| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056377 | A. Building<br>B. Wing | 02/27/2025 |

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| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard<br>Los Angeles, CA 90019 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296<br><br>Based on interview and record review, the facility failed to ensure one of one resident (Resident 12's) grievance (complaint) about missing items, which included a pair of shorts, a gown, and a brace for his left leg was documented and investigated. This failure led to the resident's grievance being dismissed and had the potential to lead to financial loss, and inability to safely ambulate without the leg brace.<br><br>Findings:<br><br>A review of Resident 12's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including severe obesity (accumulation of body fat that can negatively impact health), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and gout (causes sudden pain and swelling in the joints).<br><br>A review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/25, indicated the resident was alert and oriented with good recall. The MDS indicated Resident 12 had no inattention, disorganized thinking, or altered levels of consciousness.<br><br>During a concurrent observation in resident 12's room and interview on 2/24/25 at 10:33 am, Resident 12 was lying in bed, the call light was within reach. Resident 12 stated he had experienced missing items which included a pair of shorts, a gown, and a brace for his left leg. Resident 12 stated one of the CNA's took the shorts to the laundry and the shorts went missing. Resident 12 stated he reported the missing items to the Social Services Assistant (SSA), but nothing was done.<br><br>During a concurrent record review and interview on 2/25/25 at 8:09 am with the Social Services Director (SSD), the SSD stated she did not know anything about the missing shorts and braces. The SSD stated maybe Resident 12 reported the missing items to the Social Services Assistant (SSA). The SSD reviewed Resident 12's inventory list dated 12/21/24. The inventory list indicated Resident 12 had 4 heels boots and 7 pairs of different types of shorts. The SSD stated when resident items go missing, the social services department investigated and looked for the items, and if the items were not found the items were to be listed on the Theft and Loss Report Log. The SSD stated facility would then either reimburse the items in cash or replace the items. The SSD reviewed the Theft and Loss Report Log, and confirmed there was no documentation Resident 12's had missing items.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/25/25 at 8:30 am in Resident 12's room, Resident 12 stated his shorts went missing two days after his initial admission in December. Resident 12 stated the braces went missing two weeks ago. Resident 12 stated he told the SSA about the brace and shorts.<br><br>During a concurrent interview and record review on 2/25/25 at 2:19 PM, a prescription dated 11/26/24 for the Prafo boot (a medical brace that helps with foot and ankle conditions) was found in Resident 12's electronic chart. The prescription indicated to, Apply PRAFO Boot while in bed for left lower extremity. Resident 12 stated when he left for the hospital, earlier in February, he left the boot at the facility and when he returned to the facility, the brace was missing.<br><br>During an interview on 2/25/25 at 2:24 PM with the Social Services Assistant (SSA), the SSA confirmed Resident 12 informed her (SSA) of the missing a pair of shorts, a gown, and brace. The SSA stated she looked in Resident 12's closet but did not find anything. The SSA stated when residents went to the hospital, the SSA would pack up the resident's belongings and place them in the Social Service's office for safe keeping and list the items in the inventory list. The SSA stated Resident 12 was in and out of the hospital and was not sure if an inventory list had been created. The SSA stated the process for when resident's items go missing included to write down the missing items and inform the SSD. The SSA stated if those items could not be located, the missing items were then listed in the Theft and Loss Report Log. The SSA was unable to locate Resident 12's missing boots. The SSA would not confirm or agree that there was a break in the process of reporting lost items for Resident 12. The SSA stated, I'm unsure, I would have to ask my director. The SSA stated she documented the resident's initial inventory list upon admission and saw poofy boots. The SSA did not know the medical/technical terms for the boots.<br><br>During a follow up interview on 2/27/25 at 9:42 am with the SSD, the SSD stated Resident 12's shorts would be replaced, and the therapy department would follow up with the boot. The SSD stated the facility should have acted quicker regarding Resident 12's missing items. The SSD stated the facility should minimize the time looking for missing items and missing items cases should be closed within 24-48 hours. The SSD stated, there was a break in the process. The SSD stated she would feel not heard if she reported items missing and nothing was done.<br><br>During an interview on 2/27/25 at 2:00 PM with the Director of Nursing (DON), the DON stated when resident items were missing, those items were to be communicated to the charge nurse and placed in communication book. The DON stated the SSD was responsible for locating the missing items and following up. The DON stated if the items were not found, then the facility would replace or reimburse the resident with the item. The DON stated she would feel bad if her items went missing and where not found.<br><br>During a review of the facility's policy and procedures (P&P) titled, Theft and Loss Policy, dated 1/25, indicated The facility strives to have an established Theft and Loss Program and policies and procedures to ensure reasonable efforts to safeguard the property of the residents. The P&P indicated the Resident Property Loss Report shall include, description of article, estimated value, date and time the theft and loss, the action taken. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>43851<br><br>Based on interview and record review, the facility failed to develop an individualized person-centered care plan to meet the resident's needs for one of five sampled residents (Resident 66), as evidenced by failing to create a care plan with goals and interventions for Resident 66's refusal of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). This deficient practice had the potential to lead to inadequate and the delay of care for Resident 66.<br><br>Findings:<br><br>During a review of Resident 66's Admission Record, the Admission Record indicated the facility admitted the resident on 4/14/2023 with diagnoses including Type II diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and morbid obesity (a severe form of obesity characterized by an excessive amount of body fat that significantly impacts health and well-being).<br><br>A review of the Physician's Orders dated 1/23/2024, indicated the resident was to receive Lispro Insulin (a medication used to manage diabetes by lowering blood sugar levels) per sliding scale (a chart with pre-established insulin doses used to determine the dose to be administered to an individual based on blood sugar levels) subcutaneously (a method of administering medication by injecting it into the fatty layer of tissue just beneath the skin) before meals and at bedtime for DM.<br><br>During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool) dated 1/3/2025, the MDS indicated the resident had moderate cognitive impairment (some impairment in the ability to think, understand, and reason). The MDS further indicated Resident 66 was receiving a hypoglycemic medication (medication used to lower blood sugar levels).<br><br>During a review of Resident 66's Medication Administration Review (MAR) dated 1/1/2025 - 1/31/2025, the MAR indicated the resident refused Lispro Insulin 66 times.<br><br>During a review of Resident 66's MAR dated 2/1/2025 - 2/28/2025, the MAR indicated the resident refused Lispro Insulin 41 times from 2/1/2025 - 2/25/2025.<br><br>During a review of Resident 66's Care Plan, the Care Plan did not indicate there was a Care Plan created to the resident's refusal of Lispro Insulin.<br><br>During a concurrent interview and record review on 2/25/2025 at 11:13 AM, Resident 66's Care Plan, MAR for 1/2025, and MAR for 2/2025 were reviewed with Registered Nurse (RN) 2. RN 2 confirmed Resident 66 had pattern and history of refusing insulin. RN 2 confirmed that Resident 66's Care Plan did not indicate a Care Plan was created for the resident refusing insulin. RN 2 stated a Care Plan indicates the problem, goals, and interventions for a resident. RN 2 stated a Care Plan informs the staff of the resident's plan of care. RN 2 stated not having a Care Plan for Resident 66's refusal of insulin had the potential for the resident to have a delay in care.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a interview on 2/27/2025 at 11:19 AM, the Director of Nursing (DON) stated Care Plans were created for resident's who were non-compliant or who refused treatment so the resident can be monitored. The DON stated Resident 66 should have a care plan created for the refusal of insulin. The DON stated not having a care plan for the refusal of insulin could have the potential for Resident 66 to receive inadequate care.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Plans - Timing, reviewed 11/15/2024, the P&P indicated Each resident shall have a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable .Each resident has the right to participate in choosing or refusing treatment options and must be given the opportunity to participate in the development, review, and revision of his/her care plan.<br><br>During a review of the facility's P&P titled, Develop-Implement Comprehensive Care Plans, reviewed 11/15/2024, the P&P indicated The facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs .Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences .When a resident's choice to decline care or treatment poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, efforts by the interdisciplinary team to educe the resident and the representative as appropriate, and attempts to find alternative means to address the identified risk. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836<br><br>Based on interview, and record review, the facility failed to revise (update) the care plan for 3 sampled residents (Resident 82, 84, and 1) by:<br><br>-Failing to update the elopement (the act of leaving a facility unsupervised and without prior authorization) / wandering care plan quarterly (every 3 months) as per the facility's policy for Resident 82.<br><br>-Failing to update the activities care plan quarterly to reflect Resident 84's activity preferences.<br><br>-Failing to update and revise a Pressure Ulcer (damage to the layers of the skin caused by prolonged pressure on a part of the body) Care Plan to meet the individual needs for Resident 1 with a ischium (a bone in the pelvis that forms the lower and back part of the hip bone) pressure ulcer. This deficient practice had the potential to affect the provision of necessary care, treatment, and services for Resident's 82, 84, and 1.<br><br>Findings:<br><br>a. A review Resident 82's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain's function was impaired due to an imbalance in the body's metabolism), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities).<br><br>A review of the history and physical (H&P) completed on 6/4/2024 indicated Resident 82 did not have the capacity to understand or make decisions.<br><br>A review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 12/6/2024, indicated Resident 82 had moderate cognitive impairment a decline in thinking and memory that makes it hard to complete complex tasks) and did not indicate that wandering behavior was exhibited.<br><br>A review of Resident 82's Wandering/Elopement Risk evaluation dated on 6/18/2024, indicated the resident wandered aimlessly (randomly) without purpose and had no history of elopement.<br><br>A review of Resident 82's Wandering/Elopement Risk evaluation dated 12/6/2024, indicated the resident did not wander aimlessly without purpose and had no history of elopement.<br><br>A review of Resident 82's Devices/Physical Restraint assessment dated [DATE], indicated that a Wander guard device was needed to alert staff if Resident 82 attempted to get out and was close to the exit door.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the Physician's Order dated 6/3/2024, indicated use of a Wander guard to alert staff when Resident 82 attempted to get out and was close to the exit door. It indicated to monitor placement of the Wander guard on every shift.<br><br>A review of Resident 82's elopement/wandering care plan last revised on 6/18/2024, indicated interventions that included a Wander guard alarm (wearable bracelet designed to alert caregivers when a resident or patient at risk of wandering approaches a monitored door or exits a designated safe area) to be always worn due to poor safety awareness, assist in reorientation from opening doors, and provide diversional activities. It further indicated that the resident would not elope/wander out of the facility every shift and will accept redirection when observed near exits thru next review date.<br><br>b. A review of Resident 84's face sheet, indicated resident was admitted on [DATE] with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic kidney disease (CKD- a condition in which the kidneys are damaged and cannot function properly over a long period of time), and atrial fibrillation (an irregular and rapid heart rhythm).<br><br>A review of Resident 84's H&P dated on 7/24/2024, indicated that resident had a lack of capacity.<br><br>A review of Resident 84's MDS dated [DATE], indicated the resident had no cognitive impairment. The MDS further indicated that it was somewhat important for the resident to do their favorite activities and have books, newspapers, and magazines to read.<br><br>A review of the Resident 84's quarterly Activity Participation Review assessment dated [DATE], indicated the resident was in the room visit sensory stimulation (the use of various stimuli to activate the senses, such as sight, smell, hearing, touch, and taste) program and would participate in group activity when she was able, and that the resident enjoyed her headphones and refused invitation to group activities and special events. It further indicated the interventions / approaches were partially effective in attaining goals and the approaches have been revised.<br><br>A review of Resident 84's activities care plan last revised on 10/4/2024, indicated interventions that included assisting the resident to and from the activity area in the morning, afternoon, and special events, provide self-directed activity materials such as reading, music, and memory games. The care plan did not mention that resident was in the sensory stimulation program or that resident enjoyed wearing headphones as indicated in Resident 84's Activity Participation Review Assessment.<br><br>During a concurrent interview and record review on 2/27/2025 at 9:35 AM with the Activities Director (AD), the AD stated that he reviewed and revises the activities care plan quarterly. The AD stated that it was important to review and revise the care plans so that they know what the resident's activity preferences were and to ensure the activities were appropriate for each resident. The AD stated Resident 84's care plan should have been updated to reflect their current interests. The AD further stated that if the care plans were not updated or revised then they would not be resident centered.<br><br>During an interview on 2/27/2025 at 1:39 PM, the Director of Nursing (DON) stated resident care plans should be updated on a quarterly and when there was a change of condition. The DON stated it was important for the care plans to be updated to ensure the interventions were being implemented, effective, and that the resident's goals were met.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy and procedure (P&P) titled, Activities, revised 3/2023 indicated resident's individualized activities of interest shall be noted in the assessment, identified in the plan of care, and updated as necessary to reflect the changes in the resident's preferences.<br><br>A review of the facility's P&P titled, Comprehensive Care Plans-Timing, revised on 3/2023, indicated the interdisciplinary team reviews and revises the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessment.<br><br>50296<br><br>c. A review of Resident 1's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), cerebral palsy (a movement disorder that affects posture and balance), and lumbar spina bifida (a birth defect where the spinal cord does not fully close during fetal development).<br><br>A review of Resident 1's MDS dated [DATE] indicated the resident was alert and oriented and had good recall. The MDS indicated Resident 1 had impairment on one side of the resident's upper extremity and on both sides of the resident's lower extremity.<br><br>During a concurrent observation in Resident 1's room and interview on 2/24/25 at 9:26 am, Resident 1 was lying in bed, siderails up x 2, the call light was within reach. Resident 1 stated she was on an alternating pressure bed (bed with an air mattress that changes pressure points) because she had a wound on the left hip and the mattress was used to prevent more pressure ulcers (Stage I: red, warm to touch, stays red when pushed down on, Stage II: break in top layer of skin, Stage III crater-like appearance damage to top layers and fat layers, Stage IV: damage to all layers of skin, including muscle, bone may be visible) . The mattress was set at 3, 20 min alternating pressure. Resident 1 stated the pressure ulcer dressing was changed daily.<br><br>During a concurrent interview and record review on 2/25/25 at 1:24 PM with the Treatment Nurse (TN), Resident 1's Pressure Ulcer Care Plan dated 10/4/24 was reviewed. The Pressure Ulcer Care Plan indicated the last revision was dated 10/4/24. The TN confirmed the care plan was not revised. The TN stated the care plan was a guide and if not revised then facility staff would not know if the care plan was effective.<br><br>During a concurrent interview and record review on 2/25/24 at 1:28 PM, with the Minimum Data Set Nurse (MDSN), Resident 1's Pressure Ulcer Care Plan dated 10/4/24 was reviewed. Resident 1's Pressure Ulcer Care Plan indicated last revision date was 10/4/24. The MDSN stated Care plans had to be revised every three months. The MDSN confirmed there was no way to know if the interventions were effective if interventions were not revised. The MDSN stated the risk to the Resident 1 would be ineffective wound healing.<br><br>During an interview on 2/27/25 at 1:29 PM, the DON stated the care plans had to be updated and reviewed quarterly, if no changes were needed then the same goals and interventions would continue. The DON stated if the care plan was not working the treatments/care plans had to be revised. The DON stated facility staff were not assessing the care plans. The DON stated the interventions were not updated which made it seem like nothing was being done.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's P&P titled, Skin Assessment, dated 3/23 indicated quarterly assessments would be completed using the standardized assessment tool in accordance with the RAI guidelines for completion.<br><br>A review of the facility's P&P titled, Comprehensive Care Plans-Timing, dated 3/23 indicated the interdisciplinary team was to review and revise the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851<br><br>Based on interview and record review, the facility failed to ensure three of five sampled residents (Resident 66, 31 and Resident 10) received care and services in accordance with professional standards of practice. Resident 66 did not have the administration site rotated when receiving insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). Resident 31 and Resident 10 did not receive medications in a timely manner. These deficient practices caused an increased risk in the residents reaching their mental, physical and psychosocial needs.<br><br>Findings:<br><br>a. During a review of Resident 66's Admission Record, the Admission Record indicated the facility admitted the resident on 4/14/2023 with diagnoses including Type II diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and morbid obesity (a severe form of obesity characterized by an excessive amount of body fat that significantly impacts health and well-being).<br><br>A review of the Physician' Orders dated 1/23/2024, indicated Resident 66 was to receive Lispro Insulin (a medication used to manage diabetes by lowering blood sugar levels) per sliding scale (a chart with preestablished insulin doses used to determine the dose to be administered to an individual based on blood sugar levels) subcutaneously (a method of administering medication by injecting it into the fatty layer of tissue just beneath the skin) before meals and at bedtime for DM.<br><br>During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool) dated 1/3/2025, the MDS indicated the resident had moderate cognitive impairment (some impairment in the ability to think, understand, and reason). The MDS further indicated Resident 66 was receiving a hypoglycemic medication (medication used to lower blood sugar levels)<br><br>During a review of Resident 66's MAR dated 2/1/2025 - 2/28/2025, the MAR indicated the resident received insulin in the left arm on 2/10/2025 at 5:34 AM, 4:30 PM, and 8:49 PM. The MAR indicated the resident received insulin in the left lower quadrant of the abdomen on 2/14/2025 at 5:28 PM, and 8:50 PM.<br><br>During a concurrent interview and record review on 2/25/2025 at 11:13 AM, Resident 66's MAR dated 2/1/2025 - 2/28/2025 was reviewed with Registered Nurse (RN) 2. RN 2 confirmed that Resident 66 did not have her administration sites rotated when insulin was administered on 2/10/2025 and 2/14/2025. RN 2 stated administration sites should be rotated to prevent infection.<br><br>During an interview on 2/27/2025 at 11:19 AM, the Director of Nursing (DON) stated staff should rotate the administration sites of insulin when the insulin was administered to the resident. The DON stated there was a potential for Resident 66 to develop fatty lumps under the skin when insulin administration sites are not rotated.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's Policy and Procedure (P&P) titled, Insulin Administration, effective 2/2024, indicated Procedure .Injection sites should be rotated to reduce the risk of damaging the skin tissue.<br><br>49836<br><br>b. A review of the Admission Record indicated Resident 31 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including malignant neoplasm of left breast (breast cancer), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), asthma (chronic lung disease that makes breathing difficult), myocardial infarction (heart attack), and cerebral infarction (stroke).<br><br>A review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 12/4/2024, indicated Resident 31 had moderate cognitive impairment (a decline in thinking and memory that makes it hard to complete complex tasks) and needed maximum assistance for toilet use, personal hygiene, and bathing.<br><br>During an interview on 2/24/2025 at 10:14 AM, Resident 31 stated she had not received her morning medications and she should be getting her medications around 9 AM every day.<br><br>A review of Resident 31's Order Summary Report on 2/24/2025 indicated the resident had the following medications due for administration every day at 9 AM:<br><br>-Prednisone (a steroid medication treats conditions associated with inflammation), 5 milligrams (mg) to be given by mouth one time a day.<br><br>-Anastrozole (hormone-based chemotherapy) 1 mg by mouth one time a day.<br><br>-Qvar Aerosol Solution (medication to treat asthma) 80 micrograms (mcg) 1 puff inhale by mouth two times a day.<br><br>-Avapro (medication to treat high blood pressure) 150 mg by mouth one time a day hold for systolic blood pressure (SBP) 100.<br><br>During an interview on 2/24/2025 at 10:58 AM, the licensed vocational nurse (LVN 1) stated he had not given Resident 31's 9 AM medications yet because he had been, Busy all morning and was falling behind. LVN 1 stated administering medications late placed the health of the residents at risk.<br><br>A review of Resident 31's Medication Administration Record (MAR) dated 2/24/2025 indicated LVN 1 administered prednisone, anastrozole, qvar aerosol solution, and avapro medications at 11:11 AM, which was two hours and 11 minutes after the scheduled dose.<br><br>A review of Resident 31's polypharmacy (taking 5 or more medications) care plan reviewed 12/10/2024 indicated the interventions were to monitor for possible signs and symptoms of adverse drug reactions and to review the resident's medications with the MD or pharmacist for proper dosing, timing and frequency of administration and adverse reactions.<br><br>(continued on next page) |

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| | 056377 | A. Building<br>B. Wing | 02/27/2025 |

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| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard<br>Los Angeles, CA 90019 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and concurrent record review on 2/26/2025 at 11:05 AM, the assistant Director of Nursing (ADON), stated that administering medications on time was important in the management of a resident's condition. The ADON stated that if a resident did not get a breathing treatment on time, for example, the resident could go into respiratory distress. The ADON further stated that if medications were late, they need to inform the MD right away to obtain new orders. After review of the progress notes and MD orders for Resident 31, the ADON could not find a nursing note or orders that indicated the MD was notified regarding the late administration of Resident 31's 9 AM scheduled medications. The ADON stated that it was important to always notify the MD when medications were late because the MD needed to be aware of the condition of the resident and may need to change the schedule of the medications.<br><br>During an interview on 2/26/2025 at 11:28 AM, LVN 4 stated there was a risk when medications were not given on time because certain medications need to be given at specific times. LVN 4 further stated that if medications were not given timely it increased the chance of the resident to experience side effects.<br><br>During a telephone interview on 2/26/2025 at 11:50 AM, the pharmacy consultant (PC) stated that medications were given with specific time frames due to the half-life (the time it takes for the amount of a drugs active substance to clear out of the body) of the medications. The PC further stated that if medications were administered too close together it could result in drug toxicity (accumulation of an excessive amount of any medication in the bloodstream).<br><br>During a telephone interview on 2/26/2025 at 1:59 PM, the Medical Director (MDR) stated her expectations for the facility staff were to ensure the residents were given medications timely and on a consistent basis. The MDR stated that it was necessary to administer medications consistently to control the resident's medical issues and if the resident's medical issues were not controlled, their health can decline.<br><br>c. A review of the Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including DM, atrial fibrillation (irregular, fast heartbeat), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).<br><br>A review of the quarterly MDS dated [DATE], indicated Resident 10 had moderate cognitive impairment and needed maximum assistance for toilet use, personal hygiene, and bathing.<br><br>A review of Resident 10's Order Summary Report on 2/24/2025 indicated the resident had orders to receive the following medications at 7:30 AM:<br><br>-Metformin hydrochloride (HCl) 500 MG 1 tablet by mouth two times a day with food.<br><br>-Jardiance 10 MG 10 mg 1 tablet by mouth one time a day.<br><br>A review of Resident 31's MAR on 2/24/2025 indicated that LVN 1 administered the Metformin and Jardiance, due at 7:30 AM, at 2:30 PM, which was six hours late.<br><br>A review of Resident 10's MAR, dated 2/24/2025 indicated the resident had the following medication due to be administered every day at 5:15 PM:<br><br>(continued on next page) |

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| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard Los Angeles, CA 90019 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Metformin HCl 500 MG 1 tablet by mouth two times a day with food.<br><br>A review of Resident 10's MAR on 2/24/2025 indicated that LVN 6 administered the Metformin, due at 5:15 PM, at 5:30 PM, which was two hours and 15 minutes after LVN 6 administered the same medication at 2:30 PM.<br><br>A review of Resident 10's blood sugar log indicated the last blood sugar was 128 and taken on 2/8/2025 at 7:55 AM.<br><br>A review of Resident 10's MD orders did not indicate an order to monitor blood sugars.<br><br>A review of Resident 10's DM care plan last revised on 2/8/2025 indicated interventions that included to monitor resident for hypo/hyperglycemia.<br><br>During a concurrent interview and record review on 2/27/2025 at 9:46 AM with the Registered Nurse (RN 2), reviewed the MAR of Resident 10 with RN 2 who stated that the resident's Metformin and Jardiance should not have been given six hours late. RN 2 further stated that the second dose of Metformin that was given at 5:30 PM should have been rescheduled with an order by the MD and Resident 10's blood sugar should have been checked. RN 2 stated she could not find any blood sugar results that were taken on 2/24/2025 or find a progress note or MD orders that would indicate that the MD was notified of the late medication administration. RN 2 stated that the blood sugars should be checked before administering any diabetic medications and was not sure why it was not done. RN 2 stated Resident 10 could have experienced hyperglycemia because the Metformin and Jardiance were given late and experienced hypoglycemia because the Metformin doses were given in within two hours of each other.<br><br>During a concurrent interview and record review on 2/27/2025 at 1:39 PM with the DON, Resident 10's administration details for Metformin 500 mg and Jardiance 10 mg, dated 2/24/2025 were reviewed. The administration details indicated one tablet of Metformin 500 mg and one tablet of Jardiance 10 mg was administered on 2/24/2025 at 2:30 PM and one tablet of Metformin 500 mg was administered at 5:30 PM. The DON stated that not administering Metformin and Jardiance in a timely manner increased Resident 10's risk for hyperglycemia that could progress into coma, hospitalization , and death. The DON further stated that administering the two Metformin doses too close together could overdose (excessive dose of a drug) the resident and cause the resident to become hypoglycemic. Also reviewed the blood sugar log for Resident 10 with the DON and it indicated that Resident 10's blood sugar was not checked on 2/24/2025. The DON stated that routine blood sugar checks are only done if there is an MD order. The DON stated that if the blood sugar was not routinely checked you would not know if the resident's blood sugar was being managed.<br><br>During an interview on 2/27/2025 at 3:30 PM, the MDR stated if a medication was administered late, she expects the facility staff to notify her so that they can reschedule the dose. The MDR stated that diabetic oral medication should be given at the time they were scheduled because a resident can experience symptoms such as hyperglycemia. The MDR stated that if a diabetic medication that was given more than once a day was given late, she would recommend rescheduling the doses so that it would not be administered closely as the resident could become hypoglycemic.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy and procedure (P&P) titled, Diabetes Clinical Protocol, effective November 2024 indicated that resident on oral medication(s) who were well controlled: monitor blood glucose levels twice weekly (or more frequently if there is a change in drug or drug dosages); monitor HbA1c on admission or what diabetes is newly diagnosed every 3-6 months or more or less frequently as directed by the physician. This policy indicated discrepancies with the MDR's statement regarding blood sugar checks.<br><br>A review of the facility's P&P titled, Administering Medications, last revised on March 2023, indicated medications must be administered in accordance with the orders.<br><br>A review of the facility's P&P titled, Preparation and General Guidelines, last revised on 2/26/2025, indicated medications were administered within 60 minutes of scheduled time, except before, with or after meal orders, which were administered based on mealtime. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>50714<br><br>Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of 25 sampled residents (Resident 42), by failing to ensure Resident 42's oxygen nasal cannula tubing (a device that gives you additional oxygen through your nose) was not resting on the floor while Resident 42 was using the oxygen nasal cannula.<br><br>This deficient practice had the potential for Resident 42 to experience respiratory infections (infections of parts of the body involved in breathing) associated with using an unsanitary (dirty, unhealthy, or unclean in a way that could endanger health) oxygen nasal cannula tubing.<br><br>Findings:<br><br>During a review of Resident 42's Admission Record, the Admission Record indicated the facility originally admitted Resident 42 on 1/18/2019 and last admitted the resident on 3/16/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute and chronic respiratory failure with hypoxia (your lungs suddenly [acute] or gradually [chronic] aren't able to get enough oxygen into your blood, leading to a dangerously low level of oxygen in your body), acute and chronic respiratory failure with hypercapnia (your body cannot get rid of carbon dioxide [gas we naturally produce and need to remove when our bodies use oxygen for energy] causing breathing difficulties due to the build up of carbon dioxide in your system), and anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells and your body does not get enough oxygen in your blood).<br><br>During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 12/19/2024, the MDS indicated Resident 42 had the ability to understand others and make himself understood.<br><br>A review of Resident 42's Order Summary Report (OSR), the OSR indicated the resident had a physician order for oxygen 2 liters per minute (2 liters of oxygen flow into a patient's nose every minute) via nasal cannula as needed (PRN) for oxygen saturation less than 92% (your body is not getting enough oxygen, a condition called hypoxemia).<br><br>During a review of Resident 42's Care Plan, titled Resident 42 with tendency to remove oxygen nasal cannula and leave hanging off the concentrator (a medical device that gives you extra oxygen) and oxygen tank touching the floor while in bed or w/c (wheelchair) dated 2/202025. The care plan interventions indicated staff were to observe for the nasal cannula not being stored in the nasal cannula bag and to inform the charge nurse or supervisor. The goal of the care plan was for the facility to prevent Resident 42's oxygen nasal cannula from touching the floor.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation in Resident 42's room and interview on 2/24/2025 at 9:43 AM with Certified Nurse Assistant 3 (CNA 3), Resident 42's oxygen nasal cannula tubing was observed on the floor while Resident 42 was using the oxygen nasal cannula tubing to breath supplemental oxygen (giving someone extra oxygen to breathe, usually through a mask or tube, when their body can't get enough oxygen from the air alone, often due to a lung condition, and helps them feel better and be more active). Resident 42 was observed to be sleeping in his bed. CNA 3 stated, the oxygen nasal cannula tubing was on the floor, was dirty, and the staff needed to exchange the dirty oxygen nasal cannula tubing with a clean one.<br><br>During an interview on 2/27/2025 at 7:45 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated if the staff left Resident 42's oxygen nasal cannula tubing on the floor, the facility staff would have to exchange the tubing with a new one and place a label with a date on the new tubing. LVN 2 stated if the facility staff left the oxygen nasal cannula tubing on the floor, the staff should consider the oxygen nasal cannula tubing to as contaminated (something has been made impure or unsafe by encountering something dirty or harmful). LVN 2 stated the staff could expose Resident 42 to getting an infection if the staff did not exchange the dirty oxygen nasal cannula tubing for a new, clean one.<br><br>During an interview on 2/27/2025 at 7:50 AM with the Director of Nursing (DON), the DON stated if the facility staff left a resident's oxygen nasal cannula tubing on the floor, the dirty oxygen nasal cannula tubing would expose Resident 42 to getting an infection. The DON stated the staff had to exchange the oxygen nasal cannula tubing with a new one and date the tubing so the facility staff would know when to change the tubing next.<br><br>During a review of the facility's polity and procedures (P&P), titled Oxygen Therapy, dated 3/2023, the P&P indicated, the facility would change visibly soiled (dirty) oxygen tubing. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50714<br><br>Based on observation, interview, and record review, the facility failed to ensure pain management was provided for one of 25 sampled residents (Resident 5) that was consistent with professional standards of practice. Resident 5's pain was not reassessed to ensure pain medication was effective. This deficient practice resulted in Resident 5 experiencing uncontrolled pain.<br><br>Findings:<br><br>A review of Resident 5's admission record indicated the resident was admitted to the facility on [DATE] with the diagnoses including fibromyalgia (a chronic condition where someone experiences widespread pain and tenderness throughout their body), unspecified arthritis (a disease that causes damage, stillness, and pain in your joints), and migraine (intense throbbing head pain).<br><br>A review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2024, indicated Resident 5 had the ability to make herself understood and had the ability to understand others.<br><br>A review of the At Risk for Pain care plan related to Fibromyalgia and migraine, dated 1/22/2025 indicated the goal for Resident 5 was to verbalize adequate pain relief or the ability to cope with incomplete pain relief. The care plan interventions indicated to administer analgesia (medications that relieve different types of pain) as ordered, anticipate Resident 5's need for pain relief and respond immediately to any complaint of pain. The care plan interventions also indicated to evaluate the effectiveness of pain interventions every shift including resident satisfaction of results, Lidocaine External Patch 4% apply to left and right foot at bedtime for pain management, and to monitor effectiveness of pain medication if administered<br><br>According to a review of Resident 5's pain assessment dated [DATE], the facility documented Resident 5's pain level at 6:02 AM was 7, using the pain scale for 0 being no pain to 10 being the worst possible pain). The pain assessment at 7:28 AM indicated the facility documented Resident 5's pain level was 0, and at 10:34 AM the facility documented Resident 5's pain level was 10.<br><br>During a concurrent observation and interview on 2/24/2025 at 10:10 AM with Resident 5 in Resident 5's room, Resident 5 was observed rubbing her legs and grimacing when she was describing her pain. Resident 5 stated her pain level was 10 and she had received Norco (hydrocodone-acetaminophen 10-325 mg) around 5 AM and a nurse had not come back to check on her pain level. Resident 5 stated her feet hurt with the pain going up her legs and reported a pain level of 10.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Medication Administration Record (MAR) indicated Resident 5 received Lidocaine External 4% patch on 2/23/2025 at 9 PM and the facility removed the patch on 2/24/2025 at 8:50 AM. The MAR indicated the facility provided Resident 5 with a quiet environment on 2/24/2025. The MAR indicated the facility did not provide Resident 5 with Capsaicin External Cream 1% or Diclofenac Sodium External Gel 1% on 2/24/2025. The MAR indicated Resident 5 received a hydrocodone-acetaminophen 10-325 mg tablet on 2/24/2025 at 6:02 AM for a pain level of 7 and on 2/24/2025 at 10:34 AM for pain level of 10. The MAR indicated the facility did not provide Resident 5 with any ice packs on 2/24/2025. The MAR indicated Resident 5 received a Tramadol tablet on 2/24/2025 at 1:59 PM for pain level 6. The MAR indicated Resident 5 received a Tylenol Extra Strength tablet on 2/24/2025 at 12:40 PM for pain level of 5.<br><br>During an interview 2/24/2025 at 10:15 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 5 had a pain level rated at an 8.<br><br>A review of the Physician's Order Summary Report (OSR) dated 2/25/2024, indicated Resident 5 had orders for non-pharmacological interventions (any treatment or approach to managing a health issue that does not involve taking medication), dimming the light / providing a quiet environment, before the facility would give Resident 5 pain medication. The OSR indicated the facility would monitor Resident 5's pain levels.<br><br>The OSR indicated the facility could give Resident 5 Capsaicin Cream 0.1% (a medication to help relieve a certain type of pain known as neuralgia [shooting or burning pain in the nerves]) to ankle every 8 hours as needed for ankle pain. The OSR indicated the facility could give Resident 5 Diclofenac Sodium External Gel 1% (a medication that treats the tissue around a joint, where two bones meet, becomes swollen and irritated, usually causing pain, stiffness, and redness) every 12 hours as needed for moderate ankle pain. The OSR indicated the facility could give Resident 5 hydrocodone-acetaminophen (used to relieve moderate to severe pain) oral (by mouth) tablet 10-325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet every 6 hours as needed for severe pain.<br><br>The OSR indicated the facility could give Resident 5 Lidocaine External Patch 4% (a medication used to relieve nerve pain) by applying it to Resident 5's left and right foot at bedtime then take it off after 12 hours. The OSR indicated the facility could give Resident 5 Tramadol (a strong painkiller) 50 mg by mouth every 6 hours as needed for moderate pain. The OSR indicated the facility could give Resident 5 Tylenol Extra Strength 500 mg two tablets by mouth every 8 hours as needed for mild pain.<br><br>A review of Resident 5's Progress Notes dated 2/24 - 2/25/2025, indicated there was no documentation regarding Resident 5's uncontrolled pain nor the facility contacting Resident 5's doctor.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and record review on 2/24/2025 at 10:15 AM with LVN 1, LVN 1 reviewed Resident 5's MAR dated 2/24/2025. LVN 1 stated Resident 5 received Norco on 2/24/2025 at 6:02 AM and the previous nurse, LVN 7, documented Resident 5's pain level at 0 on 2/24/2025 at 7:28 AM. LVN 1 stated he could not explain the discrepancy in LVN 7's documentation indicating LVN 7 assessed Resident 5's pain was 0 and pain had been relieved on 2/24/2025 at 7:28 AM and Resident 5's statement that her pain had not been relieved, that Resident 5's pain level was 8 on 2/24/204 at 8:00 AM and that Resident 5's pain increased to a pain level of 10 at 2/24/2025 at 10:10 AM. LVN 1 stated that he usually checks on the effectiveness of pain medication given to a resident in 30 minutes to an hour. LVN 1 stated he was not sure about what the facility's policy was regarding checking a resident's pain level after the facility gives a resident a pain medication. LVN 1 stated if the staff did not check on the resident's pain level, the resident could still have pain that the facility did not manage effectively.<br><br>During an interview and record review on 2/25/2025 at 8:41 AM with Registered Nurse 2 (RN 2), RN 2 reviewed Resident 5's MAR dated 2/25/2025. RN 2 stated if staff gave Resident 5 a pain medication, the staff should follow up in 30 minutes to assess for effectiveness. RN 2 stated on 2/24/2024 Resident 5 received a pain medication at 6:02 AM, and the nurse (LVN 7) did not check Resident 5's pain until 7:28 AM on 2/24/2025. RN 2 stated that an hour and a half was too long before the nurse (LVN 7) checked back with Resident 5 regarding the effectiveness of the pain medication. RN 2 stated if Resident 5's pain medication was not effective, staff could have called Resident 5's doctor to manage Resident 5's pain better.<br><br>During an interview and record review on 2/25/2025 at 9:07 AM with the Director of Nursing (DON), the DON reviewed Resident 5's MAR and stated the facility staff should follow up in an hour to check the effectiveness of a pain medication given to a resident. The DON stated the facility staff would not be able to evaluate the effectiveness of a pain medication if they did not follow up in a hour. The DON stated the staff should have checked on Resident 5's pain level in an hour after she was given a pain medication by mouth. The DON agreed that the facility's record showed Resident 5 was given a pain medication on 2/24/2025 at 6:02 AM and the nurse did not reassess Resident 5's pain until 2/24/2025 at 7:28 AM which was past the hour time frame.<br><br>During an interview and record review on 2/25/2025 at 10:44 AM with RN 2, Resident 5's care plan for At Risk of pain related to Fibromyalgia and migraine, dated 1/22/2025 was reviewed. RN 2 stated the evaluation of pain medication effectiveness should be done within 30 minutes to 1 hour.<br><br>During a concurrent interview and record review on 2/26/2025 at 10:31 AM with the DON, the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 3/2023 was reviewed. The P&P indicated the facility staff would reassess a resident pain at least every shift for acute (sudden) pain and significant changes in levels of chronic pain (pain that lasts for a long time, usually more than three months) at least weekly in stable (something is firmly fixed, not likely to change or move suddenly) chronic pain. The DON stated the P&P was for general pain assessment and not for assessment / reassessment after pain medication was given. The facility was asked to provide a policy regarding follow up of pain assessment after a resident was given pain medication and was told this policy was the only policy they had. The DON stated she would look to see if the facility had a different policy.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/26/2025 at 11:04 AM, the DON stated the facility did not have another pain management/assessment policy and the P&P titled Pain Assessment and Management, dated 3/2023, was the facility's only policy. She stated the P&P wording regarding reassessment of pain every shift was not adequate in regard to assessing/reassessing the effectiveness of oral pain medication. The DON stated the P&P should indicate the reassessment of pain should have similar wording to the nursing standard of care (the level of care that a reasonable and responsible nurse would provide to a patient in a similar situation) for pain management and the facility should reassess a resident's pain within an hour of giving an oral pain medication. |

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| | 056377 | A. Building<br>B. Wing | 02/27/2025 |

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| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard<br>Los Angeles, CA 90019 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333<br><br>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%). There were six medication errors out of 30 total opportunities which contributed to an overall medication error rate of 20 % for one of three sampled residents (Resident 50) observed during medication administration (MedPass). The facility failed to have a medication distribution system to ensure safe administration of medications and ensure Resident 50 was administered medication in accordance with the physician's orders and the facility's policy and procedures titled, Medication Administration - General Guidelines.<br><br>The deficient practice of failing to administer medications in accordance with the physician's orders increased the risk that Resident 50 may experience adverse reactions, complications, that could lead to a decline in the residents' condition, harm, or hospitalization .<br><br>Cross Reference with F760<br><br>Findings:<br><br>During a review of Resident 50's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (a stroke that occurs when blood flow to the brain is blocked) affecting left non-dominant side, hypertension (high blood pressure), cardiomegaly (a condition where the heart is larger than normal), atrial fibrillation (AF, abnormal heartbeat), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 9/26/24 the MDS indicated Resident 50's cognitive skills (mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making was moderately impaired. Resident 50's MDS indicated the resident required setup for eating and oral hygiene, required substantial assistance for personal hygiene and was dependent on staff physical assistance for bathing or showering, dressing, getting in and out of bed or a wheelchair, and toileting.<br><br>During a review of the History and Physical (H&P) dated 2/29/2024 the H&P indicated Resident 50 had the capacity to understand and make decisions.<br><br>A review of Resident 50's Order Summary Report indicated:<br><br>-Apixaban (Eliquis, an anticoagulant, a blood thinner) 5 (five) milligrams (mg - unit of measure of weight) give one tablet by mouth every 12 hours, scheduled at 9 a.m., and 9 p.m., for AF, order date 4/26/2023.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Amlodipine (Norvasc, a medication used to treat high blood pressure) 5 mg, give one tablet by mouth one time a day, scheduled at 9 a.m., for hypertension, hold if systolic blood pressure (SBP, when the heart beats, top number) is less than 110 millimeters of mercury [mm Hg]), (mmHg - unit of measure), order date 8/28/2024.<br><br>-Lexapro (used to treat depression, a constant feeling of sadness and loss of interest) 5 mg, give one tablet by mouth one time a day, scheduled at 9 a.m., for depressive disorder manifested by (m/b) verbalization of sadness, order date 10/18/2024.<br><br>-Aspirin Enteric Coated (EC) 81 mg, give one tablet by mouth one time a day, scheduled at 9 a.m., for myocardial infarction (MI, also known as a heart attack, occurs when blood flow to the heart is blocked) prophylactically (PPX, measures designed to preserve health), order date 6/17/2020.<br><br>-Docusate Sodium 100 mg, give one capsule by mouth two times a day, scheduled at 9 a.m., and 5 p.m., for constipation, hold for loose bowel movement, order date 10/18/2024.<br><br>-Calcium 500 mg with Vitamin D 200 units (unit of measure), give one tablet by mouth one time a day, scheduled at 9 a.m., for supplement, order date 10/18/2024<br><br>-Acetaminophen (Tylenol, used to treat pain) 325 mg, give two tablets (650 mg) by mouth every six hours as needed for pain management. Not to exceed three grams (gm - a unit measure of weight) from all sources in 24 hours, order date 8/28/2024<br><br>During a review of Resident 50's, Care Plans, the care plans for Resident 50 indicated the following:<br><br>a. Hypertension (HTN) related to lifestyle and stroke, dated 3/27/2020. The interventions included instructions to give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure when standing) and increased heart rate (tachycardia) and effectiveness.<br><br>b. Black Box Warning (a serious warning given by the Food and Drug Administration [FDA] for drugs or drug classes that may cause serious harm or death) for use of Apixaban (Eliquis), dated 3/27/2020. Resident 50's care plan goal indicated; the resident will not experience side effects/ interactions with the use of Apixaban (Eliquis).<br><br>c. Risk for repeat Cardiovascular Accident (CVA) as resident had a CVA prior to admission, revision date 2/6/2025, and goal indicated to minimize risk with interventions. Interventions indicated, administer medication(s) as ordered.<br><br>d. Risk for adverse reaction related to polypharmacy, revision date 2/6/2025. Resident 50's care plan interventions included review resident's medications with MD/Consultant pharmacist for .proper dosing, timing and frequency of administrations .<br><br>e. Anticoagulant therapy, Apixaban for atrial fibrillation, at risk for active bleeding ., revision date 2/6/2025. Resident 50's care plan intervention indicated give Apixaban 5 mg by mouth every 12 hours for AF . Resident/family/caregiver teaching to include the following: take/give medication at the same time each day.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | f. On Lexapro related to depression manifested by verbalization of sadness. Resident 50's care plan goal indicated, the resident will experience no adverse side effects from medication use .and resident's care plan intervention indicated, administer medications as ordered<br><br>During a concurrent observation and interview on 2/25/2025 at 10:17 a.m., with a Licensed Vocational Nurse (LVN) 3 on Station 2 at Medication Cart (MedCart) 2, LVN 3 stated she was preparing the morning medications for Resident 50 that was scheduled for 9 a.m.<br><br>During a medication pass observation on 2/25/2025 at 10:20 a.m., with LVN 3, LVN 3 prepared the following morning medications, scheduled for 9 a.m., administration for Resident 50.<br><br>-Apixaban 5 mg, one tablet<br><br>-Amlodipine 5 mg, one tablet<br><br>-Lexapro 5 mg, one tablet<br><br>-Aspirin Enteric Coated (EC) 81 mg, one tablet<br><br>-Docusate Sodium 100 mg, one capsule<br><br>-Calcium 500 mg with Vitamin D 200 units, one tablet<br><br>-Acetaminophen 325 mg, two tablets (650 mg).<br><br>During a concurrent observation and interview on 2/25/2025 at 10:27 a.m., with LVN 3, LVN 3 stated she prepared for Resident 50 a total of seven medications, one of the seven medications was Tylenol an as needed (PRN) medication for pain. LVN 3 entered Resident 50's room to administer the medications. Resident 50 stated she did not want the stool softener, docusate sodium or the calcium, and stated she will take the rest of the medications.<br><br>During an interview on 2/25/2025 at 10:38 a.m., LVN 3 stated there were 17 more residents to administer morning medications to, that were scheduled for 9 a.m. administration time. LVN 3 stated the supervisor and Director of Nursing (DON) was made aware of the heavy load that included four out of her 32 residents received medications through a gastrostomy tube (GT - a tube inserted through the belly that brings nutrition, fluids, and medications directly to the stomach) which takes a little more time and that she was not able to pass medications to all of residents on time.<br><br>During an earlier interview on 2/25/2025 at 10:11 a.m., with LVN 1, on Station 2, at MedCart 3, LVN 1 stated he still had 12 more residents to pass medications scheduled for 9 a.m., out of a total of 27 residents, and he usually finished passing morning medications each day around 11:30 a.m. LVN 1 stated he notified a Registered Nurse Supervisor. LVN 1 stated it can be overwhelming especially when you tried to give the best care, not rush residents, and not make mistakes.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/25/2025 at 1:32 p.m., the DON stated licensed nurses should administer medications within an hour of the scheduled administration time, between an hour before scheduled up to an hour after the scheduled administration time. The DON stated the resident's physician must be notified if resident's medications would be administered outside of the time frame and then following the physician's instructions if it was okay to administer the medication.<br><br>During an interview on 2/25/2025 at 3:06 PM, the DON stated the physician was not called prior to administering medications late to Resident 50 on Station 2, MedCart 2. The DON stated the physician should have been called before administering medications late to residents.<br><br>A review of the facility's Policy and Procedure (P&P) titled, Medication Administration - General Guidelines, dated 10/2012, indicated the facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Medications were administered in accordance with written orders of the prescriber. The P&P indicated medications were administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered (based on mealtimes). |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333<br><br>Based on observation, interview and record review, the facility failed to ensure 11 of 20 sampled residents (Resident 1, 8, 10, 11, 32, 37, 50, 54, 66, 95, and 99), were free of significant medication error. The facility failed to:<br><br>-Ensure Resident 50 was administered Eliquis (apixaban, an anticoagulant, a blood thinner), Norvasc (amlodipine, a medication used to treat high blood pressure), and aspirin for myocardial infarction (MI, also known as a heart attack, occurs when blood flow to the heart is blocked) prophylactically (PPX, measures designed to preserve health), in accordance with the physician's orders for eleven days during February 2025.<br><br>-Ensure Residents 10, 54, 95 and 99 were administered Eliquis in accordance with physician's orders and facility's policy and procedures titled, Medication Administration - General Guidelines to minimize the risk of adverse consequences (an undesired effect of a drug) including an increased risk of bleeding.<br><br>-Ensure Resident 1 was administered Depakote (valproic acid, a medication used to control seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movement, sensation, or awareness]) on 2/20, 2/22, 2/23, and 2/25/2025 at 9 a.m., and 1 p.m., as ordered and not within 39 minutes to less than two hours of the next scheduled dose.<br><br>-Ensure Resident 37 was administered Keppra (levetiracetam a medication used to control seizures) on 2/20, 2/22, 2/23, 2/24, and 2/25/2025 at 9 a.m., and 5 p.m. daily as ordered.<br><br>-Ensure Residents 8, 11, 32 and 66 were administered medications in accordance with physician orders and facility's policy and procedures titled, Medication Administration - General Guidelines to minimize the risk of adverse consequences which could lead to a deterioration in the resident's condition, hospitalization , harm, or death.<br><br>These deficient practices resulted in:<br><br>-Residents 10, 50, 54, 95 and 99 were at increased risk of bleeding, including serious bleeding that can be fatal and increased risk of uncontrolled blood pressure, that could lead to stroke, heart attack, hospitalization , or death<br><br>-Residents 1 and 37 was placed at high risk for hepatotoxicity (liver toxicity, a condition that occurs when the liver is damaged by harmful substances, such as medications, toxins, or chemicals, which can lead to impaired liver function and, in severe cases, liver failure).<br><br>-Residents 8, 11, 32, and 66 were placed at risk for uncontrolled blood glucose (a type of sugar) levels.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | On 2/26/2025 at 4:42 PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM) and Director of Nursing (DON), regarding the facility's failure to identify and ensure Resident 1, 8, 10, 11, 32, 37, 50, 54, 66, 95, and 99, who were at increased risk of bleeding, toxicity or hyperglycemia (increased blood sugar) were free of significant medication error and received necessary care and services in accordance with professional standards of practice.<br><br>On 2/27/2025 at 4:18 PM, while onsite at the facility, the IJ was removed in the presence of the ADM and DON, after the ADM submitted an acceptable Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. The acceptable removal plan was as follows:<br><br>The Licensed Nurse completed change in condition assessments on 2/26/25 and reported the medication errors for each resident effected with the related medications. The residents would be monitored every shift for adverse reactions. Effected residents were monitored by the DON. Licensed Nurses would be re-educated by the DON before their next Med Pass or on or before 3/15/25 on the standard of practice and facility policy and procedure for administering medications and in accordance with the physician's ordered time to reduce the risk of medication error, serious injury, harm and or death.<br><br>The DON evaluated the resident medication administration assignments, including evaluation of residents on antiseizure, anticoagulants, hypertensive and anticonvulsant medications, including gastrostomy tubes, dialysis, blood pressure parameter checks, diabetics with insulin administration, controlled pain medications and seizure protocol on 2/26/25.<br><br>The DON contacted the pharmacy consultant and requested an additional medication cart on 2/26/25, which was verified. The cart would be delivered on 2/26/25. The DON redistributed the resident assignment to ensure the load over four medication carts on 2/26/25.<br><br>The Interdisciplinary Team met on 2/26/25 and developed and implemented a plan of care to closely monitor effected residents for adverse effects related to receiving medications at the wrong time resulting in a medication error on 2/25/25.<br><br>The Medical Records staff generated an audit of all in house residents medication administration records including the time of administration for all shifts, identifying any residents who were effected by the medication error. A copy of the audit was provided to the DON for review on 2/27/25.<br><br>All licensed nurses in the oncoming shifts were prioritized with re-education with the objective to achieve 100% of the licensed nurses before the start of their shift beginning 2/27/25.<br><br>The Director of Staff Development / designee would complete a medication pass observation skill competency with LVN 1 and 2 prior to the start of their shift.<br><br>Cross Reference F759<br><br>Findings:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | a. A review of the Admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (a stroke that occurs when blood flow to the brain is blocked) affecting left non-dominant side, hypertension (high blood pressure), cardiomegaly (a condition where the heart is larger than normal), and atrial fibrillation (AF, abnormal heartbeat).<br><br>During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool) dated 9/26/24, the MDS indicated Resident 50's cognitive skills (mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making was moderately impaired. Resident 50's MDS indicated the resident required setup for eating and oral hygiene, required substantial assistance for personal hygiene and was dependent on staff physical assistance.<br><br>During a review of Resident 50's History and physical (H&P) dated 2/29/2024, the H&P indicated Resident 50 had the capacity to understand and make decisions.<br><br>During a review of Resident 50's Order Summary Report, the Order Summary Report indicated Resident 50's orders included:<br><br>-Apixaban (Eliquis, an anticoagulant, a blood thinner) 5 (five) milligrams (mg - unit of measure of weight) give one tablet by mouth every 12 hours, scheduled at 9 a.m., and 9 p.m., for AF, order date 4/26/2023.<br><br>-Amlodipine (Norvasc, a medication used to treat high blood pressure) 5 mg, give one tablet by mouth one time a day, scheduled at 9 a.m., for hypertension, hold if systolic blood pressure (SBP, when the heart beats, top number) is less than 110 millimeters of mercury [mm Hg]), (mmHg - unit of measure), order date 8/28/2024.<br><br>-Aspirin Enteric Coated (EC) 81 mg, give one tablet by mouth one time a day, scheduled at 9 a.m., for myocardial infarction (MI, also known as a heart attack, occurs when blood flow to the heart is blocked) prophylactically (PPX, measures designed to preserve health), order date 6/17/2020.<br><br>During a review of Resident 50's, Care Plans, the care plans for Resident 50 indicated the following:<br><br>-Black Box Warning (is a serious warning given by the Food and Drug Administration [FDA] for drugs or drug classes that may cause serious harm or death) for use of Apixaban (Eliquis), dated 3/27/2020. Resident 50's care plan goal indicated; the resident will not experience side effects/ interactions with the use of Apixaban (Eliquis).<br><br>-Anticoagulant therapy, Apixaban for atrial fibrillation, at risk for active bleeding, revised 2/6/2025. Resident 50's care plan intervention indicated give Apixaban 5 mg by mouth every 12 hours for AF. Resident/family/caregiver teaching to include the following: take/give medication at the same time each day.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | -Hypertension (HTN) related to lifestyle and stroke, dated 3/27/2020. The interventions included instructions to give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure when standing) and increased heart rate (tachycardia) and effectiveness.<br><br>-Risk for repeat Cardiovascular Accident (CVA) as resident had a CVA prior to admission, date revised 2/6/2025, and goal indicated to minimize risk with interventions. Interventions indicated, administer medication(s) as ordered.<br><br>-Risk for adverse reaction related to polypharmacy (the simultaneous use of multiple drugs by a single patient, for one or more conditions), revision date 2/6/2025. Resident 50's care plan interventions included to review resident's medications with MD/Consultant pharmacist for proper dosing, timing and frequency of administrations.<br><br>During a concurrent observation and interview on 2/25/2025 at 10:17 a.m., with a Licensed Vocational Nurse (LVN) 3 on Station 2 at Medication Cart (MedCart) 2, LVN 3 stated she was preparing the morning medications for Resident 50 that was scheduled for 9 a.m. During a medication pass observation on 2/25/2025 at 10:20 a.m., with LVN 3, LVN 3 prepared and administered Resident 50's morning medications, scheduled for 9 a.m., administration that included Apixaban 5 mg, one tablet, Amlodipine 5 mg, one tablet, and Aspirin Enteric Coated (EC) 81 mg, one tablet.<br><br>During an interview on 2/25/2025 at 10:32 a.m., Resident 50 stated she usually gets her medications late, but she knew the nurses were very busy.<br><br>During an interview on 2/25/2025 at 10:38 a.m., LVN 3 stated she had 17 more residents to administer morning medications to that were scheduled for 9 a.m LVN 3 stated the supervisor and Director of Nursing (DON) was made aware of the heavy load, which included four of her 32 residents received medications through a gastrostomy tube (GT - a tube inserted through the belly that brings nutrition, fluids, and medications directly to the stomach), which takes more time and that she was not able to pass medications to all of residents on time.<br><br>During an earlier interview on 2/25/2025 at 10:11 a.m., with LVN 1, on Station 2, at MedCart 3, LVN 1 stated he had 12 more residents to pass medications scheduled for 9 a.m., out of a total of 27 residents, and usually finished passing morning medications each day around 11:30 a.m. LVN 1 stated he notified a Registered Nurse Supervisor. LVN 1 stated, It can be overwhelming, especially when you are trying to give the best care, not rush residents, and not make mistakes.<br><br>During an interview on 2/25/2025 at 1:32 p.m., the DON stated licensed nurses should administer medications within an hour of the scheduled administration time or up to an hour after the scheduled administration time. The DON stated the resident's physician must be notified if resident's medications would be administered outside of the time frame and then following the physician's instructions, if it was okay to administer the medication.<br><br>During a record review of Resident 50's Medication Administration Audit Report, Resident 50's Medication Audit Report was reviewed between 2/1 to 2/25/2025. The Medication Administration Audit Report indicated Resident 50 was administered apixaban, amlodipine, and aspirin late and for apixaban less than 12 hours from the next scheduled dose as follow on:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | -2/2/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 3:09 p.m. (six hours and nine minutes late).<br><br>-2/2/2025 apixaban 5 mg scheduled for administration at 9 p.m., was administered at 8:33 p.m., five hours and 24 minutes after the last dose was given at 3:09 p.m., instead of the ordered 12 hours between doses.<br><br>-2/4/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 10:57 a.m. (one hour and 57 minutes late).<br><br>-2/8/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 10:35 a.m. (one hour and 35 minutes late).<br><br>-2/9/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 1:55 p.m. (four hours and 55 minutes late).<br><br>-2/9/2025 apixaban 5 mg scheduled for administration at 9 p.m., was administered at 8:17 p.m., six hours and 22 minutes after the last dose was given at 1:55 p.m., instead of the ordered 12 hours between doses.<br><br>-2/12/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 10:58 a.m. (one hour and 58 minutes late).<br><br>-2/13/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 11:08 p.m. (two hours and eight minute late).<br><br>-2/16/2025 apixaban 5 mg, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 1:02 p.m. (four hours and two minutes late).<br><br>-2/16/2025 apixaban 5 mg scheduled for administration at 9 p.m., was administered at 8:43 p.m., seven hours and 41 minutes after the last dose was given at 1:02 p.m., instead of the ordered 12 hours between doses.<br><br>-2/21/2025 apixaban, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 10:33 a.m. (one hour and 33 minutes late).<br><br>-2/22/2025 apixaban 5 mg scheduled for administration at 9 a.m., was documented administered at 6:03 p. m. (nine hours and three minutes late).<br><br>-2/22/2025 apixaban 5 mg scheduled for administration at 9 p.m., was documented administered at 8:51 p. m. two hours and 48 minutes after the last dose was given at 6:03 p.m., instead of the ordered 12 hours between doses.<br><br>-2/23/2025 apixaban, amlodipine, and aspirin scheduled for administration at 9 a.m., was documented administered at 11:10 a.m. (two hours and 10 minutes late)<br><br>(continued on next page) |

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| | 056377 | A. Building<br>B. Wing | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard<br>Los Angeles, CA 90019 |

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|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | -2/22/2025 apixaban 5 mg scheduled for administration at 9 p.m., was documented administered at 9:22 p.m. , ten hours and 22 minutes after the last dose was given at 11:10 a.m., instead of the ordered 12 hours between doses.<br><br>b. A review of Resident 10's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including Type II diabetes (DM, a condition that occurs when the body does not use insulin properly, leading to high blood sugar levels), hypertension (high blood pressure), myocardial infarction (MI), and AF.<br><br>During a review of Resident 10's, MDS dated [DATE], the MDS indicated Resident 10's cognitive skills for daily decision-making was moderately impaired.<br><br>During a review of Resident 10's Order Summary Report, the Order Summary Report indicated Resident 10 had orders for:<br><br>-Eliquis 2.5 mg, to give one tablet by mouth two times a day scheduled at 9 a.m. and 5 p.m., for AF, with an order date of 3/27/2024.<br><br>-Eliquis: Monitor for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae (tiny spots of bleeding under the skin), internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by (+) Yes or (-) No. Notify MD if (+) every shift (Day shift, Evening Shift, and Night Shift), order date 11/10/2023.<br><br>-Metformin 500 mg, one tablet by mouth four times a day for DM, give with food, order date 11/2/2023<br><br>During a review of Resident 10's, Care Plans, the care plans indicated:<br><br>-Resident 10 had High Risk for Bleeding, Bruising, and/or Skin Discoloration related to anticoagulant therapy, Eliquis, dated 12/1/2022. Resident 10's care plan goal indicated, the resident will remain free of abnormal bleeding or bruising, and the care plan intervention indicated, administer medications as ordered and monitor for side effects. Observe / record / report to MD as needed, abnormal or unexplained bruising.<br><br>-Resident 10 had a Black Box Warning for use of Metformin (Glucophage) for diabetes mellitus (DM), revised 2/8/2025. Resident 10's care plan goal indicated the resident will not experience side effect/ interactions with the use of Metformin, and the care plan interventions included, Black Box Warning, post marketing cases of metformin-associated lactic acidosis (lactic acid build up in the bloodstream) have resulted in death, hypothermia (body loses heat faster than it can produce heat), hypotension (low blood pressure), and resistant bradyarrhythmia (an irregular heartbeat that's slower than normal). The onset of metformin-associated lactic acidosis is often subtle, accompanied only by myalgias (muscle pain), respiratory distress (difficulty to breath), somnolence (drowsiness), and abdominal pain.<br><br>During a review of Resident 10's Nursing Progress Notes dated 2/24/2025 at 8:46 a.m., Resident 10's progress notes indicated, On monitoring for discoloration to right wrist. Resident still noted with discoloration in affected wrist.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | During a record review of Resident 10's Medication Administration Audit Report, Resident 10's Medication Audit Report was reviewed between 2/1/2025 to 2/25/2025, the Medication Administration Audit Report indicated resident was administered apixaban less than 8 hours from the next scheduled dose as follow on:<br><br>-2/17/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 11:12 a.m. (two hours and 12 minutes late).<br><br>-2/24/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 2:29 p. m. (five hours and 29 minutes late).<br><br>-2/24/2025 apixaban 2.5 mg scheduled for administration at 5 p.m., was administered at 5:17 p.m., two hours and 48 minutes after the last dose was given at 2:29 p.m., instead of the ordered eight hours between doses.<br><br>-2/25/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 1:34 p. m. (four hours and 34 minutes late).<br><br>-2/17/2025 metformin 500 mg, scheduled for administration at 7:30 a.m., to be given with food was documented administered at 11:10 a.m. (over three hours late).<br><br>-2/18/2025 metformin 500 mg, scheduled for administration at 7:30 a.m., to be given with food was documented administered at 10:09 a.m. (over two hours late).<br><br>-2/17/2025 metformin 500 mg, scheduled for administration at 7:30 a.m., to be given with food was documented administered at 9:57 a.m. (two hours late).<br><br>-2/20/2025 metformin, scheduled for administration at 5:30 p.m., to be given with food was documented administered at 7:39 p.m. (two hours late).<br><br>-2/24/2025 metformin, scheduled for administration at 7:30 a.m., to be given with food was documented administered at 2:28 p.m. (almost seven hours late).<br><br>-2/17/2025 metformin, scheduled for administration at 5:30 p.m., to be given with food was documented administered at 5:17 p.m. (less than three hours since last administration of 2:38 p.m.).<br><br>c. During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was admitted to the facility on [DATE] with diagnoses that included repeated falls, cardiomegaly, hypertension, and atrial flutter (a condition in which the heart's upper chambers [atria] beat too quickly)<br><br>During a review of Resident 54's, MDS dated [DATE], the MDS indicated Resident 54's cognitive skills for daily decision-making was severely impaired.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | A review of Resident 54's H&P dated 6/22/2024 indicated, She has been in ED (emergency department) three times in three days following falls at her SNF (a previous skilled nursing facility). First visit on 6/15/2024 after a witnessed fall while getting up from bed and tempted to use her walker and fell . Resident 54's H&P indicated the resident had persistent atrial fibrillation and was on anticoagulant therapy, Fall Risk Precautions, and did not have medical decision making capacity.<br><br>During a review of Resident 54's Order Summary Report for February 2025, the Order Summary Report indicated Resident 54 had an order for Eliquis 2.5 mg, to give one tablet by mouth two times a day scheduled at 9 a.m., and 5 p.m., for AF / atrial flutter.<br><br>During a review of Resident 54's Care Plans revised 1/5/2025, the care plans indicated Resident 54:<br><br>-was at risk for falls related to gait/balance problems, at risk for fall due to history of repeated falls prior to admission to facility. The most recent fall was on 12/25/2024.<br><br>-has Black Box Warning for use of apixaban (Eliquis): atrial fibrillation, resident's care plan goal revised 10/14/2024 indicated Resident 54 will not experience side effects/interactions with the use of apixaban (Eliquis).<br><br>During a record review of Resident 54's Medication Administration Audit Report, Resident 54's Medication Audit Report was reviewed between 2/1/2025 to 2/25/2025, the Medication Administration Audit Report indicated resident was administered apixaban less than 8 hours from the next scheduled dose as follows on:<br><br>-2/17/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 11:48 a.m. (two hours and 48 minutes late).<br><br>-2/17/2025 apixaban 2.5 mg scheduled for administration at 5 p.m., was administered at 5:42 p.m., five hours and 54 minutes after the last dose was given at 11:48 a.m., instead of the ordered eight hours between doses.<br><br>-2/18/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 11:40 a.m. (two hours and 40 minutes late).<br><br>-2/18/2025 apixaban 2.5 mg scheduled for administration at 5 p.m., was administered at 5:14 p.m., five hours and 54 minutes after the last dose was given at 11:40 a.m., instead of the ordered eight hours between doses.<br><br>-2/20/2025 apixaban 2.5 mg, scheduled for administration at 9 a.m., was documented administered at 12:03 p.m. (three hours and three minutes late).<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | During an interview on 2/25/2025 at 3:06 PM with DON, the DON provided a list of 23 residents which included Residents 8, 10, 11, 32, 54, 66, 95, 99. Eleven of the 23 residents were on Station 2, MedCart 2 and 12 of the 23 residents were on Station 2, MedCart 3, that were administered morning medications scheduled for 9 a.m., over 60 minutes pass the scheduled administration time, close to the next scheduled dose, and/ or not in accordance with the physician's orders between 2/17/2025 - 2/25/2025. The DON stated there was no documentation that the physician was called prior to LVN 1 and LVN 2 administering medications late to residents on Station 2 MedCart 2, and to residents on Station 2 MedCart 3 on 2/25/2025. The DON stated the physician should have been called before administering medications late to residents and they were working to notify the physicians now.<br><br>d. During a review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including seizures (a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in behavior, movement, sensation, or awareness), cerebral palsy (a brain disorder that affects a person's ability to move and maintain balance and posture), and cerebral infarction (stroke, death of brain tissue caused by a lack of blood flow) due to occlusion or stenosis of right middle cerebral artery (a narrowing or blockage of the blood vessel that supplies blood to the brain).<br><br>During a review of Resident 1's, MDS dated [DATE], the MDS indicated Resident 1's cognitive skills (mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making was intact. Resident 1's MDS indicated the resident required set up for eating, moderate assistance for oral hygiene and was dependent on staff for physical assistance.<br><br>During a review of Resident 1's, H&P dated 1/29/23 the H&P indicated Resident 1 had the capacity to understand and make decisions.<br><br>During a review of Resident 1's Order Summary Report, the Order Summary Report indicated Resident 1 had an order for Depakote (valproic acid) Solution 250 milligrams (mg - unit of measure of weight) per 5 (five) milliliters (ml - unit of measure of volume) 250 mg/5 ml, to give 5 ml by mouth three times a day, scheduled at 9 a.m., 1 p.m., and 5 p.m., for seizure, order date 2/23/2023.<br><br>During a review of Resident 1's, Care Plan revised 2/7/2025, the care plan indicated Resident 1 had a Black Box Warning (a serious warning given by the Food and Drug Administration (FDA) for drugs or drug classes that may cause serious harm or death) for use of Depakote (valproic acid), indication for seizures, care plan goal indicated the resident will not experience side effects/interactions (when one drug alters the effectiveness of another drug) with the use of Depakote. Resident 1's care plan intervention indicated, Black Box Warning .monitor resident closely . Hepatic failure resulting in fatalities has occurred in patients receiving valproate .Severe or fatal hepatotoxicity may be preceded by nonspecific symptoms such as malaise (a general feeling of being unwell), weakness, lethargy (lack of energy), facial edema (swelling), and vomiting. In patients with epilepsy (a neurological condition that causes unprovoked, recurrent seizures [is a sudden rush of abnormal electrical activity in your brain]), a loss of seizure control may also occur.<br><br>During a record review on 2/27/25 at 1:30 p.m., with the Director of Nursing (DON), Resident 1's Medication Administration Audit Report was reviewed for 2/17/2025 to 2/26/2025, the Medication Administration Audit Report indicated the following:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | -Resident 1's scheduled 9 a.m. dose of valproic acid was given at 1:37 p.m., on 2/20/2025, which was four hours and 37 minutes later than scheduled and dose. The valproic acid ordered for 1 p.m. was given at 2:16 p.m. on 2/20/2025, which was 39 minutes after the last dose was given at 1:37 p.m.<br><br>-Resident 1's scheduled 9 a.m. dose of valproic acid was given at 10:58 a.m., on 2/22/2025, which was one hour and 58 minutes later than scheduled dose and the valproic acid ordered for 1 p.m. was given at 12:12 p. m. on 2/22/2025, which was one hour and 14 minutes after the last dose was given at 10:58 a.m.<br><br>-Resident 1's scheduled 9 a.m. dose of valproic acid was given at 11:21 a.m., on 2/23/2025, which was two hours and 21 minutes later than scheduled and the valproic acid ordered for 1 p.m. was given at 12:54 p.m. on 2/23/2025, which was one hour and 33 minutes after the last dose was given at 11:21 a.m.<br><br>-Resident 1's scheduled 9 a.m. dose of valproic acid was given at 12:33 p.m., on 2/25/2025, which was three hours and 33 minutes later than scheduled and the valproic acid ordered for 1 p.m. was given at 2:28 p.m. on 2/25/2025, which was one hour and 55 minutes after the last dose was given at 12:33 p.m.<br><br>During an interview on 2/27/2025 at 1:38 p.m., the DON stated giving a seizure medication 40 minutes after the first dose or close to the next scheduled dose was not acceptable. The DON stated this would be considered double dosing and could cause Resident 1 to experience adverse reactions (unwanted or harmful effect that can occur when taking a drug or undergoing a medical procedure) and could cause Resident 1 to reach toxic levels of the valproic acid, could trigger a seizure or lead the resident becoming hospitalized for uncontrolled seizures or death.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration - General Guidelines, dated 10/2012, the P&P indicated the facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Medications were administered in accordance with written orders of the prescriber. Medications were administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered (based on mealtimes).<br><br>e. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including seizures and traumatic subdural hemorrhage (a brain injury that occurs when blood builds up between the brain and the skull) with loss of consciousness of unspecified duration<br><br>During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37's cognitive skills for daily decision-making was moderately impaired. Resident 37's MDS indicated the resident required set up for eating and was dependent on staff for physical assistance with oral hygiene, bathing, and dressing,<br><br>During a review of Resident 37's, H&P dated 3/31/22, the H&P indicated Resident 37 can make needs known but cannot make medical decisions.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | During a review of Resident 37's Order Summary Report, the Order Summary Report for February 2025 indicated Resident 37 had an order for Keppra (levetiracetam) 500 mg, to give one tablet by mouth two times a day, scheduled at 9 a.m. and 5 p.m., for seizures.<br><br>During a review of Resident 37's, Care Plan revised 2/7/2025, the care plan indicated Resident 37 had a seizure disorder and the care plan intervention indicated to give seizure medication as ordered by doctor, to monitor and document side effects and effectiveness.<br><br>During a record review, Resident 37's Medication Administration Audit Report was reviewed for 2/17/2025 to 2/26/2025, the Medication Administration Audit Report indicated the following:<br><br>-Resident 37's scheduled 9 a.m. dose of levetiracetam was given at 2:12 p.m., on 2/20/2025, which was five hours and 12 minutes later than scheduled and the levetiracetam ordered for 5 p.m. was given at 5:47 p.m. on 2/20/2025, which was three hours 35 minutes after the last dose was given at 2:12 p.m.<br><br>-Resident 37's scheduled 9 a.m. dose of levetiracetam was given at 11:01 a.m., on 2/22/2025, two hours later than scheduled.<br><br>-Resident 37's scheduled 9 a.m. dose of levetiracetam was given at 11:24 a.m., on 2/23/2025, two hours and 24 minutes later than scheduled.<br><br>-Resident 37's scheduled 9 a.m. dose of levetiracetam was given at 12:11 p.m., on 2/24/2025, over three hours later than scheduled.<br><br>-Resident 37's scheduled 5 p.m. dose of levetiracetam was given at 10:54 p.m., on 2/24/2025, almost six hours later than scheduled.<br><br>-Resident 37's scheduled 9 a.m. dose of levetiracetam was given at 12:06 p.m., on 2/25/2025, which was three hours and six minutes later than scheduled and the levetiracetam ordered for 5 p.m. was given at 5:29 p.m. on 2/20/2025, which was four hours 23 minutes after the last dose was given at 12:06 p.m.<br><br>During an interview on 2/26/2025 at 1:37 p.m., with the facility's Pharmacist Consultant (PC) stated the facility was supposed to have a process in place to have another nurse help to ensure medication administration did not run into the noon or next medication administration time if residents had medications scheduled for two or three times a day. The PC stated he suggested to the facility's Assistant Director of Nursing (ADON) and the DON several months ago, having another nurse to assist with medication pass to prevent late medication administration. The PC stated when medications were administered over three hours late, that was not acceptable practice. The PC stated it was important to give apixaban as ordered because of the pharmacokinetics (the movement of drug into, though, and out of the body) of the medication to maintain therapeutic effects (the response(s) after a treatment of any kind, the results of which were judged to be useful or favorable).<br><br>The PC stat |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>47441<br><br>Based on observation, interview and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when staff were:<br><br>-Unable to verbalize the cooling process of food.<br><br>-Unable to verbalize and demonstrate the correct process of checking quaternary ammonium compound (QUAT, a chemical that disinfect) sanitizer concentration testing for the red buckets and three compartment sink's (sink for dishwashing that have wash, rinse and sanitize compartments) use.<br><br>These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 90 of 92 medically compromised residents who received food and ice from the kitchen.<br><br>Findings:<br><br>a. During an observation on 2/24/2025 at 9:33 a.m. in the walk-in refrigerator, observed cooked turkey sausage in a container with prepared date of 2/23/2025 and with the use by date of 2/26/2025. Observed breaded chicken labeled with prepared date 2/23/2025 and with the use by date of 2/26/2025.<br><br>During a concurrent interview and record review on 2/25/2025 at 10:18 a.m. with the Dietary Supervisor (DS), Cooling Monitoring Form dated 2/2025 was reviewed. The Cooling Monitoring Form indicated, there were no breaded chicken and sausage record times and temperatures monitoring entry on 2/23/2025. The DS stated there was no entry for sausage and breaded chicken on 2/23/2025 and staff were to monitor time and temperature for the sausage and breaded chicken. The DS stated it was important to cool down food safely to prevent bacterial growth in food. The DS stated without proper cool down of food, residents could get food poisoning and foodborne illnesses as a potential outcome.<br><br>During an interview on 2/25/2025 at 10:25 a.m., [NAME] 1 stated the temperature of cooked food must be above 160 degrees Fahrenheit ([ F], a degree of temperature) and it should go down to 150 F to 140 F after two (2) hours then go down further to 70 F after three (3) to four (4) hours. [NAME] 1 stated properly cooled foods should be at a temperature of 70 F and below.<br><br>During an interview on 2/25/2025 at 10:29 a.m., the DS stated cooling of food must be below 60 F within 2 hours and cool down further within 4 hours to 41 F. The DS stated staff needed to start the process all over again if the food did not cool down to 60 F in 2 hours to prevent bacterial growth and for food safety.<br><br>During a review of the facility's P&P titled Hazardous Foods Cooling Monitor dated 11/15/2024, the P&P indicated, Potentially hazardous foods should be cooled from 140 F to 70 F within two hours and cooled from 70 F to 41 F or lower in an additional four hours. (IV.) Record action taken to achieve proper temperature cooling every hour on DS-23-Form A-Cooling Monitor Log, or similar form.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's job description titled [NAME] Job Description, dated and signed by [NAME] 1 on 8/12/2022, the job description indicated, specific job functions included preparing and cooking food in a safe, efficient, and sanitary manner.<br><br>During a review of the facility's competency checklist titled Food and Nutrition: Competency Checklist-Cook signed and dated by [NAME] 1 and DS on 4/22/2024, the checklist indicated, [NAME] 1 needed improvements on monitoring and logging time/temperature of food and correctly utilize cool-down procedure/log.<br><br>During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5 C (41 F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna.<br><br>b. During a concurrent demonstration and interview on 2/25/2025 at 2:11 p.m., of checking the concentration QUAT sanitizer with Dietary Aide 4 (DA 4) and the DS, DA 4 pulled a sanitizer test strip and dipped it in the third sink for five (5) seconds. DA 4 stated he counted in his head as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. DA 4 compared the test strip in the color chart and stated it was 200 parts per million ([ppm], described the concentration of the solution and anything above 200 ppm was not acceptable because the chemical was too strong.<br><br>During a concurrent demonstration and interview on 2/25/2025 at 2:14 p.m. of checking the concentration of the QUAT sanitizer with the DS, the DS stated QUAT sanitizer is the chemical they used for the third compartment sink to sanitize the pots and pans. The DS pulled a test strip and dipped it in the third compartment sink and counted one Mississippi, two Mississippi up to ten (10) Mississippi. The DS stated it had to be 10 seconds because that is what the manufacturer's guidelines wanted them to do. The DS stated they needed to follow the manufacturer's guidelines to make sure the sanitizer was in the right concentration for sanitizing dishes. The DS stated if you counted 1.2.3.4.5 then it was less than 10 seconds, and the reading of the sanitizer concentration may not be accurate. The DS stated if the sanitizer reading was not accurate, it would not sanitize the dishes causing foodborne illnesses as a potential outcome for the residents. The DS stated the acceptable QUAT sanitizer concentration was only 200 ppm as anything higher than that would be harmful for the residents.<br><br>During a review of the facility's manufacturers guidelines titled, Dishwashing Procedure, undated, the guidelines indicated Test M-C 10 sanitizer solution periodically to assure solution is effective using QUAT test strips. Reading should be between 200 to 400 ppm.<br><br>During a review of the facility's test strips manufacturer's guidelines titled Quat Sanitizer Test Strips undated, the guidelines indicated, Dip the test strip into the sanitizing solution for 10 seconds, then instantly match the resulting color with the color chart on the package to determine the concentration. The minimum reading properly diluted sanitizer solution is 200 ppm. Acceptable range 200-400 ppm.<br><br>During a review of the facility's P&P titled Washing and Sanitizing dated 11/15/2024, the P&P indicated, Chemical sanitation requires greater controls than hot water sanitation. (1) Follow manufacturer's guidelines (3) Improper test strips yield inaccurate results when testing for chemical sanitation.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's job description titled Dietary Aide dated and signed by DA 4 on 10/20/2022, the job description indicated, specific job specification included performing dishwashing procedures appropriately with care for sanitizing, water temperatures and drying practices.<br><br>During a review of the facility's competency checklist titled Food and Nutrition: Competency Checklist- Food Service Worker, dated and signed by DA 4 and the DS on 4/2/2024, the checklist indicated, DA 4 was deemed competent in stating proper sanitizer solution range and correctly prepares sanitizer solution, tests concentrations.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using test kit or other device.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11 (C) shall meet criteria specified under 7-204.11 Sanitizers, criteria shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>47441<br><br>Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree yellow zucchini did not hold its shape on the plate and the puree Spanish rice had chunks of rice for residents on puree diet (foods that are smooth with pudding like consistency).<br><br>These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 9 of 92 residents on puree diet, resulting to unintended (not planned) weight loss and chocking (when food gets stuck in your airway, blocking the flow of air to your lungs).<br><br>Findings:<br><br>During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus, dated 2/24/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray:<br><br>Puree cilantro lime chicken number 6 scoop (2/3 cup [c] a household measurement)<br><br>Gravy or sauce of choice 1 ounce (oz, a unit of measurement)<br><br>Puree Spanish rice number 8 scoop (1/2 c)<br><br>Puree zucchini and yellow squash number 10 scoop (3/8 c)<br><br>Puree bread or roll with butter or margarine number 16 scoop (1/4 c)<br><br>During an observation on 2/24/2025 at 11:54 a.m. of the puree food preparation, observed [NAME] 1 poured the thickener in the puree foods on the steamtable without measuring it.<br><br>During an interview on 2/24/2025 at 12:01 p.m. with [NAME] 1, [NAME] 1 stated she did not use a guideline on how puree food should look like and there was no guideline on how much amount of thickener to use. [NAME] 1 stated she just tried to make the puree foods not too watery and too thick and just enough to spread on the plate so the food could be well presented.<br><br>During an observation on 2/24/2025 at 12:25 p.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), observed puree yellow zucchini was not holding its shape and was touching other puree food on the plate.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) on 2/24/2025 at 1:07 p.m. of puree diet with the Dietary Supervisor (DS), the DS stated the puree yellow zucchini was a little bit flat on the plate and it did not hold its shape as compared to other puree foods that held the scoop shape. The DS stated they have spreadsheets and recipe books that contained recipes and portion sizes of the food, and it included the amount of thickener to use. The DS stated the thickener should be measured to achieve a smooth pudding-like consistency. The DS stated the puree food should hold its shape and not too liquify and not following the recipes could lead to a food products that were too clumpy or too watery. The DS stated the puree Spanish rice had rice particles in it and it should not be. The DS stated puree food that did not hold it shape with thin in consistency and puree Spanish rice with rice particles could potentially cause choking and difficulty in swallowing to residents. The DS further stated the residents might not eat the puree food leading to loss of appetite and weight loss.<br><br>During an interview on 2/26/2025 at 11:00 a.m., with the Registered Dietitian (RD), the RD stated they used National Dysphagia Diet ([NDD], an old and outdated national guideline for diets used for residents with difficulty swallowing and chewing) instead of the International Dysphagia Diet Standardization Initiative guidelines ([IDDSI], a global standards used for texture modified and thickened liquids for individuals with dysphagia of all ages, in all care settings, and all cultures). The RD stated the plan is to start the in-service next month. The RD stated puree diets are for residents with dysphagia (difficulty swallowing), difficulty chewing and missing teeth. The RD stated puree diet should contain food that are smooth, homogenous (similar) consistency, pudding or mashed potato consistency. The RD stated if the food went flat and spread out on the plate, it might be too thin and grains in puree rice was not okay. The RD stated the puree rice must have no particles and the potential outcome for too thin of a food and rice with particles for residents on puree diets would be risk of aspiration (inhaling something into the airways, usually food, saliva or stomach contents).<br><br>During a review of the facility's policies and procedures (P&P) titled Menus dated 11/15/2024, the P&P indicated, To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences.<br><br>During a review of the facility's P&P titled Standardized Recipes dated 11/15/2024, the P&P indicated, To provide the dietary department with guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. Procedure:<br><br>Standardized recipes are provided with the menu cycle.<br><br>Standardized recipes have adjustments for yields needed.<br><br>Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modification.<br><br>Recipes will have diet modifications noted.<br><br>The dietary manager or designee will monitor and routinely verify the recipes used by the cooks.<br><br>During a review of the facility's diet manual titled Puree Level 1 dated 11/15/2025, the diet manual indicated, Puree all foods to the consistency of smooth, moist mashed potatoes or pudding-like consistency (use appropriate recipes). No course textures, chunks, lumps or particles are allowed.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's recipe titled Pureed Potatoes, Pasta, Rice, and Other Grains, undated, the recipe indicated, Ingredients: rice cooked drained 2 1/2 cup, broth, hot or hot 2% milk 1 1/4 cup, food thickener 1 1/2 teaspoon. Directions: (1) Remove portions required from regular prepared recipe and drain, if necessary. Place in food processor or blender and process until smooth. Amount of thickener would vary slightly. Start with 1 1/2 teaspoon and add gradually. Ensure mix achieves smooth, lump free, and extremely thick consistency.<br><br>During a review of the facility's recipe titled Pureed Vegetables, undated, the recipe indicated, Ingredients: seasoned vegetables; cooked and drained 2 1/2 cup, food thickener 1 1/2 teaspoon. Directions: Remove portions required from regular prepared recipe, drain and reserve cooking liquid. Place in food processor or blender and process until smooth. Amount of thickener would vary slightly. Start with 1 1/2 teaspoon and add gradually. Ensure mix achieves smooth, lump free, and extremely thick consistency. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>47441<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when:<br><br>1. Kitchen equipment and kitchen areas were not cleaned and sanitized.<br><br>a. Reach in refrigerator vents had dust buildup by the entrance door<br><br>b. Reach in freezer B bottom shelves had dirt debris<br><br>c. Reach in freezer shelves had dust buildup.<br><br>d. Dry storage area shelves had dust buildup.<br><br>e. Walk-in refrigerator vents had dust buildup.<br><br>2. Kitchen equipment and utensils were not maintained in its proper condition, smooth and easy to clean.<br><br>a. Torn gasket in Freezer A.<br><br>b. Two racks in the walk-in refrigerator had amber discoloration, rusted, cracked and chipped.<br><br>c. Ten residents cracked trays.<br><br>d. Scoop drawer was rusted.<br><br>3. Seven (7) dented cans were stored with non-dented cans.<br><br>4. Staff did not prevent cross-contamination (transfer of harmful bacteria from one place to another) during food preparation.<br><br>a. Staff used the same whisk (a kitchen tool made of curve wire that is used to stir or beat such as eggs and cream) for puree chicken, puree zucchini, puree bread and puree Spanish rice without washing it after each use.<br><br>b. Staff used the same brown chopping board and knife for chopping board and knife for chopping cooked chicken and vegetables without washing it.<br><br>5. Staff did not perform handwashing<br><br>a. After touching their watches during food preparation and food handling.<br><br>b. Staff did not handwash when touching soiled dishes then putting away clean dishes.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Staff failed to cool down turkey sausages and breaded chicken on 2/23/2025 and it was indicated in the cooling log.<br><br>7. Pots and pans were stacked wet in the storage area<br><br>8. Quaternary ammonium compound (QUAT, a chemical that disinfect) sanitizer concentrations were not checked correctly.<br><br>These failures had the potential to result in harmful bacterial growth and cross contamination that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 90 of 92 medically compromised residents who received food and ice from the kitchen.<br><br>Findings:<br><br>1. a. During an observation on 2/24/2025 at 8:51 a.m., of the reach in refrigerator by the entrance door, observed the vent had dust buildup and the bottom shelves had food debris.<br><br>b. During an observation on 2/24/2025 at 8:54 a.m., of the reach-in freezer B, observed food debris at the bottom shelves.<br><br>c. During an observation on 2/24/2025 at 8:58 a.m., of the reach in freezer shelves, observed black dust buildup on the freezer walls.<br><br>During a concurrent observation and interview on 2/24/2025 at 9:08 a.m. with the Dietary Supervisor (DS), the DS stated staff just cleaned the freezer and refrigerator yesterday, but they do a detail clean once a month and the last time it was detailed clean was two (2) weeks ago. The DS stated the freezer vent had dust, there were food debris on the bottom of the freezer shelves and the reach in freezer shelves had dust buildup. The DS stated it was important to have freezers and refrigerators free of dust, dirt and food debris due to cross-contamination to food in the freezer and refrigerator. The DS stated the potential outcome of cross-contamination of food would be foodborne illnesses to residents.<br><br>During an observation and interview on 2/24/2025 at 9:21 a.m. with the DS, the DS stated the refrigerator vents had dust buildup and maintenance needed to clean it as it was not okay due to cross-contamination.<br><br>d. During an observation on 2/24/2025 at 9:24 a.m. of the dry storage area rack where paper products were stored, observed rack had dust buildup.<br><br>During a concurrent observation and interview on 2/24/2025 at 9:45 a.m., of the rack in the dry storage area with the DS, the DS stated the rack had dust buildup and it was not okay because they need to worry about little critters (animal) and cross-contamination of food. The DS stated residents could have foodborne illness from food contamination.<br><br>e. During an observation on 2/24/2025 at 9:33 a.m., of the walk-in refrigerator, observed refrigerator vents had dust buildup.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 2/24/2025 at 10:06 a.m., with the DS, the DS stated there was a dust buildup in the vent of the walk-in refrigerator and it was not okay due to contamination to food. The DS stated the maintenance staff needed to clean more frequently instead of once a month.<br><br>During a review of the facility's policies and procedures (P&P) titled Sanitation of Reach in Refrigerator, dated 11/15/2024, the P&P indicated, The reach in refrigerator will be maintained in a sanitary condition.<br><br>During a review of the facility's P&P titled Freezer Operation and Cleaning, dated 11/15/2024, the P&P indicated, The freezer will be cleaned periodically, as necessary.<br><br>During a review of the facility's P&P titled Food Receiving and Storage, dated 11/15/2024, the P&P indicated, (2) The focus of protection for dry storage is to keep non-refrigerated foods, disposable dishware, and napkins in a clean, dry area, which is free from contaminants.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-602.12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph 4-602.11 (D)(6).<br><br>2. a. During an initial kitchen tour observation on 2/24/2025 at 9:01<br><br>a.m., of the reach in freezer A, observed torn front gasket.<br><br>During a concurrent observation and interview on 2/24/2025 at 9:16 a.m. with the DS, the DS stated the reach in freezer A bottom gaskets were torn and it was not acceptable because the freezer would not be working efficiently and would not hold temperature for food safety. The DS stated it was important to maintain freezer temperatures to ensure foods are edible and temperatures are in the acceptable range. The DS stated residents could have foodborne illnesses if food becomes inedible due to unacceptable temperatures.<br><br>b. During an observation on 2/24/2025 at 9:33 a.m., of the walk-in refrigerator, observed the racks had chips, amber discoloration and rust.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 2/24/2025 at 10:10 a.m., with the DS, the DS stated the was a brown discoloration on the racks due to condensation and it was not easy to clean. The DS stated the racks had cracks and could cause cross-contamination to food leading to food borne illnesses for the residents as a potential outcome.<br><br>During a review of the facility's P&P titled Food Storage, dated 11/15/2025, the P&P indicated, (d) Shelving should be sturdy and provided with a surface which is smooth and easily cleaned.<br><br>c. During a concurrent observation and interview on 2/25/2025 at 10:10 a.m., of the resident's tray with the DS, observed ten resident's tray had cracks, chips and loss its glaze. The DS stated crack trays were not acceptable as the crack particles could go to the food as physical contamination (refers to the presence of any hair, glass, metals, jewelry and dirt in the food) and could injure the residents.<br><br>During a review of the facility's P&P titled Discarding Chipped/Cracked Dishes and Single Service Items dated 11/15/2025, the P&P indicated, Policy: The dietary staff will maintain a sanitary environment in the dietary department by discarding compromised service ware and single service items. Chipped, cracked, or non-sanitizing surfaces on china and glassware will not be used. The dietary staff will discard chipped or cracked dish or glassware.<br><br>d. During an observation on 2/25/2025 at 10:34 a.m. of the scoop drawer, observed the scoop drawer was rusted, and scoops were stored in it.<br><br>During a concurrent observation and interview on 2/25/2025 at 10:36 a.m. of the scoop drawer with the DS, the DS stated the scoop drawer had chips, the paint was coming off and there was brown in color discoloration that looked like rust. The DS stated the scoops should not be stored in there as it could cause food contamination.<br><br>During a review of the facility's P&P titled Food Contaminants dated 11/15/2024, the P&P indicated, Physical Contamination: are foreign objects that may inadvertently enter the food. Examples include but not limited to, staples, fingernails, jewelry, hair, glass, metal shavings from can openers, and pieces or fragments of bones from fish or chicken for example.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints.<br><br>3. During an observation on 2/24/2025 at 9:24 a.m., of the dry storage shelves, observed two (2) dented cans stored with non-dented cans.<br><br>During a concurrent observation and interview on 2/24/2025 at 9:48 a.m. with the DS, the DS stated they have a separate area to place all the dented can from non-dented cans as they could not use dented cans due to cross-contamination. The DS stated there were seven (7) dented cans stored with non-dented cans and it was not okay due as it could cause botulism (rare but serious bacterial infection) to the residents as a potential outcome.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled Food Storage, dated 11/15/2024, the P&P indicated, (d) Dented or bulging cans should be placed in separate storage area and returned for credit.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601. 12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.<br><br>4. a. During an observation on 2/24/2025 at 11:54 a.m., of [NAME] 1 preparing puree food, observed [NAME] 1 mixed the puree cilantro lime chicken with a whisk. [NAME] 1 rinsed the whisk in the three-compartment sink with water and placed it on trayline (an area where foods were assembled from the steamtable to resident's plate)).<br><br>During an observation on 2/24/2025 at 12:01 p.m., of [NAME] 1 preparing puree yellow zucchini, observed [NAME] 1 used the same whisk she used for the puree cilantro lime chicken to mix puree yellow zucchini without washing and sanitizing it.<br><br>During an observation on 2/24/2025 at 12:03 p.m., of [NAME] 1 preparing puree bread, observed [NAME] 1 rinsed the same whisk she used in mixing puree yellow zucchini in the three-compartment sink with water then used it to mix the puree bread.<br><br>During an observation on 2/24/2025 at 12:06 p.m., of [NAME] 1 preparing puree Spanish rice, observed [NAME] 1 rinse the same whisk she used for mixing puree bread in the three-compartment sink with water then used it to mix puree Spanish rice.<br><br>During an interview on 2/24/2025 at 1:38 p.m. with the DS, the DS stated he expected staff to use different utensils for each food items during preparation of food or go wash and sanitize it before reusing the utensils. The DS stated it was important to prevent cross contamination of one food to another due to allergy ingredient contamination. The DS stated allergic reaction for residents would be the potential outcome from using the utensil or chopping board with different food and residents could also get hospitalized because of this.<br><br>During a review of the facility's P&P titled Washing and Sanitizing-Dietary, dated 11/15/2025, the P&P indicated, To provide food and nutritional service employees with guidelines for washing and sanitizing dietary related items and equipment. (3) Low temperature dishwasher (chemical sanitation) (a) Wash - 120 F; and (b) Final rinse - 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in final rinse. Manual washing and sanitizing: 3-step process is used to manually wash, rinse and sanitize dishware correctly.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. During an observation on 2/24/2025 at 12:59 p.m. of the food preparation, observed [NAME] 2 used the same brown chopping board and knife in chopping cooked chicken and green beans for finely chopped diets.<br><br>During an interview on 2/25/2025 at 9:41 a.m. with the DS, the DS stated staff used different colors of chopping board to prevent cross-contamination. The DS stated they used white chopping board for cooked vegetables only and brown for cooked meats. The DS stated staff should be using a brown for cooked meats and white for cooked vegetables to prevent allergies contaminants and foodborne illnesses.<br><br>During a review of the facility's P&P titled Safe Food Preparation, dated 11/15/2024, the P&P indicated, The facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe Food Preparation: (3) Examples of ways to reduce cross-contamination include but not limited to: (d) Clean and sanitize work surfaces, including cutting boards and food-contact equipment (e.g., food processors, blenders, preparation tables, can openers, and slicers), between uses and consistent with applicable code.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306.<br><br>5. a. During an observation on 2/24/2025 at 9:42 a.m., of the food preparation, [NAME] 1 was wearing a wristwatch while cooking food.<br><br>During an observation on 2/24/2025 at 12:31 p.m. during trayline, observed [NAME] 1 wearing a wristwatch.<br><br>During an observation on 2/24/2025 at 12:47 p.m. of the staff dishing out (transferring) food from the steamtable to the resident's plate, observed [NAME] 1 touched her wristwatch then continued dishing out food from the steamtable to the resident's plates.<br><br>During an observation on 2/24/2025 at 12:49 p.m. of the Dietary Aide 1 (DA 1) in the trayline, DA 1 touched her watch then continued working in trayline.<br><br>During an interview on 2/242/2025 at 1:42 p.m. with the DS, the DS stated they were not allowed to wear jewelry in the kitchen and watches due to cross-contamination. The DS stated staff should watch their hands after they touched their watches and before they go back to work to prevent food contamination.<br><br>A review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands.<br><br>b. During an observation on 2/25/2025 at 1:47 p.m. of the dishwashing process, observed Dietary Aide 3 (DA 3) touched the soiled dishes then went back to the cleaned area and touched the clean dishes without washing their hands.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 2/25/2025 at 1:50 p.m. with the DS, the DS stated DA 3 should be changing her gloves when going from dirty to clean area as it would contaminate the clean dishes with DA 3's contaminated hands. The DS stated this could cause foodborne illness from contaminated dishes as a potential outcome.<br><br>During a review of the facility's P&P titled Hand Hygiene dated 11/15/2024, the P&P indicated, Facility staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances: (A) Wash hand with soap and water:<br><br>Before and after food preparation<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands.<br><br>6. During an observation on 2/24/2025 at 9:33 a.m. in the walk-in refrigerator, observed cooked turkey sausage in a container with prepared date 2/23/2025 and with the use by date (last date that a food product can be consumed at its peak quality and safety) of 2/26/2025 and breaded chicken with prepared date 2/23/2025 and with the use by date of 2/26/2025.<br><br>During a concurrent interview and record review on 2/25/2025 at 10:18 a.m. with the DS, Cooling Monitoring Form dated 2/2025 was reviewed. The Cooling Monitoring Form indicated, there were no breaded chicken and sausage times and temperatures monitoring entry on 2/23/2025. The DS sated, there was no entry for sausage and breaded chicken on 2/23/2025 and staff were to monitor time and temperature for the sausage and breaded chicken. The DS stated it was important to cool down food safely to prevent bacterial growth in food. The DS stated without proper cool down of food, residents could get food poisoning and foodborne illnesses as a potential outcome.<br><br>During a review of the facility's P&P titled Hazardous Foods Cooling Monitor dated 11/15/2024, the P&P indicated, Potentially hazardous foods should be cooled from 140 degrees Fahrenheit ([ F], a scale of temperature) to 70 F within two hours and cooled from 70 F to 41 F or lower in an additional four hours. (IV.) Record action taken to achieve proper temperature cooling every hour on DS-23-Form A-Cooling Monitor Log, or similar form.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5 C (41 F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna.<br><br>7. During an observation on 2/25/2025 at 2:01 p.m. of the pots and pans washing process, observed employees stacking pots and pans wet.<br><br>During a concurrent observation and interview on 2/25/2025 at 2:14 p.m. of the pots and pans storage area with the DS, the DS stated the pans were stacked wet and were not completely dry as there were still water droplets. The DS stated they could not stack pans wet because bacteria could grow on the stacked wet pans causing cross-contamination and chemical contamination as a potential outcome. The DS stated, staff needed to air dry pots and pans.<br><br>During a review of the facility's P&P titled Pot and Pan Cleaning, dated 11/15/2024, the P&P indicated, (IX) Invert the pots and pans and place them on a drying rack or counter. Place small items in a flat bottom dish rack to dry. (X.) Allow items to air dry. Do not use a towel. (XI) When items are dry, store them in the proper storage area.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.<br><br>8. During a concurrent demonstration and interview on 2/25/2025 at 2:11 p.m., of checking the concentration QUAT sanitizer with Dietary Aide 4 (DA 4) and the DS, DA 4 pulled a sanitizer test strip and dipped it in the third sink for five seconds. (surveyor counting 1001, 1002, 1003, 1004, 1005). DA 4 stated he counted in his head as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.<br><br>During a concurrent demonstration and interview on 2/25/2025 at 2:14 p.m. of checking the concentration of the QUAT sanitizer with the DS, the DS stated QUAT sanitizer is the chemical they used for the third compartment sink to sanitize the pots and pans. The DS pulled a test strip and dipped it in the third compartment sink and counted one Mississippi, two Mississippi up to ten (10) Mississippi. The DS stated it had to be 10 seconds because that is what the manufacturer's guidelines wanted them to do. The DS stated they needed to follow the manufacturer's guidelines to make sure the sanitizer was in the right concentration for sanitizing dishes. The DS stated if you counted 1.2.3.4.5 then it was less than 10 seconds, and the reading of the sanitizer concentration may not be accurate. The DS stated if the sanitizer reading was not accurate, it would not sanitize the dishes causing food borne illnesses as a potential outcome for the residents.<br><br>During a review of the facility's test strips manufacturer's guidelines titled Quat Sanitizer Test Strips undated, the guidelines indicated, Dip the test strip into the sanitizing solution for 10 seconds, then instantly match the resulting color with the color chart on the package to determine the concentration.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled Washing and Sanitizing dated 11/15/2024, the P&P indicated, Chemical sanitation requires greater controls than hot water sanitation. (1) Follow manufacturer's guidelines (3) Improper test strips yield inaccurate results when testing for chemical sanitation.<br><br>During an interview on 2/26/2025 at 11:00 a.m., with the Registered Dietitian (RD), the RD stated she does monthly sanitation in the kitchen and the last time she did it was 1/2024 to ensure staff follow protocol for food safety and infection control. The RD stated rust and dirt are contaminants to food and residents could get sick from food poisoning due to contaminated foods.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using test kit or other device. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>47441<br><br>Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when three of three dumpsters (large trash container designed to be emptied into a truck) were not completely closed or covered when not actively used. This failure had a potential to result to attracting birds, flies, insects, pest and possibly spread infection to 90 of 92 facility residents.<br><br>Findings:<br><br>During an observation on 2/25/2025 at 9:39 a.m. of the dumpster, two (2) of 3 dumpsters were overflowing with trash and not completely covered when not actively used.<br><br>During an observation on 2/25/2025 at 2:08 p.m. of the dumpster, 3 of 3 dumpsters were overflowing with trash and not completely covered when not actively used.<br><br>During an observation on 2/25/2025 at 2:23 p.m. of the dumpster, 3 of 3 dumpsters were overflowing with trash and not completely covered when not actively used. Observed the first dumpster had an uncovered gap in the middle, second dumpster was overflowing with trash and the third dumpster was not completely closed.<br><br>During a concurrent observation and interview on 2/25/2025 at 2:30 p.m. with the Dietary Supervisor (DS), the DS stated the first dumpster cover was broken causing the middle gap, the second dumpster was overflowing with trash, and it was not okay. The DS stated the third dumpster was not completely closed and it was not okay because it was not actively in use. The DS stated the dumpster needed to be covered to prevent animals going in the trash and getting the trash out that could cause bacterial, and disease spread and infection. The DS stated the boxes of soda were not broken down in the second dumpster causing it to overflow.<br><br>During an interview on 2/25/2025 at 10:34 a.m. with the Maintenance Director (MND), the MND stated the lids of the dumpsters must be closed after throwing the trash. The MND stated staff could not overfill the trash for infection control as it could attract pest and other animals.<br><br>During a review of the facility's policies and procedures (P&P) titled Dispose of Garbage and Refuse dated 11/15/2024, indicated The facility properly disposes of garbage and refuse. (1) Garbage and refuse containers are maintained in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lid covered. (3) Garbage storage shall be maintained in a sanitary condition to prevent the harborage and feeding of pests.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.<br><br>(continued on next page) |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.<br><br>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, A review of Food Code 2017, indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>43851<br><br>Based on interview and record review, the facility failed to ensure two of nine sampled facility employees (Licensed Vocational Nurse [LVN] 6 and Restorative Nurse Assistant [RNA] 1) were screened with documented evidence for PPD test (a purified protein derivative [PPD] skin test is a test that determines if you have tuberculosis [TB], a serious infection, usually of the lungs) and clearance as required by the facility's policy and procedure.<br><br>This deficient practice had the potential to place residents, visitors, and facility staff to tuberculosis exposure by allowing staff to work without proof they were either negative for or did not have symptoms of tuberculosis infection.<br><br>Findings:<br><br>During a review of LVN 6's employee file, dated 1/12/2025, LVN 6's employee file indicated LVN 6 solely answered the facility's questionnaire for the Healthcare Worker Tuberculosis Symptom Screen. LVN 6's employee file indicated the PPD skin test documentation and chest x-ray documentation were both blank. The employee file did not indicate whether LVN 6 previously had tested positive for tuberculosis.<br><br>During a review of RNA 1's employee file, dated 9/20/2024, RNA 1's employee file indicated RNA 1 answered the facility's Team Member Health Questionnaire and the facility's Healthcare Worker Tuberculosis Symptom Screen. RNA 1's employee file indicated the PPD skin test documentation and chest x-ray documentation were both blank. The employee file did not indicate whether RNA 1 previously had tested positive for tuberculosis.<br><br>During an interview on 10/18/2025 at 10:18 AM with Registered Nurse Consultant 1 (RNC-an expert advisor, helping other healthcare facilities and teams improve their nursing practices, patient care quality, and overall systems by offering advice, evaluating current procedures, and teaching new methods), RNC 1 stated she could not explain why the facility allowed an employee who did not have a TB screen and clearance to work. RNC 1 stated an employee without a TB screen and clearance could expose residents to TB if the facility did not screen and clear the employee.<br><br>During an interview on 2/27/2025 at 12:44 PM with the ADM and the Director of Nursing (DON), the ADM and DON stated if the facility did not have proof of a staff member's PPD test and clearance, the employee would need to have proof of the test and clearance before the facility would allow the employee to work. The ADM and DON stated they would follow their policy for TB testing.<br><br>During a review of the facility's policy and procedure (P&P) titled, Tuberculosis - Screening of Resident and Healthcare Workers, dated 9/1/2021, the P&P indicated the facility would screen their healthcare worker (HCW) annually. The P&P indicated the facility would perform a single step tuberculosis skin test or IGRA (Interferon Gamma Release Assay, a blood test that detects tuberculosis) unless the HCW was previously positive for tuberculosis. The P&P indicated the HCW was previously positive for tuberculosis, the facility would have the HCW complete the tuberculosis screening questionnaire followed by a chest x-ray if the HCW had symptoms of tuberculosis. |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296<br><br>Based on observation, interview and record review the facility failed to ensure 17 of 38 resident rooms (rooms 101, 102, 103, 104, 111, 112, 113, 214, 215, 216, 217, 218, 219, 220, 221, 222, and 238) met the requirement of that each resident must have at least 80 square feet of useable living space in multiple resident rooms and at least 100 square feet of useable living space for single rooms. This failure had the potential to affect the delivery of care, safety and wellbeing of the residents.<br><br>Findings:<br><br>During a concurrent observation and interview on 2/27/25 at 12:54 PM, in Resident 403's room, the room was clean and free from clutter and obstruction. Resident 403 stated the room is clean and she can move freely in the room without any issue. Resident 403 stated the room is not cluttered.<br><br>During an interview on 2/27/25 at 1:00 PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated he can move freely in his assigned rooms and perform his duties without obstruction.<br><br>During a review of the Client Accommodations Analysis dated 2/27/25, the Client Accommodations Analysis indicated the room measurements for the following rooms:<br><br>Room # Room Size Number of Beds<br><br>101 236.12 square feet 3<br><br>102 243.45 square feet 3<br><br>103 237.45 square feet 3<br><br>104 231.92 square feet 3<br><br>111 230.84 square feet 3<br><br>112 228.46 square feet 3<br><br>113 228.35 square feet 3<br><br>214 229.59 square feet 3<br><br>215 228.53 square feet 3<br><br>216 229.16 square feet 3<br><br>217 229.01 square feet 3<br><br>218 543.98 square feet 6<br><br>(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 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 219 228.89 square feet 3<br><br>220 228.99 square feet 3<br><br>221 229.81 square feet 3<br><br>222 227. 76 square feet 3<br><br>238 393.41 square feet 3<br><br>During a review of the facility's Room Variance Waiver dated 4/28/24 indicated rooms 101, 102, 103, 104, 110, 111, 112, 113, 214, 215, 216, 217, 219, 220, 221, and 238 were less than 80 square feet and were approved for the room waiver. The Room Variance Waiver also indicated room [ROOM NUMBER] had more than four beds and was approved for the room waiver.<br><br>During multiple observations in the affected rooms during the recertification from 2/24/25 to 2/27/25, the deliveries of care to the residents were affected by the room sizes and there were adequate spaces for residents and staff moving freely.<br><br>During a review of the facility's policy and procedure (P&P) titled, Bedroom Measurements, dated 3/23, the P&P indicated the facility provides rooms which measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056377 | A. Building<br>B. Wing | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Rehabilitation Center on Pico | 3233 W. Pico Boulevard<br>Los Angeles, CA 90019 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836<br><br>Based on observation, interview, and record review, the facility failed to provide a functioning call light for one sampled resident (Resident 86). This deficient practice had the potential to result in a delay in meeting Resident 86's needs for hydration, toileting, and activities of daily living.<br><br>Findings:<br><br>A review of the Admission Record for Resident 86 indicated the resident was admitted to the facility on [DATE], with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizophrenia (a mental illness that is characterized by disturbances in thought), muscle weakness, and gait and mobility abnormalities (change in walking pattern).<br><br>A review of the quarterly Minimum Data Set (MDS - a resident assessment tool) dated 1/22/2025, indicated Resident 86 had moderate cognitive impairment a decline in thinking and memory that makes it hard to complete complex tasks) and needed assistance for toilet use, personal hygiene, and bathing.<br><br>During a concurrent observation and interview on 2/24/2025 at 10:48 AM, Resident 86 was observed using the call light. The light above the door was not flashing and there was no audible sound to indicate the call light was activated. The certified nursing assistant (CNA 6), who was outside in the hallway checked Resident 86's call light and stated the call light was not working. CNA 6 stated I will have maintenance fix the call light right away.<br><br>A review of Resident 86's functional and bed mobility care plan last reviewed on 1/29/2025, indicated multiple interventions including having the call light within reach and to encourage the resident to call for assistance.<br><br>During an interview on 2/26/2026 at 11:21 AM, the maintenance director (MND) stated the call lights were supposed to be checked monthly and as needed to ensure they were working. The MND stated he was not aware that Resident 86's call light was not functioning until he was informed by CNA 6. MND further stated that he was unsure when the last time Resident 86's call light was checked because they did not keep a log for the checks.<br><br>A review of the facility's policy and procedure titled, Resident Call System, and last revised March 2023, indicated the facility should be adequately equipped to allow residents to call for staff assistance through a communication system. It further indicated the Environmental Services Department completed routine audits and maintenance to ensure all portions of the system are functioning. |