STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056405	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerritos Vista Healthcare Center	17836 Woodruff Avenue Bellflower, CA 90706

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to treat one of eight sampled Residents (Resident 37) with dignity and respect while providing feeding assistance. This deficient practice had the potential for Resident 37 to feel rushed while eating, uncomfortable, and disrespected. Findings: During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses of intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and dysphagia (difficulty swallowing). During a review of Resident 37's untitled care plan initiated on 12/5/2025, the care plan indicated Resident 37 had an alteration in nutritional status with goals that included minimizing the risk for weight loss. Interventions for Resident 37 included the restorative nursing feeding (RNA) feeding program (a program designed to assist residents that require help eating at mealtimes) as indicated. During a review of Resident 37's minimum data set (MDS, a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 37 was rarely or never understood. During an observation on 3/18/2025 at 8:10 a.m., RNA 1 was feeding Resident 37 who was sitting up in bed. RNA 1 was standing over Resident 37 while feeding her. During an observation on 3/18/2025 at 8:12 a.m., RNA 1 stopped feeding Resident 37 after seeing the State surveyor in the hallway, left Resident 37's room, went into the room across the hallway from Resident 37 grabbing a stool and then brought the stool back into Resident 37's room to sit next to Resident 37 at eye level to finish feeding her. During an interview on 3/18/2024 at 8:24 a.m., RNA 1 stated he was initially standing while feeding Resident 37. RNA 1 stated it was important to sit at eye level while feeding the residents to ensure the resident was comfortable. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2025 at 11:49 a.m., the director of nursing (DON) stated staff were to be sitting at eye level with the residents while feeding them. The DON stated it was important not to stand over the residents while eating so the residents do not feel rushed to eat, residents comfort, and dignity and respect for the resident. During a review of the facility's policy and procedure (P/P) titled Assistance with Meals dated 3/2022, the P/P indicated residents who were not able to feed themselves were to be fed with attention to safety, comfort and dignity by not standing over residents while assisting them with meals.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to ; A.Assess and fix a malfunctioning bed in a timely manner for one of one residents (Resident 114). This failure had the risk for fire and the potential to place all residents at risk for injury. B. Provide adult briefs (disposable absorbent underwear) that comfortably fit for one of three sampled residents (Resident 233). This failure had the risk for fire and the potential to place Resident 114 at risk for injury and result in skin breakdown and lowered self esteem for Resident 233. Findings: A.During a review of Resident 114's Admission record, the Admission record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including, muscle weakness, and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of sacral (lowest part of the spinal cord, tail bone) region. During a review of Resident 114's History and Physical (H&P), dated 6/17/2024, the H&P indicated Resident 114 had the capacity to understand and make decisions. During a review of Resident 114's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 114's cognition (ability to learn reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 114 required setup or clean-up assistance for eating, required moderate assistance (helper did less than half the effort) for eating, and was dependent (helper does all of the effort) for toileting and bathing. During an interview on 3/17/2025 at 11:23 a.m., with Resident 114, Resident 114 stated she reported that her bed was broken and smelled like smoke on 3/15/2025 to the nursing staff (unspecified). Resident 114 stated no one from the maintenance department had come to look at the bed. During a concurrent observation and interview on 3/20/2025 at 11:14 a.m., with the maintenance supervisor (MS), the Maintenance Department Request Log was reviewed. The Log indicated on 3/16/2025, Resident 114's bed motor smelled like a burning substance, and under the column indicating Repair Date/By OK Was documented. The MS stated the Log does not indicate who checked Resident 114's bed or when it was checked. The MS stated he evaluated Resident 114's bed on 3/18/2025, and stated there was no smoke and the bed was working. During a concurrent interview and record review on 3/20/2025 at 12:24 p.m., with the registered nurse supervisor (RNS) 1, the Maintenance Department Request Log was reviewed. RNS 1 stated malfunctioning equipment should be removed from a resident's room and reported to the maintenance supervisor right away. RNS 1 stated a bed motor that smells like burning warrants a phone call to the maintenance supervisor to come to assess the bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/2025 at 3:21 p.m., with the Director of Staff Development (DSD), the DSD stated there is no training or written process for malfunctioning equipment outlining when to call the maintenance supervisor versus writing it in the Maintenance Department Request Log and waiting for the next business day. During an interview on 3/20/2025 at 3:51 p.m., with the Director of Nursing (DON), the DON stated if a bed motor smells like a burning substance, it should have been a priority for maintenance to check the bed because there was a potential risk for fire placing all residents at risk for injury. B. During a review of Resident 233's Admission Record, the Admission Record indicated, Resident 233 was admitted to the facility on [DATE] with diagnoses including morbid (severe) obesity, generalized muscle weakness, and heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs). During a review of Resident 233's History and Physical (H&P), dated 3/12/2025, the H&P indicated, Resident 233 had the capacity (ability) to understand and make decisions. During a review of Resident 233's MDS dated [DATE], the MDS indicated Resident 233 required dependent assistance (Helper does all of the effort) from two or more staff for toileting hygiene, bed mobility, maximal assistance (Helper does more than half the effort) from one staff for roll left to right, shower, and upper body dressing. During a review of Resident 233's Care Plan (CP), revised on 3/18/2025, the CP Focus indicated, Resident 233 had mid pannus (belly) area hyperkeratosis (a condition that the outer layer of the skin gets increased thickness due to inflammation caused by friction, pressure, and chemicals). The CP Interventions indicated, assess for causative factors that caused the initial development, and attempt to minimize reoccurrence. During a concurrent observation and interview on 3/17/2025, at 10:46 a.m., with Resident 233 in her room, Resident 233 was sitting on the edge of her bed and grimacing. Resident 233 stated, she was not in pain, but she was uncomfortable because she was wearing adult briefs did not fit her properly. Resident 233 stated, she needed to wear size five Extra Large (XL), but nursing staff provided her size three XL. Resident 233 stated, she spoke to Social Service Director (SSD) regarding this issue, but the SSD told her (Resident 233) that she needed to get the authorization to order bigger size adult briefs. Resident 233 stated, three XL was too small, and the side tabs of the 3 XL adult briefs did not reach to the front of the adult briefs to close and hold. Resident 233 stated, she refused a few therapy sessions due to ill-fitting adult briefs because she was worried that it would fall off and expose her private parts to the therapist. Resident 233 stated, she got a rash (skin irritation and inflammation) because of improperly fitting adult briefs, and she felt very uncomfortable. During an interview on 3/19/2025, at 3:32 p.m., with the SSD, the SSD stated, she did not recall that Resident 233 complained regarding her adult briefs. The SSD stated, she did not need authorization to order larger size adult briefs. The SSD stated, nursing staff should have notified her regarding this issue, and Resident 233 should not have to wear adult briefs that were too small and suffer from the rash. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/2025, at 3:51 p.m., with the DON, the DON stated, all staff should have assessed Resident 233's needs for adult briefs that fit properly and accommodate her needs as soon as possible. The DON stated, the staff should assist and promote the resident's well-being and dignity. During a review of Resident 233's Care Plan (CP), revised on 3/18/2025, the CP Focus indicated, Resident 233 had mid pannus(belly) area hyperkeratosis (a condition that the outer layer of the skin gets increased thickness due to inflammation caused by friction, pressure, and chemical). CP Interventions indicated, assess for causative factors that caused the initial development, and attempt to minimize reoccurrence. During a review of the facility's policy and procedure (P&P), titled Maintenance Service, revised December 2009, the P&P indicated the maintenance department is responsible for maintain the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include, but are not limited to: .establishing priorities in providing repair service. During a review of the facility's P&P titled, Accommodation of Needs , revised 3/2021, the P&P indicated, Policy Statement: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. Policy Interpretation and Implementation: 1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis . 4. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting, revised 3/2023, the P&P indicated, Policy Interpretation and Implementation: 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish . 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated and revised as appropriate. 50144

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 49573 Based on observation, interview, and record review the facility failed to ensure accurate resident assessments, and that assessment status' were reflected on medical records for two of three sampled residents (Resident 130 and Resident 103) by: A. Failing to provide accurate information in the Minimum Data Set ([MDS], a resident assessment tool) assessment for one of three sampled residents (Resident 130) when resident was discharged to home. B. Failing to ensure the bowel and bladder assessment entries on the Minimum Data Set (MDS- a resident assessment tool) was accurately reflected and documented for Resident 103. These failures had the potential to result in a negative effect on Resident 130 and Resident 103's plan of care and delivery of necessary services, care, and treatment. Findings: A. During a review of Resident 130's Admission Record, the Admission Record indicated Resident 130 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy ([GT-Tube], a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), hypertension ([HTN]-high blood pressure), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 130's MDS, dated [DATE], the MDS indicated Resident 130 had intact cognitive (thinking process) skills for daily decision making, and required supervision (helper provides verbal cues and/or touch assistance) with self-care abilities such as oral hygiene, personal hygiene, upper body dressing, required moderate assistance (helper does less than half the effort) with toileting hygiene, lower body dressing, putting on and taking off footwear, required maximal assistance (helper does more than half the effort) with shower/bathe. The MDS also indicated Resident 130 was to be discharge, return not anticipated with discharge status to short term general hospital ([GACH], a general acute care hospital). During a review of Resident 130's Discharge Summary Reported dated 2/13/2025, the discharge summary report indicated Resident 130 was discharged to home with family. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/20/2025 at 2:38 p.m. with Registered Nurse Supervisor (RNS) 1, the Order Summary Report and the MDS dated [DATE] was reviewed. RNS 1 stated Resident 130 was discharge to home on 2/13/2025 with home health. RNS 1 stated the MDS should have been coded that resident was discharge to home since Resident 130 was discharge to home with home health. RNS 1 stated the MDS should have been coded to reflect the resident was discharge to home so that Center for Medicare and Medicaid ([CMS], a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program) can follow up. RNS 1 stated the MDS assessment should be coded to reflect what the resident has, what was being done for the residents while they are in the facility, and where the residents go after the facility. During a concurrent interview and record review on 3/20/2025 at 4:40 p.m. with the Director of Nursing (DON), the MDS dated [DATE] was reviewed. The DON stated the MDS assessment was a proper assessment of the residents and how the facility provide care interventions and care planning for the residents, to see if residents were progressing or declining in their health. The DON stated the MDS assessment was an accurate assessment of the resident, and it must be coded correctly so the facility can get an accurate report from CMS. The DON stated Resident 130's MDS assessment should have been coded to reflect that Resident 130 was discharged to home and not the short-term acute hospital. During a review of the facility's policy and procedure (P/P), titled Resident Assessment, dated no date, indicated healthcare professionals completed portions of the MDS are to certify the accuracy of the sections they have completed by entering the signatures, title, date completed and the section(s) completed accuracy of transcription of the data and computer data entry are important and special attention must be given to correct these errors. B. During a review of Resident 103's admission record, the admission record indicated Resident 103 was initially admitted to the facility on [DATE] and last re-admission was on 2/3/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), overactive bladder (a problem with bladder function that causes the sudden need to urinate), and Extended Spectrum Beta Lactamase resistance (ESBL resistance-specific enzymes released by a bacteria that neutralizes the effects of antibiotics). During a review of Resident 103's History and Physical (H&P), dated 2/5/2025, the H&P indicated, Resident 103 had the capacity (ability) to understand and make decisions. During a review of Resident 103's MDS, dated [DATE], the MDS indicated Resident 103 required moderated assistance (Helper does less than half the effort) from one staff for toilet transfer, chair/bed to chair transfer, and supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for bed mobility. During a review of Resident 103's Care Plan (CP), revised on 2/21/2025, the CP Focus indicated, scheduled toileting plan to prevent decreased self-esteem, skin breakdown, and falls. The CP Interventions indicated, monitor for evidence of toileting needs manifested by restlessness and discomfort, offer toileting assistance, monitor for episodes of incontinence, assist to toilet, bedside commode as indicated (7a.m. to 3 p.m.=every four hours, 3p.m. to 11 p.m.=every four hours, 11 p.m. to 7 a.m.= every four hours). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 103's Order Listing Report (OLR), dated 3/19/2025, the OLR indicated, bowel management program: monitor bowel elimination and document the following, 0=no bowel movement, 1=bowel (number of times per shift), amount (S=small, M-medium, L-large), and consistency (S=soft, H-hard, L-loose) was ordered on 2/3/2025. During a concurrent observation and interview on 3/17/2025, at 2:51 p.m., with Resident 103 in her room, Resident 103 was sitting on a wheelchair and wheeling herself out of her room to go to the activity room. Resident 103 stated, she was not incontinent (unable to voluntarily control retention of urine or feces in the body) for bowel and bladder, but she was not able to go to the bathroom without help when she was admitted to the facility. Resident 103 stated, her mobility improved, and she had no more issue. Resident 103 stated, she could feel sensation when time to go bathroom and she did not consider herself as incontinent. During a concurrent interview and record review on 3/19/2025, at 3:40 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 103's Bowel and Bladder Program Screener, dated 8/26/2024 and 2/4/2025 were reviewed. The Bowel and Bladder Program Screener indicated, Resident 103 was incontinent of bowel and bladder and was not aware of the need to go to the toilet on 8/26/2024 (on admission). The Bowel and Bladder Program Screener indicated, Resident 103 had never been incontinent for stool and was usually aware of the need to toilet. The MDSC stated, if the resident was able to feel the need to go to toilet and able to verbalize it, the resident should be considered as continent. The MDSC stated, if the resident was incontinent, the resident would not be able to verbalize and feel the need to go to the toilet. The MDSC stated, Bowel and Bladder Program Screener were not done correctly and contained conflicted information. During a concurrent interview and record review on 3/19/2025, at 3:43 p.m., with the MDSC, Resident 103's MDS section H (bowel and bladder), dated 8/26/2024 and 2/6/2025 were reviewed. The MDS section H indicated, Resident 103 was always incontinent for bowel and bladder and was not in the toileting program on 8/26/2025. The MDS section H indicated, Resident 103 was occasionally incontinent for bowel and bladder and was not in toileting program on 2/6/2025. The MDSC stated, she did not interview Resident 103 regarding bowel and bladder. The MDSC stated, her assessment was based on Certified Nurse Assistant (CNA)'s documentation. The MDSC stated, if Resident 103 was able to verbalize and she was aware of need to use bathroom, the MDS should have reflected her as continent for bowel and bladder. MDSC stated, MDS coding should be done accurately because it affects the resident's plan of care and treatment. During an interview on 3/20/2025, at 3:51 p.m., with Director of Nursing (DON), DON stated, Resident 103 was on a toilet training program on 2/3/2025 per doctor's order and it should be reflected on MDS section H that was coded on 2/6/2025. The DON stated, MDS assessments should include resident interviews. The DON stated, all assessment in MDS should be coded correctly because this would affect resident's overall care and treatment negatively. The DON stated, assessments should be accurate to get a clear representation of the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Resident Assessment, undated, the P&P indicated, Guidelines: The resident Assessment Instrument (RAI) system includes the following: a. Minimum Data Set (MDS) or the core set of items that must be assessed for each resident. This is a minimum data set and does not necessarily contain all the factors that may affect the resident's condition . 4. Sources of information to complete MDS/RAI: a. Review of resident's record; b. Communicate with the resident; c. Observe the resident; d. Communicate with health provider; e. Communicate with physician(s); f. Communicate with family. During a review of facility's policy and procedure (P&P) titled, Job Description: Minimum Date Set (MDS) Coordinator, revised 6/20/2024, the P&P indicated, Essential Duties: o Completes and audits all MDS's for accuracy of information entered, ensuring accurate input. o Schedules MDS reviews and updates quarterly, annually, and as needed for significant changes in condition. o Interacts with staff within the facility, staff of other departments, and family to coordinate care processes of resident assessment and care planning.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure two out of five sampled residents (Resident 84 and Resident 17) had their Level 1 Preadmission Screening and Resident Review ([PASRR], is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) completed accurately. This deficient practice had the potential to delay care for Resident 84, and Resident 17 and had the potential that they would not receive the proper level of care or services they required. Findings: a.During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 84's history and physical (H/P) dated 12/27/2024, the H/P indicated the resident was unable to make his own medical decisions at this time. During a review of Resident 84's Minimum Data Set ([MDS], a resident assessment tool) dated 1/24/2025, the MDS indicated Resident 84 was moderately impaired in cognitive (thinking process) skills and was dependent (helper does all the effort to complete the task) in self-care abilities such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe, upper and lower body dressing, putting on and taking off footwear. The MDS indicated Resident 84 was also dependent on mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, and shower transfers. During a review of Resident 84's PASRR level 1 screening dated 10/15/2024, the PASRR level 1 screening was negative, and a Level 2 screening was not required. The reason noted for Resident 84's negative PASRR Level 1 screening was no serious mental illness. The PASRR indicated NO was checked on question number 9, does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? During a concurrent interview and record review on 3/20/2025 at 10:30 a.m., with Registered Nurse Supervisor (RNS) 1, the Level 1 PASRR Screening dated 10/15/2025 was reviewed. RNS 1 stated the PASRR was a preadmission screening before resident gets admitted to the facility. RNS 1 stated residents needs to be evaluated for mental health services and if they were positive, the facility must be able to provide the services needed for the residenst. RNS 1 stated based on Resident 84's medical diagnoses and the medication resident was taking, PASRR Level 1 screening question 9 should have been answer YES to trigger a Level 2 PASRR screening to be completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b.During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including depressive disorder, bipolar disorder, and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's history and physical (H/P) dated 3/1/2025, the H/P indicated the resident had dementia. During a review of Resident 17's MDS dated [DATE], the MDS indicated Resident 17 was severely impaired in cognitive skills and was dependent in self-care abilities such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe, upper and lower body dressing, putting on and taking off footwear. The MDS also indicated Resident 17 was also dependent on mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, and toilet transfers. During a review of Resident 17's PASRR level 1 screening dated 3/1/2025, the PASRR level 1 screening was negative, and a Level 2 screening was not required. The reason noted for Resident 17's negative PASRR Level 1 screening was no serious mental illness. The PASRR indicated NO was checked on question number 9, does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? During a concurrent interview and record review on 3/20/2025 at 10:35 a.m., with RNS 1, the Level 1 PASRR screening dated 3/1/2025 was reviewed. RNS 1 stated that based on the PASRR, Resident 17 had a medical diagnosis of bipolar disorder and depressive disorder, the answer to question 9 should have been YES to trigger Level 2 PASRR screening. RNS 1 stated Resident 17 had the medical diagnoses and was taking psychotropic medication in the past. During an interview on 3/20/2025 at 4:40 p.m. with the Director of Nursing (DON), the DON stated the importance of a PASRR was so the facility can properly assess residents for mental health illness, to provide treatment, and to plan the care provided to residents. The DON stated if residents are not properly screened, residents will not receive the proper treatment, medication and interventions needed. The DON stated if PASRR Level 1 was not screened correctly, it would not trigger the PASRR Level 2 to be done. During a review of the facility's policy and procedure (P/P), titled Policy: Preadmission Screening and Resident Review (PASRR) dated 7/1/2023, indicated the purpose was to ensure each resident with serious mental illness (SMI) and/or intellectual/developmental disability/related conditions (ID/DD/RC) will have the appropriate setting, as well as if any specialized services and/or rehabilitative services would be needed .the facility will submit a new Level I PASRR if there is a significant change in resident's mental or physical condition, the MDS does not match the Level 1 Screening from the GACHs, or any error/discrepancy in the previous PASRR screening.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to ensure one out of eight sampled residents (Resident 87) was accurately screened for a level one Pre-Admission Screening and Resident Review (PASRR, a federal requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care). This deficient practice had the potential for Resident 87 not to receive the necessary care and services for mental health. Findings: During a review of Resident 87's Admission Record (face sheet), the Admission Record indicated Resident 87 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world) and depression (persistent feelings of sadness). During a review of Resident 87's minimum data set (MDS, a resident assessment tool) dated 1/3/2025, the MDS indicated Resident 87 was rarely or never understood. The MDS indicated Resident 87 had depression (a persistent state of sadness and loss of interest in activities that significantly impacts daily life, affecting how you feel, think, and act). During a review of Resident 87's level I PASRR Screening completed on 7/2/024, the level I Screening was negative (did not require a level II PASRR [a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness]). The level I screening, section III- Serious Mental Illness question number 9, diagnosed Serious Mental Illness (Does the individual have a serious diagnosed mental disorder such as depressive disorder) was marked No. During an interview and concurrent record review on 3/20/3035 at 11;49 a.m. with the director of nursing (DON), Resident 87's Level I PASRR Screening was reviewed. The DON stated the Level I PASRR Screening completed on 7/2/2024 was inaccurate because Resident 87 was diagnosed with depression and PTSD so question number 9 should have been marked yes. The DON stated it was important that the Level I PASRR was accurate so as a level II PASRR could be conducted if needed and ensure the facility was meeting all the resident's mental health needs and scheduling mental health follow ups as needed. During a review of the facility's policy and procedure (P/P) titled Policy: Preadmission Screening and Resident Review (PASRR) dated 7/1/2023, the P/P indicated the facility was to submit a new Level I PASRR if there was any error/ discrepancy in the previous PASRR screening or the MDS did not match the Level I screening.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to update the care plan when oxygen (life sustaining component of air) requirements changed for one of three sampled residents (Resident 40). This failure had the potential to result in Resident 40 receiving excessive oxygenation resulting in hypercapnia (elevated carbon dioxide (CO2 waste product of processed oxygen that must be exhaled) in the blood) which can lead to discomfort, difficulty breathing, and causing injury to the resident. Findings: During a review of Resident 40's Admission record , the Admission record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), acute respiratory failure (condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), and chronic obstructive pulmonary disease (COPD-a progressive lung disease causing difficulty in breathing). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 40 required moderate assistance (helper does more than half the effort) for eating, and was dependent (helper does all the effort) for hygiene, toileting, showering, and dressing. During an observation on 3/17/2025 at 9:43 a.m., Resident 40 was observed witting in bed wearing a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) connected to an oxygen concentrator (a machine that makes oxygen). The oxygen concentrator indicated 5 Liters/minute (L/min- unit of measurement) of oxygen was being delivered to the resident. During a review Resident 40's Oxygen (O2) Saturation (Sats amount of oxygen in the blood) Summary, the O2 Sats Summary indicated Resident 40 received Oxygen via Nasal Cannula on 3/14/2025, 3/17/2025, and 3/19/2025. During a concurrent observation and interview on 3/18/2025 at 2 p.m. with licensed vocational nurse (LVN) 1, LVN 1 was observed administering 2L/min to Resident 40. LVN 1 stated Resident 40 has been receiving 2L/min of oxygen through the nasal cannula. During a concurrent interview and record review on 3/18/2025 at 2:06 p.m., with registered nurse supervisor (RNS) 1, Resident 40's chart was reviewed. RNS 1 stated Resident 40 does not have physician orders for oxygen therapy or oxygen saturation monitoring. RNS 1 stated Resident 40 had a care plan initiated on 1/17/2025 and revised on 1/29/2025 indicating Resident is receiving Oxygen therapy due to COPD. RNS 1 stated the care plan did not specify the rate of oxygen. RNS 1 stated the care plan should have been reviewed and revised when Resident 40 was readmitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2025 at 3:51 p.m., with the Director of Nursing (DON), the DON stated care plans are important because they are the guides of care for the residents providing goals and help evaluate effectiveness of an intervention. The DON stated Resident 40's care plans should have been updated when Resident 40 returned to the facility with oxygen. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered, revised March 2023, the P&P indicated the interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the requir3ed quarterly MDS assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 50144 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of five sampled residents (Resident 3 and Resident 40) as evidenced by: A. Failing to ensure a replacement tracheostomy (an incision in the trachea [windpipe] made to relieve an obstruction to breathing) tube, an inner cannula (a removable tube that fits inside the outer cannula of a tracheostomy tube, allowing for easy cleaning and replacement to maintain a clear airway), and an obturator (a thin, curved piece of hard plastic or rubber that is inserted into the tracheostomy tube [cannula] to help with placing the tube into the trachea) were available at the bedside for Resident 3. B. Failing to ensure there was a physician order to administer oxygen (life sustaining element of air) for one of three sampled residents (Resident 40). These failures had the potential to result in Resident 40 receiving excessive oxygen and hypercapnia (elevated carbon dioxide [CO2 waste product of processed oxygen] in the blood) which can lead to discomfort, difficulty breathing, and causing injury to the resident and had the potential to result in respiratory distress (a serious lung condition) for Resident 3 and Resident 40. Findings: A. During a review of Resident 3's Admission Record, the Admission Record indicated, Resident 3 was initially admitted to the facility on [DATE] and last re-admission was on 10/20/2021 with diagnoses including with tracheostomy, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). During a review of Resident 3's History and Physical (H&P), dated 2/2/2025, the H&P indicated, Resident 3 had a conservator (a judge appointed person to act or make decisions for the person) to make healthcare decision. During a review of Resident 3's Minimum Data Set (MDS -a resident assessment tool), dated 2/19/2025, the MDS indicated Resident 3 required dependent assistance (Helper does all the effort) from two or more staff for eating, toileting hygiene, dressing, chair/bed to chair transfer, maximal assistance (Helper does more than half the effort) from one staff for oral hygiene, shower/bathe, personal hygiene, and bed mobility. During a review of Resident 3's Order Listing Report (OLR), dated 3/19/2025, the OLR indicated, change tracheostomy inner cannula every month size 6.4 was ordered on 11/9/2024. During a review of Resident 3's Treatment Administration Record (TAR), dated 3/2025, the TAR indicated, tracheostomy inner cannula size 6.4 was changed on 3/16/2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's untitled Care Plan (CP), initiated 2/27/2020 and revised 3/7/2025, the CP Focus indicated, Resident 3 receives special treatments for tracheostomy tube care with risk for accidental decannulation (removal of the tracheostomy tube) and associated respiratory distress. The CP Goal indicated, minimize risk of accidental decannulation and associated respiratory distress. The CP Interventions indicated, if decannulation occurs, replace tracheostomy tube with same size or smaller as soon as possible. The CP Interventions indicated, keep extra trach tube same size or smaller at bedside with other tracheostomy supplies. During a concurrent observation and interview on 3/17/2025, at 2:34 p.m., with Resident 3 in her room, Resident 3 was sitting on a wheelchair and a tracheostomy with a red cap on was noted. There was no extra replacement tracheostomy tube, inner tube, and obturator at the bedside. Resident 3 stated, she could eat and speak with a special cannula. Resident 3 stated, she did not have an extra cannula at the bedside. During a concurrent observation and interview on 3/19/2025, at 10:49 a.m., with Treatment Nurse (TN) 1 in Resident 3's room, TN 1 was looking for extra replacement tracheostomy tube, inner cannula, and obturator, but she could not find them. TN 1 stated, Resident 3 had a Shiley fenestrated cannula (tracheostomy tube that has holes in the outer cannula to help airflow. This can help people speak and cough more effectively) size 6.5 but she was not sure. TN 1 stated, there was no extra replacement tube, inner cannula, and obturator at the bedside for emergency, and she asked Registered Nurse Supervisor (RNS) 1 to bring them. TN 1 stated, they should be available at Resident 3's bedside at all times for emergencies such as dislodgement (the tube comes out unintentionally) of tube and blockage of tracheostomy. During an interview on 3/20/2025, at 3:51 p.m., with the Director of Nursing (DON), the DON stated, all emergency tracheostomy care supplies should be at the bedside of Resident 3. The DON stated extra supplies were stored in her office and in the emergency cart as well for emergency situations. The DON stated, if the emergency supplies were not available at the bedside, the resident might be on respiratory distress. b. During a review of Resident 40's Admission record , the Admission record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), acute respiratory failure (condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), and chronic obstructive pulmonary disease (COPD-a progressive lung disease causing difficulty in breathing). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 40 required moderate assistance (helper does more than half the effort) for eating, and was dependent (helper does all the effort) for hygiene, toileting, showering, and dressing. During an observation on 3/17/2025 at 9:43 a.m., Resident 40 was observed sitting in bed wearing a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) connected to an oxygen concentrator (a machine that makes oxygen). The oxygen concentrator indicated 5 Liters/minute (L/min- unit of measurement) of oxygen was being delivered to the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review Resident 40's Oxygen (O2) Saturation (Sats amount of oxygen in the blood) Summary, the O2 Sats Summary indicated Resident 40 received Oxygen via Nasal Cannula on 3/14/2025, 3/17/2025, and 3/19/2025. During a concurrent observation and interview on 3/18/2025 at 2 p.m., with licensed vocational nurse (LVN) 1, LVN 1 was observed administering oxygen at 2L/min to Resident 40. LVN 1 stated Resident 40 has been receiving 2L/min of oxygen through the nasal cannula. During a concurrent interview and record review on 3/18/2025 at 2:06 p.m., with registered nurse supervisor (RNS) 1, Resident 40's orders were reviewed. RNS 1 stated Resident 40 does not have physician orders for oxygen therapy or oxygen saturation monitoring. RNS 1 stated a physician order including the level of oxygen to administer and oxygen saturation monitoring is required to administer oxygen to a resident. RNS 1 stated administering oxygen without an order can place the resident at risk of shortness of breath secondary to hyperoxygenation (excessive oxygenation that the lungs are not able to process). During an interview on 3/20/2025 at 3:51 p.m., with the Director of Nursing (DON), the DON stated oxygen requires an order from the physician. The DON stated the order should include the amount of oxygen, oxygen saturation monitoring, parameters for when to increase or titrate, and when to change the tubing. The DON stated, if a resident receives oxygen without an order, there is a risk of giving too much oxygen and causing injury to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Tracheostomy Care, revised 8/2013, the P&P indicated, General Guidelines: 4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly). 5. Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies.6. A replacement tracheostomy tube must be available at the bedside at all times. 7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. During a review of the facility's policy and procedure (P&P), titled Oxygen Administration, revised October 2010, the P&P indicated the facility is to verify that there is a physician's order for this procedure and review the physician's orders or facility protocol for oxygen administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31333 Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rate of five percent (5%) or greater, as evidenced by the identification of two medication errors out of 26 opportunities (observations during medication administration), to yield a cumulative error rate of 7.69% for one out of five residents (Resident 186) observed during the medication administration facility task when: 1. Licensed Vocational Nurse (LVN) 2 did not monitor Resident 186 during two separate, breathing treatments of Ipratropium-albuterol solution inhalation solution and Budesonide inhalation suspension (medications to help control symptoms of lung diseases) via nebulizer (a device that converts liquid medication into a mist that can easily be inhaled to treat wheezing, shortness of breath, and other respiratory issues) . 2. LVN 2 did not instruct Resident 186 to rinse her mouth after a breathing treatment via nebulizer of Ipratropium-Albuterol inhalation solution (used to help control the symptoms of lung diseases) in accordance with the physician's order. These deficient practices had the potential to result in the resident having unmonitored adverse drug adverse reaction such as increase heartbeat, chest pain, nervousness, dizziness and headache, as well as the potential to result in developing oral thrush (an infection in which the fungus Candida albicans accumulates in the mouth). Findings: During a review of Resident 186's Admission Record, the Admission Record indicated the facility admitted the resident on 3/11/25 with diagnoses including acute respiratory failure with hypoxia (a serious condition where lungs struggle to deliver enough oxygen to the blood leading to low oxygen levels). During a review of Resident 186's Minimum Data Set, (MDS, a resident assessment tool), dated 3/17/2025, the MDS indicated the resident was cognitively (ability to think, understand and make decisions) intact. During a review of Resident 186's Order Summary Report, dated 3/11/2025, the report indicated a physician's orders for the following medications: Administer Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 3 milligrams (mg-unit of measurement of weight)/3 milliliter (ml -unit of measurement of volume) 1 vial, inhale orally via nebulizer every 4 hours for chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) with a start date of 3/12/2025 Administer Budesonide Inhalation Suspension 0.5 mg/2 ml 1 vial inhale orally via nebulizer every 12 hours for SOB (shortness of breath)/Wheezing with a start date of 3/12/2025 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication administration on 3/19/2025 at 8:48 a.m., with Licensed Vocational Nurse (LVN) 2 was observed preparing nine medications for Resident 186 including Ipratropium -Albuterol Inhalation Solution 0.5-2.5 3mg/3ml and Budesonide Inhalation Suspension 0.5 mg/2ml via nebulizer. During a concurrent observation and interview on 3/19/2025 at 9:25 a.m. with LVN 2, LVN 2 was observed administering the Ipratropium/albuterol nebulizer solution and started the nebulizer machine. LVN 2 stated the resident had to finish the nebulizer solution of Ipratropium/albuterol first and the medication runs about 15-20 minutes. LVN 2 stated a timer was set to 9:48 a.m to come back and to start Budesonide treatment for Resident 186 and check other residents. During a concurrent observation and interview on 3/19/2025 at 9:49 a.m. with LVN 2, LVN 2 stated she had just returned to check on Resident 186 albuterol solution to change to the next nebulizer solution Budesonide. LVN 2 stated she had not returned to check on resident since the breathing treatment was started. LVN 2 stated she would put an alarm again for 15 minutes, then go to other residents and would return at 10:11 a.m. During a concurrent observation and interview on 3/19/2025 at 10:12 a.m. with LVN 2, LVN 2 entered the room and stated the mask looked like it slid down and was not fully covering the Resident 186's nose. LVN 2 instructed Resident 186 to rinse mouth with water and spit into a basin. During an interview on 3/19/2025 at 10:20 a.m. with Resident 186, Resident 186 stated nurses would put on the nebulizer mask and leave the room. Resident 186 stated sometimes her mask would come off and she would put it back on. During an interview on 3/19/2025 at 10:34 a.m. with LVN 2, LVN 2 stated she would leave the Resident 186 alone during breathing treatment and while away would not be able to see if the resident was receiving the medications correctly. LVN 2 stated she was not aware that the mask for nebulizer solution for Resident 186's sometimes falls off and the resident had to put it back on herself. LVN 2 stated she supposed to stay with resident until medication was completely administered, but did not. During a concurrent interview and record review on 3/19/2025 at 3:30 p.m. with LVN 2, the Resident 186's Medication Administration Record flowsheet, (MAR, are reports that tracks medication a physician prescribes to a patient that includes medication name, dose taken, and special instructions) was reviewed. The MAR indicated, Ipratropium-Albuterol Inhalation Solution 0.5-2.5 3mg/3ml 1 vial inhale orally via nebulizer every 4 hours for COPD, rinse mouth after medication administration. LVN 2 stated had not instructed Resident 186 to rinse mouth after Ipratropium-Albuterol breathing treatment via nebulizer but had Resident 186 rinse his mouth after the Budesonide medication administration via nebulizer. LVN 2 stated it was important for Resident 186 to rinse his mouth to prevent having a residual of medication in the mouth and to prevent oral thrush (fungal infection of the mouth). During an interview on 3/20/2025 at 4:53 p.m. with Director of Nursing (DON), the DON stated the nurse should remain with the resident until a breathing treatment was finished to assess for adverse reaction even if the resident was alert. DON stated the resident should also be instructed to rinse mouth in between and after breathing treatment to prevent oral thrush. The DON stated if it was not done there would be a risk of medication interaction, risk of infection oral candidiasis of the mouth (a condition in which a fungus builds up in the mouth). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Administering Medications, Revised March 2023, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders. During a review of facility's policy and procedure (P&P) titled, Administering Medication through a Small Volume (Handheld) Nebulizer, Revised in March 2023, the P&P indicated, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway .Steps in the Procedure .15. Remain with the resident for the treatment.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 71), was free of significant medication error. The facility failed to ensure Resident 71 was not administered three doses of expired Advair (fluticasone and salmeterol, is a combination inhaler medication used to treat asthma and chronic obstructive pulmonary disease (COPD) by opening airways and reducing inflammation) Diskus (a dry powder inhaler), by three different licensed nurses between [DATE] - [DATE]. This deficient practice resulted in Residents 71 having an increased risk of receiving subtherapeutic (lower than prescribed to treat a disease effectively) doses of medication to treat breathing difficulty and shortness of breath, which could lead to respiratory distress (a condition where breathing becomes difficult or labored), respiratory failure (a serious condition that makes it difficult to breathe on your own), hospitalization , or death. Findings: During a review of Resident 71's Admission Record (a document containing diagnostic and demographic information), the Admission Record indicated Resident 71 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute (sudden onset) upper and Lower Respiratory Infection (an infection that may interfere with normal breathing) and Asthma. During a review of Resident 71's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], the MDS indicated for Resident 71's there was no behavior present for inattention, disorganized thinking, and no altered level of consciousness. Resident 71's MDS indicated the resident was independent for eating and was dependent, requiring the assistance of two or more staff for oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 71's Order Summary Report, the Order Summary Report indicated Resident 71's orders included an order for Advair Diskus 250 micrograms (mcg, unit of measure weight) per 5.0 mcg (Fluticasone, 250 mcg and Salmeterol 50 mcg), instructions indicated to inhale 1 (one) puff orally (by mouth) every 12 hours for COPD. Rinse mouth after use, order dated [DATE] During a review of Resident 71's, Care Plans, the care plans for Resident 71 indicated the following: - Focus indicated, resident is at risk for respiratory distress (shortness of breath, irregular respiration, wheezing/crackles, rhonchi, activity intolerance, edema) related to COPD, Asthma, HF (heart failure), history of COVID. On [DATE] readmitted with diagnosis of upper respiratory infection, care plan date initiated [DATE], revised [DATE]. - Goal indicated, resident will have no unrecognized signs and symptoms of respiratory distress daily. Will reduce episodes and symptoms of respiratory distress thru appropriate interventions daily. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Interventions included, assess the resident for shortness of breath, irregular respiration, wheezing, crackles, rhonchi, coughing, weakness, chest pain, activity intolerance, excessive secretions, and to inform MD promptly, administer medication and breathing treatment as ordered. During an interview on [DATE], at 12:25 PM at MedCart 4A with Licensed Vocational Nurse (LVN) 1, one inhaler of fluticasone and salmeterol 250 mcg/50 mcg was found with an open date of [DATE], labeled for Resident 71. LVN 1 stated she administered a dose of fluticasone and salmeterol 250 mcg/50 mcg inhaler to Resident 71 this morning ([DATE]). LVN 1 stated Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler was opened on [DATE] and expired on [DATE] and should have been removed and not administered to the resident after [DATE]. During an interview on [DATE] at 12:32 PM with LVN 1, LVN 1 stated expired medication (fluticasone and salmeterol 250 mcg/50 mcg inhaler) will not be as effective in treating Resident 71's COPD. LVN 1 stated administering expired inhalation medication to Resident 71 may cause the resident to experience breathing difficulties, such as respiratory distress and shortness of breath. LVN 1 stated the expired inhaler, fluticasone and salmeterol 250 mcg/50 mcg, labeled for Resident 71 should have been removed from the medication cart, reordered, and not available for administration to the resident. During an interview on [DATE] at 1:02 PM with a Registered Nurse Supervisor (RNS) 1, RNS 1 stated, fluticasone and salmeterol 250 mcg/50 mcg inhaler expires after 30 days and should not remain inside of the medication cart, because a licensed nurse may administer the medication to a resident without checking the expiration date. RNS 1 stated administering an expired medication may reduce the efficacy, potency, and quality of the medication and the resident may not respond well to the treatment and cause the resident to need the medication sooner than prescribe and lead to medication errors. During a concurrent interview, record review, and review of the manufacturer's label on [DATE], at 1:09 PM with RNS 1, RNS 1 reviewed the manufacturer's labeling for Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler, the manufacturer's label indicated, Discard the inhaler 1 (one) month after opening the foil pouch or when the counter reads '0' (zero, after all blisters have been used), whichever comes first. Resident 71's electronic Medication Administration Record (eMAR, a digital system used in healthcare to track and document medication administration) was reviewed for the month of ,d+[DATE]. RNS 1 stated three different nurses administered fluticasone and salmeterol 250 mcg/50mcg inhaler to Resident 71 after the expiration date of [DATE]. RNS 1 stated the licensed nurses should have checked expiration date before administering the expired fluticasone and salmeterol 250 mcg/50 mcg inhaler to Resident 71. The eMAR documentation indicated Resident 71 was administered fluticasone and salmeterol 250 mcg /50 mcg inhaler after the expiration on: [DATE] at 9:38 am scheduled for 9 am administration was initialed by LVN 4 [DATE] at 20:45 pm scheduled for 9 pm administration was initialed by LVN 5 [DATE] at 8:22 am, scheduled for 9 am administration was initialed by LVN 1 During an interview on [DATE] at 1:35 PM, with Resident 71 inside of the resident's room, Resident 71 stated her breathing treatment did not help too much today ([DATE]), she is having a hard time breathing. Resident 71 stated, sometimes her breathing is difficult. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:48 PM, with the Director of Nursing (DON) inside of the DON's office, DON stated the purpose of putting an open date on Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler was to ensure a replacement inhaler was ordered and received from the pharmacy before the current medication expires. DON stated administering medication after expiration is a medication error and can cause an adverse reaction to the resident. DON stated Resident 71 may not receiving the full dose of medication, which could increase the risk for breathing difficulty, respiratory distress, a worsening of the resident's COPD, and could lead to hospitalization and death. During a review of the facility's policy and procedures titled, Administering Medications, dated ,d+[DATE], indicated, Medications are administered in a safe and timely manner, and as prescribed .The expiration/beyond use date on the medication label is checked prior to administering.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview and record review, the facility failed to: a.the facility failed to ensure one of one (Resident 114) did not store TUMS (over- the-counter (OTC) antacids [medication used to relieve heartburn and indigestion) at bedside in accordance with the facility's policy. This failure had the potential for Resident 114 to be at risk for medication interactions, Resident 114's physician missing symptoms that the resident is self-treating, abusing the medication, and possible overdose. b. Remove an expired inhaler, fluticasone 250 micrograms (mcg, unit of measure weight) and salmeterol 50 mcg, (Advair, a combination medication used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease [COPD], a chronic lung disease) 250 mcg/50mcg Inhalation Powder from one of four inspected medication carts (MedCart) 4A affecting one of three residents (Residents 71). The deficient practices of failing to remove expired medications from the medication carts increased the risk and resulted in Residents 71 receiving three doses of expired medication that could have become ineffective or toxic due to improper storage which could leading to shortness of breath, respiratory failure (a serious condition that makes it difficult to breathe on your own), hospitalization or death. (Cross Reference F760) Findings: a.During a review of Resident 114's Admission record, the Admission Record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including cholangitis (inflammation of the bile ducts [tube that releases digestive secretions), muscle weakness, and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of sacral region. During a review of Resident 114's History and Physical (H&P), dated 6/17/2024, the H&P indicated Resident 114 had the capacity to understand and make decisions. During a review of Resident 114's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 114's cognition (ability to learn reason, remember, understand, and make decisions) was intact, required setup or clean-up assistance for eating, required moderate assistance (helper did less than half the effort) for eating, and dependent (helper does all of the effort) for toileting and bathing. During a review of Resident 114's order summary report, Resident 114 did not have a physician order to self-administer TUMS or an antacid. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/17/2025 at 11:23 a.m., with Resident 114, Resident 114 had a bottle of TUMS at bedside. Resident 114 stated the staff (unidentified) told her (Resident 114) to put her antacid medication away because the state surveyors were in the facility. Resident 114 stated she took the TUMS a few times and the staff (unidentified) are aware that the bottle of TUMS is at bedside. During a concurrent observation and interview on 3/17/2025 at 3:23 p.m., with licensed vocational nurse (LVN) 1, Resident 114 was observed to have the TUMS at bedside. LVN 1 stated TUMS should not be at the bedside and needed a physician order to be administered to the resident. During a concurrent interview and record review on 3/20/2025 at 2:45 p.m. with the registered nurse supervisor (RNS) 1, Resident 114's Self Administration of Drugs Assessment, dated 6/17/2025, was reviewed. RNS 1 stated the assessment indicated Resident 114 was unable to state the appropriate situation for self-administration of PRN (given as needed or requested) medications and required assistance to correctly read labels and/or identify each medication, correctly state what each medication is for, correctly state the time/frequency medications are to be taken, and correctly state the correct dosage/quantity for each administration. RNS 1 stated only authorized facility staff should have access to all residents' medications. RNS 1 stated when residents can self-administer medications stored at the bedside it places the resident at risk for medication interactions, missed symptoms that the resident is self-treating, abusing the medication, and possible overdose. During a review of the facility's policy and procedure (P&P), titled Self-Administration of Medications, revised February 2021, the P&P indicated if the team determines a resident cannot safely self-administer medications, the nursing staff administers the resident's medications any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. b. During a review of Resident 71's Admission Record (a document containing diagnostic and demographic information), the Admission Record indicated Resident 71 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute (sudden onset) upper and Lower Respiratory Infection (an infection that may interfere with normal breathing) and Asthma. During a review of Resident 71's MDS dated [DATE], the MDS indicated for Resident 71's there was no behavior present for inattention, disorganized thinking, and no altered level of consciousness. Resident 71's MDS indicated the resident was independent for eating and was dependent, requiring the assistance of two or more staff for oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 71's Order Summary Report, the Order Summary Report indicated Resident 71's orders included an order for Fluticasone and Salmeterol 250 mcg/50 mcg, instructions indicated to inhale 1 (one) puff orally (by mouth) every 12 hours for COPD. Rinse mouth after use, order dated 2/14/25 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/19/25, at 12:25 PM at MedCart 4A with Licensed Vocational Nurse (LVN) 1, one inhaler of fluticasone and salmeterol 250 mcg/50 mcg was found with an open date of 2/15/25, labeled for Resident 71. LVN 1 stated she administered a dose of fluticasone and salmeterol 250 mcg/50 mcg inhaler to Resident 71 this morning (3/19/25). LVN 1 stated Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler was opened on 2/15/25 and expired on 3/17/25 and should have been removed and not administered to the resident after 3/17/25. During an interview on 3/19/25 at 1:02 PM with RNS 1, RNS 1 stated, fluticasone and salmeterol 250 mcg/50 mcg inhaler expires after 30 days and should not remain inside of the medication cart, because a licensed nurse may administer the medication to a resident without checking the expiration date. RNS 1 stated administering an expired medication may reduce the efficacy, potency, and quality of the medication and the resident may not respond well to the treatment and cause the resident to need the medication sooner than prescribe and lead to medication errors. During a concurrent interview, record review, and review of the manufacturer's label on 3/19/25, at 1:09 PM with RNS 1, RNS 1 reviewed the manufacturer's labeling for Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler, the manufacturer's label indicated, Discard the inhaler 1 (one) month after opening the foil pouch or when the counter reads '0' (zero, after all blisters have been used), whichever comes first. Resident 71's electronic Medication Administration Record (eMAR, a digital system used in healthcare to track and document medication administration) was reviewed for the month of 3/2025. RNS 1 stated three different license nurses administered expired fluticasone and salmeterol 250 mcg/50mcg inhaler to Resident 71 on: 3/19/25 at 9:38 am scheduled for 9 am administration initialed by LVN 4 3/18/25 at 20:45 pm scheduled for 9 pm administration initialed by LVN 5 3/18/25 at 8:22 am, scheduled for 9 am administration initialed by LVN 1 During an interview on 3/19/25 at 1:48 PM, with the Director of Nursing (DON) inside of the DON's office, DON stated the purpose of putting an open date on Resident 71's fluticasone and salmeterol 250 mcg/50 mcg inhaler was to ensure a replacement inhaler was ordered and received from the pharmacy before the current medication expires. During a review of the facility's policy and procedures titled, Administering Medications, dated 3/23, indicated, The expiration/beyond use date on the medication label is checked prior to administering. During a review of the facility's policy and procedures titled, Medication Labeling and Storage, dated 2/23, indicated The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated ore deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 50144

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) titled, Dental services, revised 12/2016, which indicated routine and emergency dental services were available to meet residents' oral health services in accordance with the resident's assessment and plan of care by not replacing missing dentures and following up after a dental visit for one of three sampled residents (Resident 66). This deficient practice had the potential to result in Resident 66 having discomfort while eating or chewing foods that could lead to unintended weight loss and lower self-esteem. Findings: During a review of Resident 66's Admission Record, the Admission Record indicated, Resident 66 was initially admitted to the facility on [DATE] and last re-admission was on 10/11/2024 with diagnoses including dysphagia (difficulty swallowing), cerebral infarction (loss of blood flow to a part of the brain) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 66's History and Physical (H&P), dated 10/12/2024, the H&P indicated, Resident 66 had the capacity (ability) to understand and make decision. During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), dated 1/29/2025, the MDS indicated Resident 66 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, oral hygiene, bed mobility, chair/bed to chair transfer, dressing, and supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistant as resident completes activity) for eating. The MDS indicated, Resident 66 had no natural teeth or tooth fragments (edentulous). During a review of Resident 66's Order Listing Report (OLR), dated 3/19/2025, the OLR indicated, provide dental consult and treatment as needed for dental problems was ordered on 10/11/2024. During a review of Resident 66's Social Service Notes (SSN), dated from 2/4/2025 to 3/18/2025, the SSN indicated, there was no follow up notes regarding Resident 66's denture. During a review of Resident 66's untitled Care Plan (CP) revised 3/22/2024, the CP Focus indicated, alteration in nutritional status related to edentulous (no natural teeth). The CP Goal indicated, minimize any unplanned weight changes daily. The CP Interventions indicated, observe for chewing or swallowing difficulties and dental consult if needed. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/17/2025, at 2:59 p.m., with Resident 66 in her room, Resident 66 did not have natural teeth. There were no dentures noted at the bedside. Resident 66 stated, she did not know where her dentures were. Resident 66 stated, the first set of dentures she got did not fit properly and the second set of dentures were missing. Resident 66 stated, she requested new dentures to the Social Service Director (SSD), but no one had updated her on the status of her replacement dentures. Resident 66 stated, she had discomfort while she was trying to eat or chew foods due to missing teeth. Resident 66 stated, she felt embarrassed when she was talked to other people because she had no teeth. During a concurrent interview and record review on 3/19/2025, at 2:57 p.m., with the SSD, Resident 66's Dental Notes, dated 3/7/2025 were reviewed. The Dental Notes indicated, Resident 66 lost her dentures a few months ago, but Resident 66 said she did not want new ones. The Dental Notes indicated, Resident 66 was unable to receive treatment. The SSD stated, she did not know why Resident 66 declined a new set of dentures and she did not follow up with Resident 66 to find out the reason of refusal. The SSD stated, she should have followed up with Resident 66 and found out the reason she refused the dentures because providing the dentures to Resident 66 was important to prevent weight loss. During an interview on 3/20/2025, at 3:51 p.m., with the Director of Nursing (DON), the DON stated, providing dentures to Resident 66 in a timely manner was important because it could negatively affect the ability to eat, and it could lead to social isolation. The DON stated, the SSD should have followed up with Resident 66 after Resident 66's dental visit of 3/7/2025 because she might be able to help the resident. During a review of the facility's Policy and Procedure (P&P) titled, Dental services, revised 12/2016, the P&P indicated, Policy Statement: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Policy Interpretation and Implementation: 6. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible . 10. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. 11. All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred. During a review of the facility's Policy and Procedure (P&P) titled, Job Description: Social Services Designee, dated 3/12/2014, the P&P indicated, Essential Duties: o Assists in the provision of the medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident o Facilitates any identified problems, e.g., dental visual, communication, etc. Assists with supplying a communication board or whatever tools necessary to ensure communication to make resident needs known. o Creates, reviews and updates care plan and progress notes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a microscope) that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for 114 out of 130 total residents in the facility by not: A. Ensuring food Items were dated, labeled, and sealed properly. B. Ensuring the temperature of ground beef patties in the steam tray were above 155 Fahrenheit (F) per facility's Policy and Procedure (P&P) titled, Meal Service, undated, which indicated, food temperature would be taken to ensure ground meat or ham was at least 155 degrees Fahrenheit, during the trayline (Resident's trays are assembled and checked for accuracy before food is delivered to them). C. Ensuring Dietary Aid (DA) 1 performed hand hygiene (washing hands) and changed gloves between tasks during trayline. These failures had the potential to result in pathogen (germ) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, and can lead to other serious medical complications and hospitalization . Findings: A. During a concurrent observation and interview on [DATE], at 8:20 a.m., with Dietary Supervisor (DS), in the dry storage area, there were food items that were not dated as follows: a. Opened and used seasoned breadcrumbs in a plastic bin with no Receiving Date (RD- the day of delivery), Open Date (OD) of [DATE], and no Use By (UB). b. Opened and used dry grits in a pack that was not sealed, and the side portion was open to air with RD of [DATE], OD of [DATE], and no UD c. Opened and used dry green split peas in a plastic container with no RD, OD of[DATE] and no UB. d. Opened and used dry barley in a plastic container with no RD, OD of[DATE] and no UB. e. Opened and used small white beans in a plastic container with no RD, OD of[DATE] and no UB. f. Opened and used Sliced Rye bread in a plastic bag with RD of [DATE], OD of [DATE] and no UB. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DS stated, all food items should have been labeled with receiving date when the facility got delivery from vendors. The DS stated, all food items should have open date and used by date (expiration date). The DS stated, it was all dietary staff (including herself) responsibility to check all food items for labels, dates, properly stored and sealed. The DS stated these practices were important to make sure all food items were in good condition because the residents consumed these food items. The DS stated, all opened food items should be closed tightly to prevent contamination (the unwanted pollution of something by another substance). The DS stated, once the food items were opened, each food item has a different shelf life (a time limit on how long a product can be stored before it becomes unsuitable for consumption or use). The DS stated, all staff should refer to the Dry Goods Storage Guidelines for shelf life after opening and label UB date on food items. During a concurrent observation and interview on [DATE], at 8:39 a.m., with the DS, in the walk- in refrigerator, there were food items that were not dated, labeled, and properly sealed, as follows: a. Prepared chicken salad in plastic container with preparation date of [DATE] with no UB b. Opened and used butter milk ranch dressing in a plastic container (dressing was dripping from the cap to outer side of the container) with no RD, OD of [DATE], and no UB c. Opened and used mustard in a plastic container with no RD, OD of [DATE], and no UB. d. Opened and used sour cream in a plastic container with RD of [DATE], OD [DATE], and UB. e. Opened and used sliced American Cheese (no label) with RD of [DATE], OD [DATE], and no UB. f. Prepared fruit plate in small plate (no label) with preparation date of [DATE] with no UB. The DS stated, all food items should be dated, and dietary staff should follow the Refrigerator and Freezer Storage Chart to ensure safety of perishable items that required refrigeration. The DS stated, all pre-made or prepared food items should have the labels and UB. During a concurrent observation and interview on [DATE], at 8:44 a.m., with [NAME] (CK) 1, dry seasoning shelf near the sink, there were food items that were not dated and properly sealed, as follows: a. Opened and used Paprika powder in a plastic container (lid was opened) with RD of [DATE], OD of [DATE], and no UB. b. Opened and used Onion powder in a plastic container (lid was opened) with RD of [DATE], OD of [DATE], and no UB. CK 1 stated, all lids should be closed tightly, and all food items should have UB. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Storage of Canned and Dry Goods, revised 2019, the P&P indicated, Policy: Food and supplies will be stored properly and in a safe manner. Procedures .7. Food items will be dated and labeled when placed in the containers .9. Remove food from packaging boxes upon delivery to minimize pests. Loose items should be placed in containers or bins. Bins will be dated, labeled, and covered . 13. All food products will be used according to the specified Food Storage Guidelines. During a review of the facility's Policy and Procedure (P&P) titled, Procedure for Refrigerated Storage, revised 2019, the P&P indicated, Procedures: 6. Leftover food or unused portions of packaged foods should be covered, dated, and labeled to ensure they will be used first .11. All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: Delivery date -upon receipt, Open date-opened containers of Potentially Hazardous Foods (PHF), Thaw date-any frozen items. During a review of the facility's Policy and Procedure (P&P) titled, Dating and Labeling, undated, the P&P indicated, Policy: To ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. Procedure: 4. All items should be properly covered, dated, and labeled .6. No food item that is expired or beyond the best buy date are in stock. During a review of the facility's Policy and Procedure (P&P) titled, Labeling: Food in Refrigerator, undated, the P&P indicated, Policy: Food that is cooked or open and placed into refrigerator will be labeled with name of food item and date placed in refrigerator. Procedure: 1. Items in refrigerator will be properly covered, dated, and labeled .3. Food items will be removed and discarded after 72 hours of placement in refrigerator. B. During a concurrent observation and interview on [DATE], at 12:03 p.m., with CK 1, in the kitchen during the trayline for lunch, CK 1 was checking the temperature of food items in steam trays. CK 1 checked the temperature of the ground beef patties and the thermometer (an equipment to check the temperature) indicated, the temperature reading was 138F. CK 1 stated, she did not know why the temperature dropped dramatically, because it was above 190F when she checked the temperature at 11:55 a.m. During an interview on [DATE], at 12:13 p.m., with the DS stated, the DS stated meat temperature should be above 165F for safety, because if the food items were not reached certain levels of temperature, food might be spoiled and make the residents sick. During a review of the facility's Policy and Procedure (P&P) titled, Meal Service, undated, the P&P indicated, Procedure: Food temperature will be taken to ensure all hot foods are at a proper serving temperature. Food temperature will be recorded daily. Food item: ground meat or ham - at least 155 degrees Fahrenheits. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. During a concurrent observation and interview on [DATE], at 12:23 p.m., with Dietary Aid (DA) 1 in the kitchen, DA 1 touched a juice cup with bare hands and then put gloves on without washing hands. DA 1 pushed the lunch cart toward the door after putting the gloves on. DA 1 started touching the clean lids for the plates without washing hands or changing gloves after touching the cart. DA 1 stated, she should have performed hand hygiene and changed her gloves between the tasks to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). During an interview on [DATE], at 3:51 p.m., with Director of Nursing (DON) , the DON stated, all staff should perform hand hygiene between tasks to prevent cross contamination and protect vulnerable residents from infections. During a review of the facility's Policy and Procedure (P&P) titled, Hand Washing, undated, the P&P indicated, Hand washing: 2. After handling carts, soiled dishes and utensils .Use of Disposable Gloves: 1. Disposable gloves will be worn when handling food directly with bare hands to prevent food borne illnesses. 2. Disposable gloves are a single use item and should be discarded after each use. 3. Hands are to be washed before putting on disposable gloves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 49573 Based on observation. interview and record review, the facility failed to implement infection control measures by failing to: A. Ensure padded side rails (a padded side fitted to a bed for safety) that were wrapped with foam (a soft, porous material, and the degree of porosity can vary depending on the type of foam) and paper tape were disinfected (the process of cleaning something, especially with a chemical, to destroy bacteria) properly for one of three sampled residents (Resident 70). B. Ensure Treatment Nurse (TN)1 performed hand hygiene while she was checking lunch trays in dining room. C. Implement the facility's policies and procedures (P&P) titled Handwashing/Hand Hygiene, revised in April 2023 which indicated, all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors before and after direct contact with residents; .before preparing or handling medications, when Licensed Vocational Nurse (LVN 1), did not perform hand hygiene after medication preparation and prior to administration for one of one resident (Resident 334). These failures had the potential to result in compromised infection control measures to prevent the potential spread of infection among residents, staff, and visitors. Findings: A. During a review of Resident 70's Admission Record, the Admission Record indicated, Resident 70 was admitted to the facility on [DATE] with diagnoses including seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), liver transplant (the replacement of a diseased liver with the healthy liver from another person), and peritonitis (a redness and swelling [inflammation] of the lining of the belly or abdomen). During a review of Resident 70's History and Physical (H&P), dated 3/13/2025, the H&P indicated, Resident 70 had no capacity (ability) to understand and make decisions. During a review of Resident 70's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2025, the MDS indicated Resident 70 was dependent and required assistance (Helper does all of the effort) from two or more staff for toilet hygiene, shower/bathe, dressing, personal hygiene, maximal assistance (Helper does more than half the effort) from one staff for bed mobility, and chair/bed to chair transfer. During a review of Resident 70's Order Listing Report (OLR), dated 3/19/2025, the OLR indicated, place bilateral upper half side rails up with floor mat to decrease potential injury was ordered on 12/3/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's Care Plan (CP), revised on 1/18/2023, the CP Focus indicated, Resident 70 had seizure disorder and at risk for injury. The CP Goal indicated, Resident 70 will have no injury. The CP Interventions indicated, provide padded siderails if indicated. During a review of Resident 70's Care Plan (CP), revised on 1/21/2023, the CP Focus indicated, Resident 70 was at high risk for infection. The CP Goal indicated, reduce risk for active infection. The CP Interventions indicated, cleaning and disinfection of equipment and high touch surface areas. During an observation on 3/17/2025, at 2:26 p.m., in Resident 70's room, Resident 70's siderails were wrapped with foam and paper tape. During a concurrent observation and interview on 3/19/2025, at 10:49 a.m., in Resident 70's room, with the Maintenance Supervisor (MS), of Resident 70's siderails, the siderails were wrapped with foams and paper tapes and the left side of the paper tape was peeling off and hanging loose. The MS stated the foam was placed to prevent Resident 70 from head injuries due to seizures. The MS stated, housekeepers cleaned the foam with a bleach germicidal (a substance that containing a substance that kills germs) wipes. The MS stated, he did not realize that the label indicated, it was for nonporous (does not allow liquid or air to pass through it) and hard surfaces. The MS stated, the bleach germicidal wipes were not the appropriate cleaning agents to clean foam and paper tape. The MS stated, if the foam and paper tapes were not cleaned with a proper sanitizing (the process of removing germs either by cleaning or by disinfecting surfaces) solution, it would cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and spreading infection because it would not kill bacteria effectively. During an interview on 3/19/2025, at 4 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated, that the manufacturer's instructions on the products indicated they were to be used on hard, nonporous surfaces. The IPN stated that the foam and paper tape wrapped on the bedrails were not appropriate because they were porous and could cause the surface to not be cleaned properly, and the sanitizing agent could also break down the foam and tape. The IPN stated, this practice would place vulnerable residents at risk for infection. During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 4/2023, the P&P indicated, Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Policy Interpretation and Implementation . c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. (2) Non-critical environmental surfaces include bed rails, bedside tables, etc. (3) Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturer's instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA registered disinfectant products are followed (e.g. , use-dilution, shelf life, storage, material compatibility, safe use and disposal). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a concurrent observation and interview with Treatment Nurse (TN) 1, in the dining room during dining observation, TN 1 was checking the resident's lunch trays. TN 1 touched the resident's tray and lifted the lid. After lifting the lid, TN 1 did not wash her hands, and she touched a diet listing document and flipped the pages. After confirming the diet order, TN 1 touched the next tray and lifted the lid without performing hand hygiene. While TN 1 was checking the resident's tray, TN 1 pulled down her mask then she touched the door of the lunch cart. Without washing her hands or changing gloves, TN 1 touched another resident's tray. TN 1 stated, she should have washed her hands between tasks, and she should have performed hand hygiene when she touched her mask before checking the tray to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). During an interview on 3/19/2025, at 4 p.m., with the IPN, the IPN stated, hand hygiene should be performed between tasks and after touching high touch surfaces (those that people frequently touch with their hands, which could therefore become easily contaminated with microorganisms and picked up by others on their hands). The IPN stated, the staff should have sanitized the hands when touching the trays after touching her mask and the door of the lunch cart. During an interview on 3/20/2025, at 3:51 p.m. with the Director of Nursing (DON), the DON stated, all staff should perform hand hygiene before, after, and between the tasks. The DON stated hand hygiene was the first line of defense against infection. DON stated, touching the surfaces could cause cross contamination and staff should have performed hand hygiene to protect the residents and themselves. During a review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene, reviewed 10/2023, the P&P indicated, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene. 1.All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors . Indications for Hand Hygiene: 1. Hand hygiene is indicated: c. after contact with blood, body fluids, or contaminated surfaces. e. after touching the resident's environment. C. During a review of Resident 334's Admission Record, the Admission Record (crucial document that details a resident's initial health status, and other pertinent information upon admission) indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or inability to move on one side of the body) following cerebral infarction (a condition where blood flows to the brain is interrupted), and malignant neoplasm of prostate (Prostate cancer). During a review of Resident 334's MDS dated [DATE], the MDS indicated Resident 334's cognitive skills for daily decision making were moderately impaired. During a medication administration observation on 3/18/2025 at 8:37 a.m., with LVN 1, LVN 1 was observed preparing a total of five oral medications for Resident 334. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 3/18/2025 at 8:50 a.m.; with LVN 1, LVN 1 was observed entering Resident 334's room to administer the five oral medications prepared without performing hand washing or sanitizing hands. LVN 1 was observed using her hands to hold the straw in order for Resident 334 to drink water. During an interview on 3/19/2025 at 8:21 a.m., with LVN 1, LVN 1 stated she did not wash or sanitize hands after preparing the medications for Resident 334. LVN 1 stated she held the straw for Resident 334 in order for the resident to drink the water to take medication. LVN 1 further stated not washing or sanitizing own hands could lead to the spread of infection. During a review of the facility's policies and procedures (P&P) titled Handwashing/Hand Hygiene, revised in April 2023, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .Before and after direct contact with residents; .Before preparing or handling medications. During a review of the facility's policies and procedures (P&P titled, Administering Medications, revised in March 2023, the P&P indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 50594