicated that the resident is frequently incontinent of bowel and bladder. During a concurrent interview record review and on 11/06/24 at 10:00 a.m., with Registered Nurse 2 (RN 2), reviewed the Quarterly IDT Care Plan (a document that summarizes a person's health conditions, care needs, and current treatments) Conference Summary dated 4/11/2024 and 7/11/2024. The Quarterly IDT Care Plan Conference Summary indicated the care plan conference was attended by representatives from the departments of Nursing, Social Services, Dietary, Activity and by Resident 50's family member via telephone. The Quarterly IDT Care Plan Conference Summary indicated the care plan conference was conducted to update the care plans and to review the consents. RN 2 confirmed that the resident was not involved in these care plan conferences. RN 2 stated that there is no documentation that the resident was invited or had refused to attend the care plan conference. RN 2 stated that given that the resident has intact cognitive function and has not appointed anyone as her representative, she (Resident 50) should have been included in the care plan conference. RN 2 stated that it is the right of the resident to participate in developing her (Resident 50) care plan to ensure the care plan is resident-centered and include the resident`s input. RN 2 stated that, if the resident's input was not addressed, the care plan might not address the resident's needs. (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 procedures (P&P) titled Policy for the Interdisciplinary Team, last reviewed on 8/15/2024, the P&P indicated that It is the policy of the facility that the Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .the resident, the resident`s family and/or the resident`s legal guardian are encouraged to participate in the development and revisions to the resident`s care plan .every effort will be made to schedule care plan meeting at the best time of day for the resident and the resident`s family . 47883 b. During a review of Resident 30's Admission Record, the Admission Record indicated that the facility initially admitted Resident 30 on 2/22/2024 and readmitted the resident on 8/30/2024 with diagnoses including acute embolism and thrombosis of the deep veins of the right lower extremity (a clinical conditions in which blood clots [a clump of blood that has changed from liquid to gel-like state, which can block blood flow] is forming and affecting the veins and arteries in the right lower extremity), degenerative disease of the nervous system (a condition where the nerves or brain gradually break down or stop working properly over time), and repeated falls. During a review of Resident 30's History and Physical, (H&P) dated 2/23/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 10/17/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 30 was dependent on the assistance of two or more helpers for showering, required maximal assistance for toileting and personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During a review of Resident 30's Care Plan (CP-written guide that organizes information about the resident's care), dated 10/9/2024, the CP indicated that Resident 30 was complaining of a burning sensation upon urination. The CP interventions indicated to administer medication as ordered and reevaluate the resident on 10/12/2024. During a review of Resident 30's Situation, Background, Assessment and Recommendation communication tool (SBAR-a structured communication framework that can help teams share information about the condition of a patient the team needs to address), dated 10/9/2024, the SBAR indicated the resident had pain when urinating. The SBAR indicated that Physician 1 was informed and orders for urinalysis (UA- a test of a urine sample to check for infection) and Urine Culture and Sensitivity (C&S- a test to find out if there is bacteria in the urine that may be causing an infection and the best antibiotic [a type of medication to treat infection caused by bacteria] for the infection) were received and placed. During a review of Resident 30's Urine C&S result, dated 10/13/2024, the Urine C&S result indicated that the resident's urine had more than 100000 colonies/ml Proteus Mirabilis (a significant number of bacteria that can cause urinary tract infection). During a review of Resident 30's Nursing Notes, dated 10/10/2024, 10/11/2024 and 10/12/2024, the Nursing Notes indicated that the resident did not have any pain or burning sensation during urination. (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 concurrent interview and record review on 11/7/2024 at 9:52 AM with the Infection Preventionist (IP), the Surveillance Data Collection Form, dated 10/9/2024, was reviewed. The Surveillance Data Collection Form indicated that Resident 30's symptom of burning sensation was resolved in last three days and the urine culture result was forwarded to the Medical Doctor (MD) on 10/13/2024 and no new order for antibiotics was received as of 10/14/2024. The IP stated that Resident 30's care plan for burning sensation during urination should have been resolved on 10/14/2024 to ensure the care plan was accurate and based on resident's needs. During an interview with the Assistant Director of Nursing (ADON) on 11/7/2024 at 12:20 PM, the ADON stated that Resident 30's care plan for burning sensation during urination should have been resolved after three days of monitoring to reflect Resident 30's assessment and needs. During a review of the facility Policy and Procedure (P&P) titled Care Planning- Interdisciplinary Team, last reviewed on 8/15/2024, the P&P indicated: The care plan is based on the resident 's needs and the resident's comprehensive assessment and is developed by a Care planning /Interdisciplinary team.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure residents' low air loss mattresses (LALM, a mattress designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) were set at the correct setting for three of 23 sampled residents (Residents 88, 11, and 196). This deficient practice had the potential to place the resident at risk for discomfort and development of pressure ulcers/injuries (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure). Findings: a. During a review of Resident 88's Admission Record, the Admission Record indicated the facility admitted Resident 88 on 2/28/2023 and readmitted the resident on 10/2/2024 with diagnoses including fracture (broken bone) of the left femur (the thigh bone), fracture of the left pubic bone (a broken bone in the front part of left hip), fracture of the left ulna (a broken bone in the left forearm), and diabetes type two (2) (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 88's History and Physical (H&P - a medical document that records a resident's detailed medical history, including their current symptoms and past health conditions, along with a physical examination conducted by a healthcare provider to assess their overall health status), dated 10/3/2024, the H&P indicated that the resident had a fluctuating (to change or vary) capacity to understand and make decisions. During a review of Resident 88's Minimum Data Set (MDS- a resident assessment tool) dated 10/8/2024, the MDS indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was mildly impaired (a slight decline in mental abilities, memory and completing complex tasks) and the resident needed supervision or set assistance for eating, oral and personal hygiene, and maximal assistance for toileting hygiene, dressing, and showering. During a review of Resident 88's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) dated 10/2/2024, the care plan indicated that the resident was at high risk for further skin break down related to decreased mobility. The interventions of the care plan indicated to use a LALM as a pressure relieving device. During a review of Resident 88's physician's orders, the document indicated a physician order dated 10/4/2024 to apply a LALM for skin management. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/4/2024 at 10:08 a.m., with Licensed Vocational Nurse 7 (LVN 7) in Resident 88's room, observed Resident 88's LALM set to 210 pounds (lbs. - unit of measurement of weight). LVN 7 stated the LALM was supposed to be set to Resident 88's weight, around 140 lbs. LVN 7 stated the LALM is an intervention to promote wound healing and prevent further pressure injuries. LVN 7 stated if the LALM is not set at the correct setting then it won't be effective and there is the potential the resident may develop further pressure injuries. During an interview on 11/7/2024 at 12:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that it was important to follow the physician's order for the correct settings of the LALM for each resident. The ADON stated if the LALM is not set at the correct setting then it won't be effective and there is a potential the resident may develop further skin injuries. During a review of the LALM's Operator's Manual, undated, the manual indicated that LALM is designed for wound care therapy treatment and prevention. Further, the manual indicated to turn the pressure adjust knob to set a comfortable pressure level by using the weight as a guide. 38549 b. During a review of Resident 11's Admission Record, the Admission Record indicated the facility admitted the resident on 6/21/2024 with diagnoses including fracture (broken bone) of the shaft of the left femur (thigh bone) and orthopedic (relating to the branch of medicine dealing with the correction of deformities of bones or muscles) aftercare. During a review of Resident 11's H&P dated 6/2024, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 11's MDS dated [DATE], the MDS indicated the resident had intact cognition and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). The MDS also indicated the resident was at risk of developing pressure ulcers/injuries. During a review of Resident 11's physician's orders, dated 7/22/2024, the physician's orders indicated an order to provide the resident with an LALM for wound management. During a review of Resident 11's Weights and Vitals Summary, dated 10/14/2024, the Weight and Vitals Summary indicated Resident 11 weighed 132 lbs. During an observation on 11/4/2024 at 9:26 a.m., observed Resident 11 asleep in bed with Resident 11's LALM set to firm, or greater than 350 lbs. During an interview on 11/4/2024 at 9:31 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 11 had a current physician's order to have an LALM for wound management. During an interview on 11/4/2024 at 9:39 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated Resident 11 had a physician's order for an LALM to prevent the development of wounds. TN 1 stated the LALM should have been set between 80 - 150 lbs. TN 1 stated it was the facility's practice to set the LALM according to the resident's current weight in order to prevent wound development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/2024 at 9:59 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that the purpose of a LALM was to manage residents' wounds or prevent them from developing wounds. The ADON stated that LALM should be set according to the residents' weight. The ADON stated that if residents' LAL mattresses were incorrectly set, then it increased their risk for skin breakdown. During a review of the LALM's Operator's Manual, undated, the manual indicated to turn the pressure adjust knob to set a comfortable pressure level by using the weight scale as a guide. During a review of the facility's policy and procedure titled, Wound Care, last reviewed and revised on 8/15/2024, the policy indicated it was the policy of the facility to provide guidelines for the care of wounds to promote healing. c. During a review of Resident 196's Admission Record, the Admission Record indicated the facility admitted the resident on 10/29/2024 with diagnoses including osteomyelitis (a serious bone infection), difficulty in walking, and generalized muscle weakness. During a review of Resident 196's H&P, dated 10/30/2024, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 196's MDS, dated [DATE], the MDS indicated the resident had intact cognition and required maximal assistance from staff for most ADLs. During a review of Resident 196's physician's order, dated 11/7/2024, the physician's order indicated that the resident may have a low air loss mattress. During a review of Resident 196's care plan for stage III pressure ulcer (a deep wound that extends through the skin and into the fat tissue, but doesn't reach the muscle, tendon, or bone) on the right and left buttock, initiated on 10/30/2024, the care plan indicated for the use of a LALM. During an observation on 11/4/2024 at 9:47 a.m., observed Resident 196 in bed with Resident 196's LALM set to 280 lbs. During a concurrent observation and interview on 11/4/2024 at 10:48 a.m., with TN 1, TN1 observed and verified by stating that Resident 196's LALM was set to 280 lbs. TN 1 stated Resident 196 had a stage III pressure ulcer on her buttock, and the mattress should have been set according to Resident 196's weight, which was 133 lbs. During an interview on 11/7/2024 at 9:59 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that the purpose of a LALM was to manage residents' wounds or prevent them from developing wounds. The ADON stated that LALM should be set according to the residents' weight. The ADON stated that if residents' LAL mattresses were incorrectly set, then it increased their risk for skin breakdown. During a review of the LALM's Operator's Manual, undated, the manual indicated to turn the pressure adjust knob to set a comfortable pressure level by using the weight scale as a guide. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Wound Care, last reviewed and revised on 8/15/2024, the policy indicated it was the policy of the facility to provide guidelines for the care of wounds to promote healing.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to comprehensively assess the limited mobility and range of motion (ROM - the amount of movement that a particular joint or series of joints can achieve in a specific direction) for one of two residents (Resident 28) when the resident was readmitted on [DATE]. This deficient practice resulted in Resident 28 not having the appropriate equipment to maintain their maximum practicable independence and had the potential to cause further decline in functional mobility, ROM, and quality of life. Findings: During a review of Resident 28's Admission Record, the Admission Record indicated the facility readmitted the resident on 7/26/2024, with diagnoses including, but not limited to osteomyelitis (a serious bone infection that causes inflammation and swelling in the bone) of vertebra (bones in the spine), type two (2) diabetes mellitus (when sugar level is too high in the blood) with diabetic neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), congestive heart failure (heart is not pumping as well as it should be), and abnormalities of gait (walking) and mobility (movement). During a review of Resident 28's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 7/29/2024, the H&P indicated the resident is alert and oriented times three (knows who they are, the time/date, and where they are) and had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 9/21/2024, the MDS indicated the resident had impairment on both sides of the upper extremities (shoulder, elbows, wrists, hands) and was dependent on staff for Activities of Daily Living (ADLs- activities related to personal care) including eating, hygiene, toileting, dressing, and bathing. During a concurrent observation and interview on 11/4/2024 at 9:30 a.m., with Resident 28 in Resident 28's room, observed Resident 28 lying in bed with a push button call light on his lap. Resident 28's right wrist was contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) with the right hand hyper-extended (when a joint is forced past its normal range of motion typically in the direction opposite to how it naturally bends) backwards towards the left and his left hand contracted with his hand in a mostly closed position. Resident 28 stated he was unable to freely move his arms, wrists and hands or press the button to the call light the facility provided. Resident 28 stated he had to yell out for help to get staff's attention. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/4/2024 at 9:45 a.m., in Resident 28's room with Treatment Nurse 1 (TN 1), observed Resident 28's upper extremities and TN 1 confirmed by stating Resident 28 was unable to move his arms without assistance and not able to push the call light button. TN 1 stated Resident 28 could have an emergency and is unable to call for help, causing a delay in care. During a concurrent interview and record review on 11/4/2024 at 10:35 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 28's Initial Nursing History and Assessment form dated 7/26/2024. RN 1 stated she assessed Resident 28 when he was readmitted to the facility on [DATE] and missed notating Resident 28's upper extremity ROM limitations on the Initial Nursing History and Assessment form. During an interview on 11/4/2024 at 11:05 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the call light Resident 28 currently had been using was inadequate for Resident 28's needs because Resident 28 was unable to call for assistance, causing a delay in care. The ADON further explained Resident 28 needs to be assessed properly in order to provide the equipment for Resident 28's limited range of motion. During a concurrent interview and record review on 11/6/2024 at 11:00 a.m., with the Director of Rehab (DOR), reviewed Resident 28's Occupational Therapy Evaluation and Plan of Treatment dated 7/30/2024. The DOR confirmed by stating that although the right wrist, hand and fingers were assessed as impaired, there was no recommendation for an adaptive call light for Resident 28's needs. The DOR further stated Resident 28's left hand, wrist and fingers ROM limitations were missed because the plan of treatment indicated they were within functional limitations when Resident 28's MDS dated [DATE] indicated limitations and Resident 28 stated he was never able to push a call button at that time. The DOR stated every resident must be assessed thoroughly and correctly to provide them with the appropriate care and equipment. During a review of the facility's policy and procedure titled, Call Lights, last reviewed on 8/15/2024, the policy indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. It further indicates the resident should be able to return demonstrate how to use the call light.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47883 Based on observation, interview, and record review, the facility failed to: 1. Ensure a fall risk evaluation was completed after a fall on 8/29/2024 and ensure the fall risk evaluation completed on 9/6/2024 was accurate for one of four sampled resident (Resident 30). This deficient practice had the potential to negatively affect Resident 30's plan of care and the delivery of necessary care and services. 2. Ensure Licensed Vocational Nurse 5 (LVN 5), who was administering medications to a resident, did not leave the prepared medications unattended at the resident's bedside for one of 23 sampled residents (Resident 197). This deficient practice had the potential to result in unauthorized personnel or residents having access to the resident's medications. Findings: 1. During a review of Resident 30's Admission Record, the Admission Record indicated that the facility initially admitted Resident 30 on 2/22/2024 and readmitted the resident on 8/30/2024 with diagnoses including acute embolism and thrombosis of deep veins of the right lower extremity (a clinical condition in which blood clots [a gel-like clump of blood] are forming and affecting the veins and arteries in the right lower extremity), degenerative disease of nervous system (a condition where the nerves or brain gradually break down or stop working properly over time), and repeated falls. During a review of Resident 30's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 2/23/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 10/17/2024, the MDS indicated that the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated that Resident 30 was dependent on the assistance of two or more helpers for showering, and required maximal assistance for toileting, personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During a review of Resident 30's Nursing Notes, dated 8/29/2024, the Nursing Notes indicated Resident 30 was found in the resident's room, sitting on the floor by Certified Nurse Assistant and was sent to General Acute Care Hospital 1 (GACH 1) for evaluation. During a review of Resident 30's physician order, dated 8/29/2024, the physician order indicated an order to transfer Resident 30 to GACH 1 emergency room (ER) for further evaluation related to status post (after a significant event, procedure, or treatment) non-witnessed fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment), dated 8/29/2024, the care plan indicated that Resident 30 had an actual fall incident. During concurrent interview and record review on 11/7/2024 at 12:20 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 30's Fall Risk Evaluations dated 2/22/2024, 4/22/2024, 6/7/2024, 8/19/2024, and 9/6/2024. The ADON stated that Resident 30 did not have a Fall Risk Evaluation completed on 8/29/2024 after the actual fall. The ADON stated that the Fall Risk Evaluation dated 9/6/2024 was not accurate because it indicated that there were no falls in the past three months. The ADON further stated that it was important to perform a Fall Risk Evaluation after the fall on 8/29/2024 and accurately calculate the fall risk score in order to make a fall risk care plan accurate with measurable objectives to meet the resident's needs and desired outcomes. During a review of the facility's policy and procedure titled, Fall Risk /Prevention, last reviewed on 8/15/2024, the policy indicated, It is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls .The Fall Risk Assessment will be reviewed quarterly and after each fall. 38549 2. During a review of Resident 197's Admission Record, the Admission Record indicated the facility admitted the resident on 10/24/2024 with diagnoses including encephalopathy (a general term for a group of brain disorders that can affect the brain's structure or function) and gastrostomy (a surgical procedure that creates an opening in the abdomen and into the stomach to insert a feeding tube) status. During a review of Resident 197's H&P dated 10/30/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 197's MDS dated [DATE], the MDS indicated the resident had severely impaired cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). During an observation on 11/5/2024 at 8:07 a.m., observed LVN 5 prepare medications for Resident 197. Observed LVN 5 leave the prepared medications at the resident's bedside behind the privacy curtain while LVN 5 returned to the medication cart for a stethoscope (a medical instrument for listening to the action of someone's heart or breathing). During an interview on 11/5/2024 at 8:51 a.m., with LVN 5, LVN 5 confirmed by stating that he had left the prepared medications unattended and out of eyesight at Resident 197's bedside. During an interview on 11/7/2024 at 9:59 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that licensed nurses administering medications should not leave medications out of eyesight because another resident may have unauthorized access to them and experience adverse side effects (undesired harmful effect resulting from a medication or other intervention) or an allergic reaction. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed and revised on 8/15/2024, the policy indicated that during administration of medications, the medication cart is kept closed, locked, and secure. Medications need to be secured and locked when unattended.

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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. 47883 Based on interview and record review Licensed Vocation Nurse 1 (LVN 1) failed to ensure that residents who needed respiratory care (the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness) were provided such care, consistent with professional standards of practice to one out of three sampled residents (Residents 242) by failing to: 1. Ensure that the suction catheter (a flexible hallow tube used to remove secretions from a patient's airway) was covered with a sleeve when not in use. 2. Administer oxygen (a colorless, odorless, and tasteless gas, that support life) to Resident 242 according to the physician order. 3. Label Resident 242's suction tubing with the date for when it was last changed. These deficient practices had the potential to cause respiratory infection to Resident 242. Findings: During a review of Resident 242's Admission Record, the Admission Record indicated that the facility initially admitted Resident 242 on 10/4/2024 and readmitted the resident on 10/11/2024 with diagnoses including malignant neoplasm of the colon (the development of cancer in the colon), acute systolic heart failure (when the heart muscle cannot pump enough blood to meet the body's needs), acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), and pleural effusion (a condition where too much fluid builds up in the space between lungs and chest wall). During a review of Resident 242's History and Physical (H&P), dated 10/11/2024, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 242's Minimum Data Set (MDS - a resident assessment tool) dated 10/17/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated that Resident 242 needed supervision for eating, maximal assistance for dressing, oral and toileting hygiene, and was dependent on assistance of two or more helpers for showering. During a review of Resident 242's Physician Order, dated 10/11/2024, the Physician Order indicated the following orders: 1. Continuous administration of oxygen at 2 litters per minute (L/min-measurement of oxygen flow) via nasal canula (a device that gives additional oxygen through the nose) to keep oxygen saturation (a percentage of oxygen-saturated hemoglobin [a protein in red blood cells that carries oxygen from lungs to the body's tissues and organs] in the blood compared to total hemoglobin) above 94%. 2. Suction as needed (PRN) for increase secretion (the making and release of substances by glands). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/4/2024, at 10:50 AM, Resident 242 was observed in his room in a wheelchair with no oxygen being administered to the resident. During a concurrent observation and interview on 11/4/2024 at 10:52 AM with Licensed Vocational Nurse 2 (LVN 2), observed Resident 30's oxygen concentrator not connected to the resident, the suction tubing connected to the cannister not labeled with the date when it was last changed, and the suction catheter tip stored in Resident 242's nightstand drawer not covered with a sleeve. LVN 2 checked the Physician order and stated that oxygen had to be continuously administered to Resident 242 via nasal canula at 2 L/min to keep the oxygen saturation over 94%. LVN 2 checked Resident 242's oxygen saturation, and it was at 93%. LVN 2 connected the oxygen to Resident 242 via nasal canula at 2 L/min. LVN 2 stated that the suction tubing had to be labeled with the date when it was last changed and that the suction catheter should be covered with a sleeve to prevent contamination (the act of making something unclean or harmful) after use. During an interview on 11/7/2024 at 12:20PM with the Assistant Director of Nursing (ADON), the ADON stated that oxygen should have been administered to Resident 242 according to the Physician order, the suction tubing should have been labeled with date when it was last changed, and the suction catheter should have been covered with a sleeve when not in use to prevent Resident 42 from potentially getting a respiratory infection. During a review of the facility Policy and Procedure (P&P) named Physician Services, last reviewed on 8/15/2024, the P&P indicated: Drugs, biologicals, laboratory services, radiology and other diagnostic services shall be administered or performed only upon the written order of a person duly licensed and authorized to prescribe such drugs and services. During a review of the facility Policy and Procedure named Oxygen Concentration, last reviewed on 8/15/2024, the P&P indicated : Cannulas should be replaced weekly.

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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. 38469 Based on interview and record review, the facility failed to administer pain medication as prescribed by the physician for one of sampled resident (Resident 6). This deficient practice had the potential to result in adverse consequences (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted the resident on 9/11/2024 with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe) and muscle weakness. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 9/17/2024, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. During a review of Resident 6's physician's orders, the physician's orders indicated an order for hydrocodone-acetaminophen (Norco- brand name; used to relieve moderate to severe pain) oral tablet 10-325 milligram (mg- unit of measurement) one tablet by mouth every four (4) hours as needed for severe pain 7-10/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain) not to exceed 3 grams (g- unit of measurement) per 24 hours. During a concurrent interview and record review on 11/5/2024 at 10:46 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 6's Medication Administration Record (MAR- includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for 10/2024. The review indicated that on 10/4/2024 at 3:59 a.m. and 10/19/2024 at 4:46 p.m., Resident 6 was administered Norco 10-325 mg when Resident 6's pain level was zero (0) on both occasions. RN 2 stated on 10/4/2024 and 10/19/2024, Resident 6's pain level did not indicate that Norco 10-325 mg should be administered since Resident 6's pain level was zero. RN 2 stated that the pain level must reflect the severity of the pain for Norco 10-325 mg to be administered to avoid unnecessary use of the medications as it causes adverse consequences such as constipation (problem with passing stool), respiratory depression (when you breathe too slowly or too shallowly), and sedation (a state of calmness, relaxation, or sleepiness caused by certain drugs) which could lead to fall and injury. During a review of the facility's list of Medication Issues of Particular Relevance in Older Adults, undated, the document indicated hydrocodone under Opioid Analgesics, which can have adverse consequences including, constipation, nausea, vomiting, sedation, lethargy (a state of unusual drowsiness, lack of energy, and mental alertness), weakness, confusion, physical and psychological dependency (form of addiction that involves an emotional or mental attachment to a substance), and unintended respiratory depression.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49947 Based on interview and record review, the facility failed to complete a post-dialysis (the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) assessment for one of one sampled resident (Resident 13). This deficient practice placed Resident 13 at risk for complications of dialysis such as redness at the dialysis access site (way to reach the blood for hemodialysis), edema (too much fluid trapped in the body's tissues), excessive bleeding, and a change in vital signs (clinical measurements that indicate the state of a patient's essential body functions). Findings: During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 7/18/2024 with diagnoses including, but not limited to end stage renal disease (when the kidneys can no longer filter blood properly), dependence on renal (kidney) dialysis. A review of Resident 13's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 7/19/2024, the H&P indicated the resident did not have the capacity to make decisions. A review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 10/18/2024, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding), and required substantial/maximal assistance with all activities of daily living (ADLs - activities related to personal care). The MDS indicated Resident 13 was on dialysis. During a concurrent interview and record review on 11/5/2024 at 8:49 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 13's Nursing Facility Pre and Post Dialysis Assessment forms. LVN 1 verified by stating Resident 13's post dialysis assessment was not completed on 10/24/2024 and there was no documentation for vital signs and assessment of the access site. LVN 1 stated the charge nurses are responsible for completion of the form upon resident arrival in the facility to ensure there were no signs of complication such as abnormal vital signs, bleeding, and/or altered mental status (change in mental function). During an interview on 11/6/2024 at 10:49 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed nurses are responsible to complete the post dialysis assessment part of the Nursing Facility Pre and Post Assessment form upon resident's return to the facility and should include the vital signs and signs or symptoms of bleeding to ensure that the resident is stable and there are no signs of complications. During a review of the facility's policy and procedure titled, Dialysis Care, last reviewed 8/15/2024, the policy indicated the Post Dialysis Checklist part of this form is to be completed by the facility upon return of the resident. Information to be documented includes: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Vital signs. b. Information regarding the type of access site and condition of the dressing and access site. c. Skin condition and any skin tears, discoloration or pressure ulcers noted. d. Any additional instructions from the dialysis unit. e. Any additional comments and signature of the licensed nurse, date and time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to ensure leftover food brought from outside by resident's family and visitors were labeled with a resident identifier and use-by date for three of four residents (Resident 76, 83, and 192). This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) for the residents. Findings: a. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted the resident on 7/30/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and morbid obesity (is when you weigh more than 80 to100 pounds above your ideal body weight). During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 8/05/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required substantial/maximal assistance with toileting hygiene, shower, lower body dressing and putting on and taking off footwear. b. During a review of Resident 83's Admission Record, the Admission Record indicated the facility admitted the resident on 8/24/2024 with diagnoses that included hypertension and glaucoma (a group of eye conditions that can cause blindness). During a review of Resident 83's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS also indicated that the resident required moderate assistance with toileting hygiene, shower, lower body dressing, putting on and taking off footwear. c. During a review of Resident 192's Admission Record, the Admission Record indicated the facility admitted the resident on 10/22/2024, with diagnoses that included muscle weakness and chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems). During a review of Resident 192's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS also indicated that the resident required substantial/maximal assistance with toileting hygiene, shower, lower body dressing and putting on and taking of footwear. During a concurrent facility kitchen observation and interview on 11/4/2024 at 8:07 a.m., with the Dietary Manager (DM), observed food containers in different shapes and colors in the residents' refrigerator. The DM stated the following: - Red container with unidentifiable food content belonging to Resident 76 with no use-by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Orange container with pancake, bacon, spoon and fork with no resident name and no use-by date. - [NAME] plastic container with food content that is not identifiable belonged to Resident 192, with no use-by date. - Clear plastic container with bread and sliced turkey belonging to Resident 83 with no use-by date. The DM then stated that leftover food from outside that is kept in the resident refrigerator must be labeled with resident identifier and dated to ensure it is discarded by the use-by date. The DM stated that consuming leftover food wherein the date the food was brought in and prepared is unknown, can potentially make the resident sick with foodborne illnesses. The DM stated when food items are placed in the refrigerator, the food items must be dated and labeled with the resident's name. During a review of the facility's policy and procedure titled, Food for Residents from Outside Sources, last reviewed on 8/15/2024, the policy indicated, .prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility kitchen, nursing station's refrigerator or in the residents' personal refrigerator. In the food service department, the policy on food storage will apply. Otherwise, if unopened, refrigerated, or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, date to the date opened and disposed in 2 days after opening .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on observation, interview, and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse 5 (LVN 5) donned (put on) a gown before administering medications via gastrostomy tube (g-tube - a flexible tube that is surgically inserted through the abdominal wall and into the stomach) to a resident on enhanced barrier precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for one of 23 sampled residents (Resident 197). 2. Ensure Certified Nursing Assistant 2 (CNA 2) performed hand hygiene (the practice of washing or sanitizing your hands to prevent the spread of disease and infection) after picking up a dirty towel from the floor and before assisting a resident with lunch for one of 23 sampled residents (Resident 53). 3. Label a urinal (a handled container used to collect urine) with the resident's name for one of 23 sampled resident (Resident 30). These deficient practices had the potential to place the residents at increased risk of developing an infection. Findings: 1. During a review of Resident 197's Admission Record, the Admission Record indicated the facility admitted the resident on 10/24/2024 with diagnoses including encephalopathy (a general term for a group of brain disorders that can affect the brain's structure or function) and gastrostomy (a surgical procedure that creates an opening in the abdomen and into the stomach to insert a feeding tube) status. During a review of Resident 197's History and Physical (H&P - a medical document that records a resident's detailed medical history, including their current symptoms and past health conditions, along with a physical examination conducted by a healthcare provider to assess their overall health status), dated 10/30/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 197's Minimum Data Set (MDS - a resident assessment tool), dated 10/30/2024, the MDS indicated the resident had severely impaired cognition (thought processes) and required maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). During an observation on 11/5/2024 at 8:07 a.m., observed LVN 5 administering medications to Resident 197 via g-tube and not wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/2024 at 8:51 a.m., with LVN 5, LVN 5 stated he should have donned a gown prior to administering medications to Resident 197 via g-tube since they were on EBP. During an interview on 11/7/2024 at 1:30 p.m., with the Infection Preventionist (IP), the IP stated that any resident with an indwelling (a device that is left inside the body) medical device was placed on EBP. The IP stated it was important for staff to wear proper PPE in order to protect them from any bodily fluids they may come into contact with when performing any type of care to the resident. The IP stated this included administering medications via g-tube. The IP stated that staff and residents may be at increased of spreading infection if proper PPE is not worn during care of residents on EBP. During a review of the facility's policy and procedure titled, Enhanced Standard Precautions (ESP), last reviewed and revised on 8/15/2024, the policy indicated that the purpose of enhanced standard precautions is a resident-centered and activity-based approach for preventing MDRO transmission in skilled nursing facilities (SNF). The California Department of Public Health (CDPH) recommends the use of ESP, primarily the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization (when a microorganism [organism that can only been seen with a microscope] is present in or on a host but it doesn't cause disease or symptoms) and transmission, such as the presence of indwelling devices (e.g. urinary catheter [a flexible tube that drains urine from the bladder into a bag], feeding tube, endotracheal or tracheostomy tube [a curved tube that's inserted into the windpipe to help keep it open and allow air to reach the lungs], and vascular catheters [a thin, flexible tube that's inserted into a vein to provide access to the bloodstream]). 2. During a review of Resident 53's Admission Record, the Admission Record indicated the facility admitted the resident on 10/4/2024 with diagnoses including paranoid schizophrenia (a type of schizophrenia [mental disorder in which people interpret reality abnormally] that involves paranoia [a pattern of behavior where a person feels distrustful and suspicious of other people]). During a review of Resident 53's H&P, dated 10/6/2024, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated the resident had intact cognition and required moderate assistance for most ADLs. During an observation on 11/4/2024 at 12:19 p.m., observed a resident drop a towel on the floor in the dining room, and observed Certified Nursing Assistant 2 (CNA 2) pick it up from the floor and hand it to another staff member. Observed CNA 2 then bring Resident 53's lunch tray to the resident and assisted Resident 53 with opening and unwrapping food items on the tray. CNA 2 did not perform hand hygiene between picking up the dirty towel from the floor and serving lunch to Resident 53. During an interview on 11/4/2024 at 12:25 p.m., with CNA 2, CNA 2 verified by stating that she (CNA 2) picked up the dirty towel from the floor and then proceeded to serve lunch to Resident 53 without performing hand hygiene. CNA 2 stated she (CNA 2) should have performed hand hygiene before assisting the resident with lunch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/2024 at 1:30 p.m., with the IP, the IP stated that facility staff have been educated to perform hand hygiene before and after assisting residents with their lunch tray. The IP stated that the purpose of performing hand hygiene was to prevent the spread of infection in order to ensure that residents do not get sick. During a review of the facility's policy and procedure titled, Hand Hygiene, last reviewed and revised on 8/15/2024, the policy indicated that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. 47883 3. During a review of Resident 30's Admission Record, the Admission Record indicated that the facility initially admitted Resident 30 on 2/22/2024 and readmitted the resident on 8/30/2024 with diagnoses including acute embolism and thrombosis of deep veins of the right lower extremity (a clinical condition in which blood clots [a gel-like clump of blood] are forming and affecting the veins and arteries in the right lower extremity), degenerative disease of nervous system (a condition where the nerves or brain gradually break down or stop working properly over time), and repeated falls. During a review of Resident 30's H&P, dated 2/23/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 30's MDS dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS further indicated that Resident 30 was dependent on the assistance of two or more helpers for showering, required maximal assistance for toileting and personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During an observation on 11/4/2024 at 9:42 a.m., in Resident 30's room, Resident 30 was observed laying down in his bed with urinals observed on the left side of the bed, not labeled with Resident 30's name. During a concurrent observation and interview on 11/4/2024 at 9:43 a.m., in Resident 30's room, with Restorative Nurse Assistant 1 (RNA 1), observed Resident 30 laying in bed with urinals on the left side of the bed. RNA 1 stated that urinals have to be labeled with the resident's name to prevent cross contamination. During an interview on 11/7/2024 at 12:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that according to the facility's policy, all urinals have to be labeled with resident's name. The ADON stated not labeling the urinals may lead to the spread of infection in the facility. During a review of the facility's policy and procedure titled, Facility Rules, reviewed on 8/15/2024, the policy indicated, All clothing and personal items for residents should be labeled with resident's first and last name, for example grooming supplies, toothbrushes, urinals, etc.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for four of 38 resident rooms (Rooms 1, 3, 9, and 11). Rooms 1, 3, 9, and 11 all have two beds in each room. This deficient practice had the potential to result in inadequate useable living space for all the residents and inadequate working space for the health caregivers. Findings: During a review of the Request for Room Size Waiver letter dated 11/1/2024, submitted by the Administrator, the letter indicated the rooms (room [ROOM NUMBER], 3, 9, and 11) did not meet the 80 square feet requirement per federal regulation. The letter indicated the resident beds were in accordance with the special needs of the residents and will not adversely affect the residents' health and safety and do not impede the ability of the residents in that room to obtain their highest practicable well-being. The letter indicated the following: The following rooms provided less than 80 square feet per resident: Rooms # Beds Floor Area Sq. Ft. Sq. Ft/Resident 1 2 146 73 3 2 155 77.5 9 2 143 71.5 11 2 151 75.5 The minimum square footage for a 2-bed room should be 160 sq. ft. During the resident council (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) meeting on 11/5/2024 at 10 a.m., no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms on 11/5/2024 and 11/6/2024, the residents had ample space to move freely inside the rooms. There were sufficient space to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables, and resident care equipment.