STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 45009 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for one out of eight sampled residents (Resident 9) when: 1. Certified Nursing Assistant (CNA) 3 failed to assist Resident 9 with grooming prior to a medical appointment. 2. Resident 9 was not fed prior to leaving the facility for his medical appointment. These deficient practices had the potential to cause a negative physiological outcome for Resident 9, and resulted in Resident 9 being hungry. Findings: During an observation on 1/13/2025 at 1:05 p.m., in Resident 9's room, Resident 9 was observed being picked up for a medical appointment. Resident 9's food tray was untouched and placed on the food cart. Resident 9 was not feed before he left to his medical appointment. During a review of Resident 9's Admission Record, the admission record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). During a review of Resident 9's History and Physical (H&P) dated 6/13/2024, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS), a mandated resident assessment tool), dated 11/22/2024, the MDS indicated Resident 9's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 9 was dependent on staff for dressing, toileting hygiene, putting and taking off footwear, showering/bathing self, personal hygiene, and oral hygiene. (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 a review of Resident 9's Order Summary Report dated 8/7/2024, the order summary report indicated Resident 9 had an order to feed Resident 9 for every meal, three times a day for feeding assistance. During a review of Resident 9's Order Summary Report dated 1/3/2025, the order summary report indicated Resident 9 had an order for a follow up appointment on 1/13/2025, pick up time was at 12:55 p.m. During an interview on 1/13/2025 at 12:25 p.m. with Resident 9, in Resident 9's room, Resident 9 stated he had not eaten yet and he was hungry. During an interview on 1/16/2025 at 12:01 p.m. with CNA 3, CNA 3 stated staff were notified when a resident had an appointment through morning huddles. CNA 3 stated a Registered nurse (RN) or a licensed Vocational Nurse (LVN) would perform the morning huddles and inform staff which resident would be leaving the facility for an appointment, their pickup time, and mode of transportation. CNA 3 stated the purpose to inform staff which residents had an appointment was for CNAs to get that resident ready for that appointment. CNA3 stated CNAs must change the resident's clothes, diaper, and make sure they eat before they leave the facility. CNA 3 stated her charge nurse did not inform her that Resident 9 had an appointment on 1/13/2025. CNA 3 stated Resident 9 was a resident that received his meal tray at the end because he needed to be feed by staff. CNA 3 stated Resident 9 should have received his food earlier so he could have eaten before he left to his appointment. CNA 3 stated it was not acceptable to send a resident out for an appointment without feeding him, and it was not fair to the resident and the right thing to do was to feed Resident 9 first. CNA 3 stated there was a potential for a resident to get sick for not eating, they could feel weak and their blood sugar may drop. CNA 3 stated she did not get Resident 9 ready for his appointment because she did not know he had an appointment. During an interview on 1/16/2025 at 12:22 p.m. with CNA 4, CNA 4 stated CNAs were supposed to get residents ready for their appointments. CNA 4 stated for residents with appointments, CNAs must change the resident's clothes, comb their hair, and make sure the residents eat before they leave the facility. CNA 4 stated she was assigned to feed Resident 9 but did not get a chance to feed the resident because he was picked up. CNA 4 stated she did not know resident 9 had an appointment. CNA 4 stated it was important to feed residents before they leave to an appointment because they have medical health issues and they could potentially feel weak and faint. During an interview on 1/16/2025 at 12: 44 p.m. with RN 1, RN 1 stated during morning huddles she informed staff which residents had an appointment for that day. RN 1 stated CNAs must make sure residents with an appointment were taken care of first and must be groomed and fed prior to leaving to their appointment. RN 1 stated the assigned CNA should have told Resident 9's feeder that he had an appointment so Resident 9 could have been fed first. RN 1 stated residents must eat before their appointments, especially Resident 9 because he needed to be fed and could not take a sacked lunch due to the type of diet ordered. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated all residents should be cared for in a manner that promotes and enhances his or her sense of wellbeing, level of satisfaction with life, and feelings of self-worth and self-esteem.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedure) for four of 16 sampled residents (Residents 77, 24, 81, and 85) by failing to: 1. Ensure Resident 77 gave informed consent for the continuation of olanzapine (a psychotropic medication [medication that affect the mind, emotions, and behavior]) after his readmission from the general acute care hospital (GACH) on 10/27/2024. 2. Ensure to obtain informed consent from the residents and/or responsible party (RP) before the use of physical restraints (a physical or mechanical device) for Resident 24, 81, and 85. This deficient practice resulted in Resident 77 being unaware of the risks, benefits, and indications of his use of olanzapine, therefore, unable to make an informed decision about his care, and violated Resident 22, 81, and 85's right to make an informed decision regarding the use of physical restraints. Findings: 1. During a review of Resident 77's Admission Record (Face Sheet), the Face Sheet indicated Resident 77 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 77's Minimum Data Set ([MDS], a resident assessment tool), dated 12/27/2024, the MDS indicated Resident 77's cognition (process of thinking) was intact. The MDS indicated Resident 77 required set up assistance with eating, oral hygiene, and upper body dressing. The MDS indicated Resident 77 required supervision with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 77 was receiving an antipsychotic medication (medication to treat symptoms of schizophrenia). During a review of Resident 77's History and Physical (H&P), dated 10/29/2024, the H&P indicated Resident 77 had the capacity to understand and make decisions. During a review of Resident 77's general acute care hospital (GACH) After Visit Summary, dated 9/23/2024, the After Visit Summary indicated to stop taking olanzapine 15 milligrams (mg, unit of measurement). During a review of Resident 77's Psychiatric Follow Up Note, dated 10/14/2024, the Psychiatric Follow Up Note indicated olanzapine was removed from Resident 77's medication regimen and Resident 77 was not observed with worsening agitation (feeling of fear, dread, and uneasiness). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 77's GACH Psychiatric Progress Note, dated 10/26/2024, the Psychiatric Progress Note indicated Resident 77 felt his medication regimen was helpful and continued improvement in his anxiety and depression. During a review of Resident 77's GACH Medication List, dated 10/27/2024, the Medication List indicated to continue taking olanzapine 2.5 mg, half a tablet, by mouth, two times a day. During a review of Resident 77's Psychiatric Follow Up Note, dated 11/22/2024, the Psychiatric Follow Up Note indicated Resident 77 was restarted on olanzapine due to having delusional thinking (having false or unrealistic beliefs), increased paranoia (unjustified suspicion and mistrust of other people or their actions), and resistance to care. During an interview on 1/16/2025 at 8:25 a.m., with Resident 77, Resident 77 stated when he was readmitted to the facility in October 2024, he did not recall anyone speaking to him about any new medications from the GACH. During an interview on 1/16/2025 at 9:43 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the licensed nurses were responsible for verifying informed consent with the resident or their responsible party before a new order for psychotropic medication was administered or any change in the medication's dosage or frequency. LVN 1 stated verifying informed consent was important to ensure the resident understood the treatment they would receive, and the risks and side effects associated with the treatment. LVN 1 stated verifying the resident was provided with the education of the treatment would allow the resident to make an informed decision to accept or refuse the ordered medication. During a concurrent interview and record review on 1/16/2024 at 9:45 a.m., with LVN 1, Resident 77's Order Recap Report dated 1/1/2024 through 1/31/2025 was reviewed. The Order Recap Report indicated the following: a. Give olanzapine 15 mg, by mouth at bedtime, for psychosis (a severe mental condition in which though, and emotions are so affected that contact is lost with reality) as manifested by agitation. Order started on 9/2/2024 and was discontinued on 9/20/2024. b. Give olanzapine 1.25 mg, by mouth, two times a day for schizophrenia, bipolar mania (a period of extreme mood elevation and increase energy). Order started on 10/27/2024 and discontinued on 11/8/2024. c. Give olanzapine 1.25 mg, by mouth, two times a day for schizophrenia. Order started on 11/8/2024 and discontinued on 11/22/2024. d. Give olanzapine 1.25 mg, by mouth, two times a day for schizophrenia as manifested by delusional thinking and poor regards to his health. Order started on 11/22/2024. LVN 1 stated Resident 77's olanzapine was discontinued on 9/20/2024, when the resident was transferred to the GACH and upon readmission to the facility. LVN 1 stated olanzapine was not continued into Resident 77's medication regimen. LVN 1 stated Resident 77 was not administered olanzapine for over a month, from 9/20/2024 until 10/27/2024. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 9:50 a.m., with LVN 1, Resident 77's medical record was reviewed. LVN 1 stated Resident 77 did not have an informed consent in his medical record and the resident was not informed of the risks, side effects, nor indication of use for olanzapine. LVN 1 stated because Resident 77 had approximately a month gap from when olanzapine was initially discontinued on 9/20/2024 then restarted from the GACH on 10/27/2024, Resident 77 was required to have an informed consent for the olanzapine treatment. LVN 1 stated because Resident 77 was not informed of the risks, benefits, and indications for the use of olanzapine, Resident 77 was unable to make a true informed decision regarding his care. During a concurrent interview and record review on 1/26/2025 at 9:53 a.m., with LVN 1, Resident 77's Medication Administration Records (MAR) for the months of October 2024, November 2024, December 2024, and January 2025 were reviewed. The MARs indicated: a. Resident 77 received olanzapine 1.25 mg, by mouth, every day at 5 p.m. and 9 a.m., which started on 10/27/2024 through 11/1/2024. b. Resident 77 received olanzapine 1.25 mg, by mouth, every day from 11/1/2024 through 11/30/2024, at 9 a. m. and 5 p.m. c. Resident 77 received olanzapine 1.25 mg, by mouth, every day from 12/1/2024 through 12/31/2024, at 9 a. m., and 5 p.m. d. Resident 77 received olanzapine 1.25 mg, by mouth, every day from 1/1/2025 through 1/16/2025, at 9 a. m. and 5 p.m. LVN 1 stated Resident 77 received olanzapine twice a day over the course of approximately three months. LVN 1 stated Resident 77 should have been informed of the use of olanzapine and its risk before he was administered the first dose on 10/27/2024. During a concurrent interview and record review on 1/16/2025 at 9:58 a.m., with LVN 1, the facility's policy and procedure (P&P) titled, Psychotropic Medication Use/Informed Consent, dated 3/2024, was reviewed. The P&P indicated, The signed written consent must be recorded in the resident's medical record . For a prescription written prior to facility admission, the facility staff must verify that the resident or the resident's representative gave informed consent and make notation in the resident's records. LVN 1 stated when a medication was continued from the GACH, the licensed nurse had to verify informed consent was given and notated on the facility's paper or electronic informed consent verification form. LVN 1 stated the facility's P&P was not followed because informed consent for the use of olanzapine was not verified with Resident 77 prior to the first administration. 2. During a concurrent observation and interview on 1/13/2024 at 9:25 a.m., with Resident 24, in Resident 24's room, Resident 24's bed was observed against the wall. Resident 24 stated the facility did not discuss the risks and benefits prior to placing the bed against the wall. During a review of Resident 24's Face Sheet, the Face Sheet indicated Resident 24 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) , muscle weakness (loss of muscle strength), depression (loss of interest in activities), difficulty walking, and anxiety (feeling fear). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognitive skills for daily decision making was intact. The MDS indicated Resident 24 was dependent on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 24's H&P, dated 5/20/2024, the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's order summary report, dated 10/24/2024, the order summary report indicated per Resident 24's request the facility would place the bed against the wall. During a concurrent interview and record review on 1/16/2025 at 1:23 p.m., with LVN 2, Resident 24's electronic medical record (eMAR) was reviewed. LVN 2 stated Resident 24's care plan with a focus of Potential for injury, dated 10/25/2024, indicated Resident 24's bed would be placed against the wall per the resident's request. LVN 2 stated the care plan intervention indicated the facility would obtain informed consent. LVN 2 stated he could not find documented evidence the licensed nursing staff informed Resident 24 and obtained informed consent prior placing the resident's bed against the wall. 3. During a concurrent observation and interview on 1/13/2025 at 11:37 a.m., with Resident 81, in Resident 81's room, Resident 81's bed was observed against the wall. Resident 81 stated she did not know why her bed was placed against the wall. Resident 81 stated facility did not explain the reason the bed was placed against the wall. Resident 81 stated she did not like her bed against the wall. During a review of Resident 81's Face Sheet, the Face Sheet indicated Resident 81 was admitted to the facility on [DATE] with diagnoses including collapsed (a break) vertebra (a bone in the spine that support weight and protect the spine), depression, and chronic (constantly) pain. During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognitive skills for daily decision making was intact. The MDS indicated Resident 81 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for ADLs. During a review of Resident 81's physician order, dated 10/24/2024, the physician order indicated to place Resident 81's bed against the wall per the resident's request. During a concurrent interview and record review on 1/16/2025 at 2:23 p.m., with LVN 1, Resident 81's eMAR was reviewed. LVN 1 stated Resident 81's care plan with a focus of Potential for injury, dated 10/25/2024, indicated Resident 81's bed would be placed against the wall per Resident 81's request. LVN 1 stated the care plan intervention indicated the facility would obtain informed consent. LVN 1 stated he could not provide documentation the licensed nursing staff informed Resident 81 and obtained informed consent prior to placing the resident's bed against the wall. LVN 1 stated it was Resident 81's right to make an informed decision regarding her care and treatment at the facility. 4. During an observation on 1/13/2025 at 10:18 a.m., in Resident 85's room, Resident 85's bed was observed against the wall. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 85's Face Sheet, the Face Sheet indicated Resident 85 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety, diabetes mellitus, muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 85 required moderate (helper does less than half the effort) assistance from staff for ADLs. During a review of Resident 85's H&P dated 10/14/2024, the H&P indicated Resident 85 did not had the capacity to make medical decisions. During a review of Resident 85's care plan with a focus of Potential for injury, dated 11/14/2024, the care plan indicated Resident 85's bed would be placed against the wall per Resident 81's responsible party's request. During a telephone interview on 1/13/2025 at 3:11 p.m., with Resident 85's Responsible Party (RP) 1, RP 1 stated the facility placed Resident 85's bed against the wall without any explanation and/or reason. RP 1 stated there was no informed consent obtained prior to placing Resident 85's bed against the wall. During a concurrent interview and record review on 1/15/2025 at 3:45 p.m., with the Director of Nursing (DON), Resident 85's eMAR was reviewed. The DON stated the care plan with a focus of Potential for injury, dated 11/14/2024, indicated Resident 85's bed would be placed against the wall per RP 1's request. The DON stated the care plan intervention indicated the facility would obtain informed consent. The DON stated he was not able to provide documented evidence staff informed RP 1 of the risks and benefits prior to placing Resident 85's bed against the wall and obtained informed consent as indicated in the care plan. The DON stated without sufficient documentation and without and informed consent, Resident 85's bed against the wall would be considered a physical restraint. During a review of the facility's P&P titled Use of Restraints, revised 4/2017, the P&P indicated restraints shall only be used for the safety and well-being of the residents and never for staff convenience. During a review of the facility P&P titled Resident Rights, revised 2/2021, the P&P indicated residents would be informed in their care planning and treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for one of eight sampled residents (Resident 81) by failing to ensure the call light (a device that residents use to request assistance from staff) was within reach. This deficient practice had the potential to negatively impact the Resident 81's psychosocial well-being and/or result in delayed provision of care and services. Findings: During an observation on 1/13/2025 at 10:57 a.m., in Resident 81's room, Resident 81 was observed lying in bed. Resident 81's call light was on the floor on the left side of Resident 81's bed. During a review of Resident 81's admission record, the admission record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses including collapsed (a break) vertebra (a bone in the spine that support weight and protect the spine), depression (loss of interest in activities), and chronic (constantly) pain. During a review of Resident 81's Minimum Data Set ([MDS]- a resident assessment tool), dated 12/17/2024, the MDS indicated Resident 81's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 81 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 81's care plan with a focus of Resident at risk for falls, initiated on 4/10/2024, the care plan indicated Resident 81 was at risk for falls related to limited mobility (inability to move around easily without pain) and impaired function (difficulty performing daily tasks). The care plan interventions indicated staff would ensure Resident 81's call light was within reach and encourage use as needed for assistance. During a concurrent observation and interview on 1/14/2025 at 7:52 a.m., in Resident 81's room, Resident 81 was observed lying in bed in a semi-Fowler's position (head of the bed elevated 30-45 degrees). Resident 81's call light was on the floor on the left side of Resident 81's bed. Resident 81 was observed calling for nurse assistance asking for water. Resident 81 was not able to locate her call light. During a concurrent observation and interview on 1/16/2025 at 11:00 a.m., in Resident 81's room, with Certified Nursing Assistant (CNA 1), observed Resident 81's call light on the left side of the bed, not within reach. CNA 1 stated Resident 81's call light should have been attached to the resident's bed and within reach. CNA 1 stated it was important for Resident 81 to be able to reach the call light and use it for assistance during emergencies. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated the call light should be placed within Resident 81's reach at the residents' bedside. The DON stated the call light was important for residents' to be able to communicate with staff. The DON stated the facility's licensed staff were responsible for checking the residents' call lights and placing the call lights within reach at the bedside. The DON stated if the call light was not within reach, the residents would not be able to call for help. The DON stated not having the call light within reach placed the residents' safety at risk and placed the residents at risk for falls, and injury. During a review of the facility's policy and procedure (P&P), titled Call Light, revised 1/2024, the P&P indicated the facility would provide a call light system that would enable residents to alert the nursing staff from their rooms. The P&P indicated the call light would be placed within resident's reach in the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to follow up and obtain a copy of an Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) for one of six sampled Residents (Resident 11). This deficient practice had the potential to result in the facility not honoring Resident 11's medical care directive in the event Resident 11 was to become incapacitated (unable to make informed decisions or care for themselves). Findings: During a review of Resident 11's Admission Record (Face Sheet), the Face Sheet indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure (a chronic condition where the heart does not provide adequate blood flow to meet the body's needs), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 11/15/2024, the MDS indicated Resident 11's cognition (process of thinking) was intact. The MDS indicated Resident 11 required moderate assistance (helper does less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 11 required maximal assistance (helper does more than half the effort) with toileting, lower body dressing, and personal hygiene. During a review of Resident 11's History and Physical (H&P), dated 5/14/2024, the H&P indicated Resident 11 had the capacity to understand and make decisions. During an interview on 1/15/2025 at 8:49 a.m., with the Social Services Director (SSD), the SSD stated upon admission, residents were asked if they formulated an Advance Directive in the past or if they were interested in formulating one. The SSD stated once it was determined a resident has an Advance Directive in place, the facility would request a copy to ensure the facility would follow and respect their wishes if they were unable to speak for themselves. During a concurrent interview and record review on 1/15/2025 at 8:53 a.m., with the SSD, Resident 11's Advanced Healthcare Directive Acknowledgement Form, dated 5/8/2023, was reviewed. The Form indicated Resident 11 formulated an Advance Directive. Resident 11's Physician Orders for Life-Sustaining Treatment (POLST), dated 5/8/2023, was reviewed. The POLST indicated Resident 11 had an Advance Directive formulated on 12/26/2019. Resident 11's POLST, dated 5/14/2024, was reviewed. The POLST indicated Resident 11 had an Advance Directive formulated. The SSD stated Resident 11's Advanced Healthcare Directive Acknowledgement Form and POLSTs all indicated Resident 11 formulated an Advance Directive on 12/26/2019. The SSD stated a follow-up with Resident 11 should have occurred on 5/8/2023 and 5/14/2024, to obtain a copy of her Advance Directive. (continued on next page)

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	056415	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/15/2024 at 8:55 a.m., with the SSD, Resident 11's Progress Notes were reviewed. The Progress Notes did not indicate a follow-up with Resident 11 occurred to obtain a copy of her Advance Directive. The SSD stated she did not have a copy of Resident 11's Advance Directive and none of her records indicated anyone followed up with Resident 11 to obtain a copy. The SSD stated obtaining a copy of Resident 11's Advance Directive was important to ensure Resident 11's medical care wishes were upheld in the event she was unable to make medical decisions for herself. The SSD stated without a copy of Resident 11's Advance Directive, the facility could potentially provide medical care that went against Resident 11's wishes and Resident 11 had the right to receive the care she wants. During a review of the facility's policy and procedure (P&P) titled, Advance Directives revised 9/2023, the P&P indicated, If a resident or resident's representative has executed one or more advance directive(s), or executes upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool) was accurately coded for one of eight sampled residents (Resident 40) to reflect Resident 40's oral and/or dental status. This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 40's dentures (oral appliances that replace missing teeth) and had the potential to negatively affect Resident 40's plan of care and delivery of necessary care and services. Findings: During a review of Resident 40's Admission Record, the admission record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN]- high blood pressure). During a review of Resident 40's Minimum Data Set ([MDS]- a resident assessment tool), dated 12/20/2024, the MDS indicated Resident 40's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 40 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 40 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 1/16/2025 at 3:00 p.m., with the MDS Nurse (MDSN 1), in Resident 40's room, Resident 40's dentures were observed on top of the resident's bedside table. MDSN 1 stated Resident 40 did not have her upper and bottom teeth. During a concurrent interview and record review on 1/16/2025 at 3:20 p.m., with MDSN 1, Resident 40's MDS, dated [DATE] section L (oral and/or dental status) was reviewed. MDSN 1 stated she was responsible for completing the MDS. MDSN 1 stated Resident 40's MDS section L was coded incorrectly as it did not reflect the resident's actual oral and/or dental status. MDSN 1 stated Resident 40's use of dentures should have been coded. MDSN 1 stated accuracy of the MDS assessment was important for quality measures that help measure healthcare process, outcomes, resident perceptions, and care for the resident. MDSN 1 stated inaccuracy of the MDS assessment had the potential to result in not meeting Resident 40's care needs and services. During a review of the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment', revised 11/2019, the P&P indicated qualified professionals who have completed the MDS resident assessment are to certify the accuracy of the section they have completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, and interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for three of 21 sampled residents (Residents 24, 40, and 42) by failing to: 1. Develop and implement a care plan for Resident 42's use of side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility). 2. Initiate and implement a comprehensive care plan for Resident 40 who was using dentures (oral appliances that replace missing teeth). 3. Initiate and implement a comprehensive care plan for Resident 24 Restorative Nurse Assistant ([RNA]- a healthcare professional who help residents regain or maintain their mobility) program. These deficient practices had the potential to negatively affect Residents 24, 40, and 42's physical well-being and had the potential to result in injury and insufficient provision of care and services. Findings: a. During a review of Resident 42's Admission Record (Face Sheet), the Face Sheet indicated Resident 42 was admitted to the facility with diagnoses that included fracture (a break or crack in the bone) of the right femur (bone of the thigh), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left knee, and acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of the deep vein of the right lower extremity (leg). During a review of Resident 42's Minimum Data Set ([MDS], a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 42's cognition (process of thinking) was intact. The MDS indicated Resident 42 had impairment on one side of the lower extremity. The MDS indicated Resident 42 required supervision with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 42 required moderate assistance (helper does less than half the effort) with lower body dressing and rolling left and right. During a review of Resident 42's History and Physical (H&P), dated 12/11/2024, the H&P indicated Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's Side Rail Utilization Assessment, dated 1/2/2025, the Side Rail Utilization Assessment indicated Resident 42 requested to have quarter side rails for assistance in transfers and bed mobility. The Side Rail Utilization Assessment indicated Resident 42's plan of care was reviewed and updated to reflect the side rail use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/13/2025 at 10:36 a.m., with Resident 42, in Resident 42's room, Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. Resident 42 stated she used the side rails to assist her in moving left and right while in bed. During a concurrent observation and interview on 1/15/2025 at 1:59 p.m., with Licensed Vocational Nurse (LVN) 1, in Resident 42's room, Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. LVN 1 stated Resident 42 had bilateral side rails on her bed as a mobility aide. During an interview on 1/15/2025 at 2:05 p.m., with LVN 1, LVN 1 stated when side rails were used as a mobility aide, the resident should have a care plan developed. LVN 1 stated the care plan would indicate the reason for the side rails, the individualized goals, and interventions to be implemented. LVN 1 stated the purpose of the care plan was to continuously assess the resident's need for the side rails, the appropriateness, and to monitor the resident's safety. During a concurrent interview and record review on 1/15/2025 at 2:21 p.m., with LVN 1, Resident 42's Care Plans were reviewed. The Care Plans did not indicate Resident 42 used side rails as a mobility aide. LVN 1 stated Resident 42 did not have a care plan developed that indicated her use of bed rails nor how to properly care and monitor Resident 42's safety. LVN 1 stated without a care plan for Resident 42, a goal was not set for Resident 42's safety and need for the bed rails. LVN 1 stated without a care plan, the licensed nurses would be unable to determine Resident 42's necessity and appropriateness for the bed rails and would not have the guidance on how to care for her. During an interview on 1/16/2025 at 11:40 a.m., with the Director of Nursing (DON), the DON stated a care plan was developed when a resident used side rails. The DON stated the care plan would outline the plan of care, the problem, the goals, and interventions to be implemented. The DON stated for Resident 42, the goals for her use of side rails would include no decline in her physical functionality and independence, and to continue using the side rails safely. The DON stated interventions would include continuous education for the proper use of side rails and monitoring that Resident 42 was safe. The DON stated the care plan was a communication tool between all nurses and other departments of the resident's conditions. The DON stated without a care plan on Resident 42's side rail use, the nursing staff would not have guidance on how to properly care and monitor her. b. During a review of Resident 40's Face Sheet, the Face Sheet indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN]-high blood pressure) During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making was intact. The MDS indicated Resident 40 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 40 was assessed as not having any oral and/or dental issues (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/16/2025 at 3:00 p.m., with the Minimum Data Set Nurse (MDSN 1) in Resident 40's room, Resident 40's dentures were observed on top of the resident's bedside table. MDSN 1 stated Resident 40 had no upper and bottom teeth. During a concurrent interview and record review on 1/16/2025 at 3:20 p.m., with MDSN 1, Resident 40's electronic medical record (eMAR), was reviewed. MDSN 1 was not able to locate a care plan for Resident 40's use of dentures. MDSN 1 stated there was no care plan for the use of dentures and there should have been a care plan initiated upon Resident 40's admission to the facility. MDSN 1 stated care planning served as a communication tool among facility staff who provided care for resident at the facility. MDSN 1 stated if there was no care plan, the facility staff would not be able to provide quality of care to residents. c. During a review of Resident 24's Face Sheet, the Face Sheet indicate Resident 24 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, muscle weakness (loss of muscle strength), depression (loss of interest in activities), difficulty walking, and anxiety (feeling fear). During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognitive skills for daily decision making was intact. The MDS indicated Resident 24 was dependent from staff for ADLs During a review of Resident 24's H&P, dated 5/20/2024, the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's order summary report, dated 11/6/2024, the order summary report indicated to provide RNA program three times a week (3x/wk) for ambulation (walking). The order summary report indicated to provide RNA program omni cycle (motorized rehabilitation system that helps resident exercise) for both upper extremities (BUE, arms) 3x/wk. During a review of Resident 24's order summary report, dated 11/10/2024, the order summary report indicated the facility would provide RNA program omni cycle (motorized rehabilitation system that helps resident exercise) for both lower extremities (BLE, legs) 3x/wk. During a concurrent interview and record review on 1/15/2025 at 10:30 a.m., with LVN 1, Resident 24's active care plan was reviewed. LVN 1 stated there were no care plan addressing the resident's RNA program. LVN 1 stated Resident 24's the RNA program should be care planned. LVN 1 stated a care plan was an important communication for staff providing care to Resident 24. LVN 1 stated without care plan interventions, Resident 24 had the potential to not received needed care and services. During an interview on 1/16/2025 at 3:00 p.m., with the Director of Nursing (DON), the DON stated it was important for the facility licensed staff to develop a comprehensive care plan for each resident for continuity of care and services, based on resident needs and interventions. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated comprehensive, person-centered care plan would include measurable objectives and timeframes, services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to maintain appropriate grooming and personal hygiene for one of eight sampled residents (Residents 18) by failing to keep Resident 18's fingernails clean and neat. This failure had the potential to result in a negative impact on Resident 18's quality of life and self-esteem and had the potential for the development of an infection. Findings: During a review of Resident 18's Admission Record, the admission record indicated Resident 18 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease ([ESRD] -irreversible kidney failure), muscle weakness (loss of muscle strength), and hypertension ([HTN]- high blood pressure). During a review of Resident 18's's Minimum Data Set ([MDS]- a resident assessment tool), dated 10/25/2024, the MDS indicated Resident 18's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 18 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 1/14/2025 at 1:24 p.m., with Resident 18, in Resident 18's room, observed Resident 18's fingernails. Resident 18's fingernails were long and had a black substance underneath. Resident 18 stated did not remember the last time her fingernails were cleaned or cut. Resident 18 stated her fingernails were long and would like the staff to cut and clean her fingernails. During an interview on 1/15/2025 at 8:28 a.m., with Certified Nursing Assistant (CNA 2), CNA 2 stated the CNAs were responsible for cleaning the residents' fingernails daily and trim them as needed. CNA 2 stated it was important to keep Resident 18's fingernails clean and trimmed to prevent the growth of bacteria (infection). CNA 2 stated long, dirty fingernails had the potential for residents to scratch themself and if Resident 18 scratched herself hard enough, it could create an open wound and increased risk of infection. CNA 2 stated having dirty fingernails was not sanitary because the resident used her hands to hold utensils when eating and any bacteria could transfer into the body. During an interview on 1/16/2025 at 10 a.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated it was the CNAs' responsibility to make sure the residents' fingernails were cleaned daily and trimmed as needed. LVN 2 stated residents should be provided with care and services necessary to maintain good personal hygiene. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care, revised 2/2018, the P&P indicated facility would provide nails cleaning daily. The P&P indicated facility would trim residents' nails regularly to prevent resident from accidently scratching and injuring his or her skin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated residents would be provided with care, treatment, and services necessary to maintain good grooming and personal hygiene.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 47679 Based on observation, interview, and record review, the facility failed to obtain a physician's order for use of quarter side rails (short rails on one or both sides of the bed that can be used to assist in bed mobility) for one of two sampled residents (Resident 42), when Resident 42 used bilateral (left and right) quarter side rails for transfer assistance and bed mobility. This deficient practice had the potential to result in the unsafe use of side rails that could result in entrapment (becoming stuck between the bed and railing) and physical harm. Findings: During a review of Resident 42's Admission Record (Face Sheet), the Face Sheet indicated Resident 42 was admitted to the facility with diagnoses that included fracture (a break or crack in the bone) of the right femur (bone of the thigh), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left knee, and acute embolism (a blood clot that enters the blood stream and blocks blood flow) and thrombosis (a blood clot that forms in a blood vessel, partially or completely blocking blood flow) of the deep vein of the right lower extremity (leg). During a review of Resident 42's Minimum Data Set ([MDS], a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 42's cognition (process of thinking) was intact. The MDS indicated Resident 42 had impairment on one side of the lower extremity. The MDS indicated Resident 42 required supervision with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 42 required moderate assistance (helper does less than half the effort) with lower body dressing and rolling left and right. During a review of Resident 42's History and Physical Examination (H&P), dated 12/11/2024, the H&P indicated Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's Side Rail Utilization Assessment, dated 1/2/2025, the Side Rail Utilization Assessment indicated Resident 42 requested to have quarter side rails for assistance in transfers and bed mobility. During a concurrent observation and interview on 1/13/2025 at 10:36 a.m., with Resident 42, in Resident 42's room, Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. Resident 42 stated she used the side rails to assist her in moving left and right while in bed. During a concurrent observation and interview on 1/15/2025 at 1:59 p.m., with Licensed Vocational Nurse (LVN) 1, in Resident 42's room, Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. LVN 1 stated Resident 42 had bilateral side rails on her bed as a mobility aide. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/2025 at 2:05 p.m., with LVN 1, LVN 1 stated prior to installing side rails onto the bed, a licensed nurse would conduct an assessment to determine the appropriateness and safety of the side rails. LVN 1 stated after the assessment was completed, the resident's physician would be contacted to obtain an order to utilize the side rails. LVN 1 stated a physician's order was necessary because the order would prove that the resident's physician deemed it safe for the resident to have side rails. During a concurrent interview and record review on 1/15/2025 at 2:10 p.m., Resident 42's current Orders on 1/15/2025, were reviewed. The Orders did not indicate a physician's order for Resident 42 to have bilateral side rails. LVN 1 stated Resident 42 did not have a physician's order to allow side rails on Resident 42's bed. LVN 1 stated because there was no physician's order for Resident 42's side rails, there was no proof that Resident 42's physician permitted the use of side rails safely. LVN 1 stated Resident 42 was at risk for injury from the side rails such as entrapment or hitting any body part against the side rails. During an interview on 1/16/2025 at 11:40 a.m., with the Director of Nursing (DON), the DON stated a physician's order was required prior to the installation of side rails. The DON stated obtaining an order ensured the resident's physician was aware and determined the use of side rails was safe. The DON stated because Resident 42 did not have an order for the side rails, she was at risk of avoidable injury. During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, revised 8/2022, the P&P indicated, The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met; including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47679 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was in the facility for at least eight consecutive hours on 12/7/2024, 12/8/2024, 12/15/2024, and 1/4/2025. This deficient practice had the potential to result in initial assessment to be delayed or missed and a potential to result in an overall decrease in the quality of care for the residents. Findings: During a review of the facility's Licensed Nurse Staffing, dated 12/1/20/24 through 12/31/2024, the Licensed Nurse Staffing indicated there was no RN scheduled during the 7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift, nor the 11 p.m. to 7 a.m. shift on 12/7/2024, 12/8/2024, 12/15/2024, and 1/4/2025. During an interview on 1/15/2025 at 8:23 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the RN who worked weekends was on sick leave and to fill the RN shift, one of the Minimum Data Set Nurses (MDSN), who were licensed RNs, would come in during the 7 a.m. to 3 p.m. shift. During an interview on 1/15/2025 at 1:42 p.m., with MDSN 1, MDSN 1 stated he usually worked Monday through Friday, however, he had worked extra on some weekends to provide RN coverage. During a concurrent interview and record review on 1/16/2025 at 11:58 a.m., with the Director of Nursing (DON), the facility's Timecard Reports dated 12/7/2024, 12/8/2024, 12/15/2024, and 1/4/2025 were reviewed. The Timecard Reports indicated the following hours MDSN 1 and MDSN 2 worked: a. On 12/7/2024, MDSN 2 worked 5.97 hours. b. On 12/8/2024, MDSN 2 worked 4 hours. c. On 12/15/2024, MDSN 1 worked 4.18 hours. d. On 1/4/2025, MDSN 2 worked 4.17 hours. The DON stated the facility had RN coverage on 12/7/2024, 12/8/2024, 12/15/2024, and 1/4/2025, however, the RNs on shift did not work the required eight hours. The DON stated having an RN in the facility for eight consecutive hours ensured assessments upon admission were completed timely. The DON stated RNs were used as a resource during an emergency due to the additional experience. The DON stated without an RN on shift for the required eight hours, there could be a delay or missed admission or general assessments. The DON stated because RNs were utilized during an emergency, the RN would take charge, therefore, without an RN, the resident involved in an emergency may not receive the best care possible. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Job Description for Registered Nurse (RN) Supervisor, undated, the Job Description indicated the RN Supervisor was to supervise day-to-day activities of the facility in accordance with current federal, state, and local standards that govern the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure licensed nursing staff practiced safe and effective medication administration practices for one out of eight sampled residents (Resident 90) by failing to: 1. Ensure Licensed Vocational Nurse 3 (LVN) administered medication to Resident 90 per the doctor's order. 2. Ensure LVN 3 did not falsely document she administered medication to Residents 90. 3. Ensure LVN 3 reordered medication for Resident 90. 4. Ensure LVN 3 did not administer another resident's medication to Resident 90. 5. Inform Resident 90 's doctor a medication was not administered as ordered. These deficient practices caused Resident 90 to have an interruption with medication therapy and pain control and exposed Resident 90 to a potential of a medication error and an adverse effect to their medications. Findings: During an observation on 1/15/2025 at 2:45 p.m., in the hallway, Resident 90 was observed asking staff to be wheeled to the front desk because her back hurt and she could not physically wheel herself. During an observation on 1/15/2025 at 3:11 p.m., in the hallway, Resident 90 was observed asking LVN 4 for pain medication. LVN 4 was observed telling Resident 90 that she had already given her pain medication. During an observation on 1/15/2025 at 3:27 p.m., in Resident 90's room, LVN 4 removed a Lidocaine (substance used to relieve pain by blocking signals at the nerve endings in skin) patch from Resident 90's mid back and placed another lidocaine patch 5 percent (%) on Resident 90's mid back. During a review of Resident 90's Admission Record, the admission record indicated Resident 90 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood) and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 90's History and Physical (H&P) dated 11/22/2024, the H&P indicated Resident 90 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 90's Minimum Data Set (MDS), a mandated resident assessment tool), dated 11/25/2024, the MDS indicated Resident 90's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 90 required setup or clean up assistance for eating. The MDS indicated Resident 90 partial assistance (helper does less than half the effort) for upper body dressing, oral hygiene, and personal hygiene. During a review of Resident 90's Order Summary Report, dated 1/13/2024, the order summary report indicated Resident 90 had an order for Lidocaine HCL external patch 4 % for pain management, apply to mid lower back topically one time a day and remove per schedule. During a review of Resident 90's Medication Administration Record (MAR), dated 1/1/2025 - 1/31/2025, the MAR indicated Resident 90 was to receive Lidocaine external patch 4 % for pain management, apply to mid lower back topically one time a day and remove per schedule. The MAR indicated on 1/15/2025 Resident 90's lidocaine patch 4% was removed at 8:59 a.m. and a new lidocaine patch 4% was placed at 9:00 a.m. During a review of Resident 90's Care Plan for alteration of comfort related to pain, the care plan indicated Resident 90's goal was to display a decrease in behaviors of inadequate pain control and Resident 90 will verbalize adequate relief of pain. The care plan interventions indicated to administer analgesia (the absence of pain) as ordered, anticipate Resident 90's need for pain relief, and respond immediately to any complaints of pain. During an interview on 1/15/2025 at 2:48 p.m. with Resident 90, in the hallway, Resident 90 stated she needed assistance to be taken to the front desk because she could not propel (drive, push, or cause to move in a particular direction) her legs because her back hurt. Resident 90 stated she had asked LVN 3 for pain medication that morning but she had not received her medication. Resident 90 stated she was in a lot of pain and needed help. During a concurrent observation and interview on 1/15/2025 at 3:15 p.m. with LVN 4, in Resident 90's room, Resident 90 was observed with a patch on her mid back dated with 1/14/2025 and timed at 8:00 a.m. LVN 4 stated she thought she had given Resident 90 her lidocaine patch that morning. LVN 4 stated she should have removed the patch and placed a new patch on Resident 90. LVN 4 stated she documented she gave Resident 90 her lidocaine patch at 9:00 a.m. but she did not. LVN 4 stated it was not acceptable to document she administered a medication when she did not because it was not true. LVN 4 stated this practice would cause Resident 90 to become restless and her pain would not be managed. LVN 4 stated she did not report to anyone that she did not administer pain medication to Resident 90. LVN 4 stated she was supposed to notify the Registered Nurse (RN) supervisor and Resident 90's doctor about not administering the medication and about falsely documenting that she did. During an interview on 1/15/2025 at 4:22 p.m. with LVN 5, LVN 5 stated she relieved LVN 4, they both did rounds together and LVN 4 did not inform her that she did not give Resident 90 her medication patch. LVN 5 stated Resident 90 did not have a box of patches in the medication cart and she did not know from where LVN 4 got the lidocaine patch from. LVN 5 stated LVN 4 gave Resident 90 a lidocaine patch 5% that was ordered for another resident because that was not what Resident 90's doctor ordered. LVN 5 stated that it needed to be documented that Resident 90 received a Lidocaine patch 5% instead of the 4% and Resident 90's doctor must be informed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 8:33 a.m. with LVN 4, LVN 4 stated she grabbed another resident's lidocaine patch to give to Resident 90. LVN 4 stated it was not an acceptable practice because she gave Resident 90 a lidocaine patch 5% and her order was for a lidocaine patch 4%. LVN 4 stated she did not give Resident 90 pain medication because it was not on hand. LVN 4 stated she was supposed to call the pharmacy and reorder the medication but did not. LVN 4 stated she did not document that Resident 90 did not get the lidocaine patch, she did not document that Resident 90 received the wrong lidocaine patch, and she did not notify Resident 90's doctor. LVN 4 stated she did not follow the doctors order and Resident 90 could potentially have an adverse effect to the medication. During an interview on 1/16/2025 at 1:22 p.m. with RN 1 stated if a medication was not available to administer to a resident, the nurse must document that medication was not given, call the pharmacy to reorder the medication and inform the doctor. RN 1 stated nurses must sign that they administered a medication after administration because they must first witness that the resident took the medication. RN 1 stated nurses must notify their supervisor that a medication was not given because it was not available and their supervisor could assist by reordering the medication. RN 1 stated a nurse must notify the doctor that medication was not available and that a different patch percent was given to Resident 90. RN 1 stated giving Resident 90 another resident's medication was an unsafe practice and was not following the doctor's orders. RN 1 stated it was important to administer the correct medication to residents because medications are a plan of treatment for health issues, diagnosis and helps the residents' quality of life. During a review of facility's Policy and Procedure (P&P) titled Administering Medications, dated 4/2023, the P&P indicated medications were administered in a safe and timely manner and as prescribed. The P&P indicated medications were administered in accordance with prescriber orders, including any required time frame. The P&P indicated if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the refusal, given at another time or the withholding of a medication. The P&P indicated the individual administering the medication initials the resident's MAR on the appropriate line on the MAR after giving each medication and before administering the next one. The P&P indicated medications ordered for a particular resident may not be administered to another resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to follow and implement the pharmacist recommendation in the Medication Regimen Review (MRR) for one out of three sampled residents (Resident 9). This deficient practice had the potential to place Resident 9 at risk for complications due to bleeding. Findings: During a review of Resident 9's Admission Record, the admission record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). During a review of Resident 9's History and Physical (H&P) dated 6/13/2024, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS), a mandated resident assessment tool), dated 11/22/2024, the MDS indicated that Resident 9's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 9 was dependent on staff for dressing, toileting hygiene, putting and taking off footwear, shower/bathe self, personal hygiene, and oral hygiene. During a review of Resident 9's Order Summary Report, dated 10/9/1014, the order summary report indicated Resident 9 had an order for Apixaban (medication used to treat and prevent blood clots) oral tablet 2.5 milligrams ([mg] metric unit of measurement) for atrial fibrillation (irregular and often very rapid heart rhythm), 1 tablet by mouth every 12 hours. The order summary report indicated Resident 9 had an order for aspirin (blood thinner) 81 mg for cerebrovascular accident ([CVA] when the blood supply to part of the brain is blocked or reduced) prophylaxis, give 1 tablet by mouth in the evening. During a review of Resident 9's electronic medical record, unable to locate an order to monitor Resident 9 for signs of bleeding. During a review of Resident 9's electronic medical record, unable to locate to in the MAR to monitor Resident 9 for signs of bleeding. During a review of Resident 9's Medication Regimen Review (MRR), dated 10/1/10/2024 - 10/22/2024, the MRR indicated to monitor bleeding on the MAR due to Aspirin and Apixaban. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/16/2025 at 2:18 p.m. with Registered Nurse (RN) 1, Resident 9's order summary was reviewed. The order summary report indicated there was no order to monitor Resident 9 for bleeding. RN 1 stated the pharmacist recommendation was not in Resident 9's electronic medical record and it should be. RN 1 stated RNs were responsible for reviewing the MRR and adding the pharmacist recommendation in the resident's electronic medical record. RN 1 stated nurses should know to monitor residents for the risk of bleeding when administering the medications that Resident 9 receives. RN 1 stated it was important to monitor for bleeding when residents take blood thinners because they might bleed out through their feces or urine and these signs would be missed and the resident would not get the care they need. During a review of the facility's Policy and Procedure (P&P) titled Medication Regimen Reviews, dated 5/2019, the P&P indicated the goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure two of five sampled Residents (Resident 77 and 79)'s drug regiment was free of unnecessary medications by failing to: 1. Monitor the specific target behaviors for Resident 79's Zyprexa (olanzapine, an antipsychotic medication used to treat mental illness), Ativan (lorazepam, used to treat anxiety [excessive and persistent feelings of worry, fear, dread, and uneasiness that interfere with daily life), Desyrel (trazodone, antidepressant used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] and anxiety disorders), Cymbalta (duloxetine, used to treat depression and anxiety), and Depakene (valproic acid, used to treat seizure (is a sudden rush of abnormal electrical activity in your brain) disorders, mental/mood conditions) and attempt nonpharmacological (without drugs) intervention prior to the initiation and during the use of psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications and document the effectiveness of the nonpharmacological interventions. 2. Monitor Resident 77 for specified behavior of poor regard to his health while receiving olanzapine. This deficient practice had the potential to result in Resident 77's behavior of poor regard to his health being undetected and mismanaged and had the potential to cause adverse effects (side effects, unwanted undesirable effects that are possibly related to a drug) to Residents 79 due to the possible administration of unnecessary psychotropic medications. Findings: 1. During a review of Resident 79's Admission Record (a document containing medical and demographic information), the Admission Record indicated Resident 79 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a stroke, a serious condition that occurs when blood flow to the brain is blocked), dementia (memory loss that gets worse over time, Alzheimer's), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), altered mental status (AMS, a general term for a change in a person's mental function, consciousness, or awareness), depression, unspecified psychosis (commonly used if there is inadequate information to make the diagnosis of a specific psychotic disorder [a mental illness that causes a person to lose touch with reality]), and cognitive communication deficit (a communication difficulty caused by a cognitive impairment) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 10/29/2024, the MDS indicated Resident 79 rarely or never was able to make self-understood and rarely or never had the ability to understand others. The MDS indicated Resident 79 had severe impairment in cognition (ability to think, process, and recall information). The MDS indicated under potential indicators for psychosis (hallucinations [see things that are not there] and/or delusions [having false or unrealistic beliefs]) that Resident 79 had, None of the above. The MDS indicated Resident 79 required set up assistance with eating, partial assistance with oral hygiene, and substantial assistance with lower body dressing. The MDS indicated Resident 79 was dependent on facility staff with toileting, bathing, upper body dressing, and personal hygiene. During a review of Resident 79's History and Physical Examination (H&P), dated 5/3/2024, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions. During a review of Resident 79's general acute care hospital (GACH) Progress Note, dated 4/27/2024, the GACH Progress Note indicated Resident 79's medications included duloxetine 60 milligram ([mg] - unit of measurement) once a day, memantine 10 mg twice a day, quetiapine (Seroquel (an antipsychotic medication used to treat mental illness) 25 mg twice a day, and lorazepam (Ativan) 0.5 mg/tablet, one tablet every 6 (six) hours as needed. The GACH Progress Note indicated Resident 79's admission was for agitation on dementia and that the resident May be overly sedated on above regiment, discuss with psych. Progress Note for Resident 79 indicated, Other specified personal risk factors, not elsewhere classified (due to chronic immobility). During a review of Resident 79's Psychiatric Skilled Nursing Facility (SNF) Initial Evaluation, dated 5/7/2024, the Psychiatric SNF Initial Evaluation indicated Resident 79, Today, the patient was alert but not oriented . strengths: ability to verbalize concerns and needs .Diagnosis: mood disorder, unspecified and generalized anxiety disorder. Resident 79's Psychiatric SNF Initial Evaluation indicated Assessment and Plan: Patient is currently not experiencing worsening symptoms of disease. Safety: Patient is not currently a danger to self or others . Medication Management: We will start Ativan 1 milligram ([mg] - unit of measure of weight) by mouth (PO) every 6 (six) hours as needed (PRN) for anxiety manifested by (m/b) increasing restlessness, NTE (Not to exceed) 2 mg per 24 hours, start trazodone 25 mg PO nightly at bedtime for depression m/b inability to sleep, and start Zyprexa 2.5 mg daily for psychosis m/b auditory hallucinations .encouraged to cease medication and report side effects should they occur .Continue participation in group and milieu therapies (a structured group treatment method that uses everyday activities to help people with mental health issues) as possible. During a review of Resident 79's Psychiatric SNF Follow-Up Note, dated 9/19/2024, the Psychiatric SNF Follow-Up Note indicated, follow up for depression and mood .Mental Status Exam, under Thought Content: No suicidal ideation, no homicidal ideation, no auditory or visual hallucinations expressed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Psychiatric SNF Follow-Up Note, dated of dictation 11/20/2024, the Psychiatric SNF Follow-Up Note indicated, We will increase Zyprexa 10 mg by mouth twice daily for psychosis manifested by auditory and visual hallucinations. We will continue Cymbalta (duloxetine) 60 mg by mouth daily for depression manifested by decrease in motivation, memantine 5 mg by mouth at bedtime for memory enhancement, trazodone 50 mg by mouth at bedtime for depression manifested by inability to sleep, temazepam 15 mg by mouth as needed at bedtime for insomnia for 14 days and we will assess to see the need to continue the medication after 14 days. We will also continue Ativan 1 mg by mouth every six hours as needed for anxiety manifested by restlessness for 30 days and we will assess the need to continue the medication after 30 days . Patient is not currently a danger to self or others . encouraged to cease medication and report side effects should they occur . Continue participation in group and milieu therapies as possible. During a review of the facility's Consultant Pharmacist Medication Regimen Review (MRR) between 10/2024 through 12/2024 the following recommendations were made for Resident 79: a. MRR for the months of 10/2024 and 11/2024 indicated, Please f/u (follow-up) to evaluate monitoring of all indicated behavior (s) and side effect (s) for valproic Acid on the Medication Administration Record (MAR, a written record of all medications given to a resident). b. MRR for the month of 12/2024 indicated, Please f/u to evaluate monitoring of all indicated behavior (s) and side effect (s) for all psychotropic orders on the MAR. During a review of Resident 79's Order Summary Report, the Order Summary Report included the following physician orders: a. Duloxetine HCL Oral Capsule Delayed Release Particles 60 MG, Give 1 capsule by mouth one time a day for Major Depression manifested by (m/b) labile activity related to depression, order date 9/1/2024. b. Lorazepam Oral Tablet 1 MG, Give 1 mg by mouth every 8 hours as needed for Anxiety m/b restlessness for 30 days, order date 01/07/2025 end date 2/6/2025. c. Memantine HCl Oral Tablet 5 MG, Give 1 tablet by mouth at bedtime related to dementia with agitation, order date 9/1/2024. d. Olanzapine Oral Tablet 10 MG, Give 1 tablet by mouth at bedtime for pshychosis m/b auditory hallucinations related to unspecified psychosis, order date 10/15/2024. e. Olanzapine Oral Tablet 5 MG, Give 1 tablet by mouth one lime a day related to unspecified psychosis m/b auditory hallucinations, order date 10/14/2024. f. Trazodone HCl Oral Tablet 100 MG, Give 1 tablet by mouth at bedtime for depression m/b inability to sleep, order date 12/23/2024. g. Valproic Acid Oral Solution 250 MG/5 milliliter ([ml] - a unit of measure for volume), Give 15 ml (750 mg) by mouth at bedtime related to unspecified psychosis m/b increased restlessness, order date 12/23/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Valproic Acid Oral Solution 250 MG/5ML, Give 20 ml (1000 mg) by mouth one time a day related to unspecificed psychosis m/b increased restlessness, order date 12/23/2024. i. May participate in activities not in conflict with treatment plan. j. Monitor behaviors of labile activity every shift for use of duloxetine, order date 9/1/2024. k. Monitor behaviors of psychosis m/b auditory hallucinations every shift for use of olanzapine, order date 9/1/2024. l. Monitor for anxiety m/b restlessness every shift, order date 9/1/2024. m. Monitor for depression m/b inability to sleep every shift for trazodone, order date 9/1/2024. n. Monitor S/E (side effects) and adverse reaction for antipsychotic medications .cognitive/behavior impairment (decrease mental status), akathisia (inability to sit still), frequent falls, depression, suicidal ideation, social isolation, blurred vision, fatigue, insomnia .every shift for olanzapine, order date 9/1/2024. o. Monitor S/E for anti-anxiety Ativan (lorazepam): drowsiness, lack of energy, confusion and disorientation, depression, dizziness, impaired thinking and judgement, memory loss, forgetfulness .Paradoxical side effects (when the opposite outcome of a drug occurs, rather than the expected outcome) included hallucinations, increased confusion, amnesia, cognitive impairment that looks like dementia, falls .every shift for Ativan use, order date 9/1/2024. p. Monitor S/E for anti-depressant (trazodone) .insomnia, dizziness, drowsiness, fatigue .and increased risk for fall every shift for trazodone, order date 9/1/2024 . q. Monitor Valproic Acid S/E .drowsiness, confusion, ataxia (poor muscle control that causes clumsy movements) .every shift, order date 11/9/2024. r. Non-RX (nonpharmacological/ without drugs) Behavioral Interventions indicated, Pick the intervention (s) that best works to alleviate the behavior .every shift for intervention document the corresponding number of all interventions attempted. Document effectiveness of intervention (s) Y/N, order date 9/1/2024. Intervention key: 0 - No Intervention attempted 2 - Redirect 3 - Remove from situation/Ensure resident safety 4 - Provide calm environment (low lighting, quiet) 5 - Meaningful activity (continued on next page)

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	056415	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6 - Reapproach 7 - 1:1 8 - Offer food/drink 9 - Toilet 10 - Provide comfort (message, reposition, heat/cold) 11 - Relaxation techniques 12 - Resident refused During a review of Resident 79's undated care plans with a focus of: a. The resident uses anti-anxiety medications: Lorazepam r/t Anxiety disorder, the care plan intervention indicated, Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. Antianxiety side effects: Drowsiness, lack of energy, Clumsiness, slow reflexes, Slurred speech, Confusion and disorientation, Depression, Dizziness, lightheadedness, Impaired thinking and judgment, Memory loss, forgetfulness, Nausea, stomach upset, Blurred or double vision. Paradoxical side effects: Mania, Hostility and rage, Aggressive or impulsive behavior, Hallucinations. Resident 79's care plan included a caution, The resident is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor for safety. b. The resident has impaired physical mobility r/t (related to) Alzheimer's disease, history of CVA (cerebrovascular accident, stroke). The care plan intervention indicated, invite the resident (Resident 79) to activity programs that encourage activity, physical mobility, such as exercise group .monitor/document/report to MD (physician) PRN s/sx (signs and symptoms) of immobility .provide supportive care, assistance with mobility as needed .Document assistance as needed. c. Resident with altered sleep pattern due to depression as m/b inability to sleep. The care plan interventions indicated, monitor causes of altered sleep pattern such as medication .encourage resident to get up during the day and attend activity as tolerated .administer medication as ordered, re-evaluate effectiveness of interventions. d. The resident uses antidepressant medication: duloxetine HCL and trazodone HCL r/t depression. The care plan interventions indicated, monitor/document side effects and effectiveness. Antidepressant side effects . anxiety, insomnia, dizziness, drowsiness, fatigue .and increased risk for falls. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. The resident uses psychotropic medications r/t behavior management, olanzapine for psychosis. The care plan interventions indicated administer medications as ordered. Monitor/document for side effects and effectiveness monitor/document/report to MD side effects and adverse reactions of psychoactive medications .frequent falls .depression .social isolation .fatigue, insomnia. The care plan included a Boxed warnings (formerly known as Black Box Warnings, are the highest safety-related warnings that medications can have assigned by the Food and Drug Administration [FDA]) which indicated, Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. f. Psychosis, dementia ., The care plan interventions included, encourage the resident to participate to the fullest extent possible with each interaction. g. The resident has impaired cognitive function or impaired thought process r/t Alzheimer's Dementia, psychosis and history of cerebral infarction. The care plan interventions indicated, communication .identify yourself at each interaction .engage the resident in simple structured activities that avoid overly demanding tasks .provide a program of activities that accommodates the resident's abilities. During a review of Resident 79's Medication Administration Record (MAR) for the months of 10/2024, 11/2024, 12/2024, and 1/2025 indicated Resident 79 was administered PRN lorazepam 1 mg a total of 87 times for restlessness or altered mental status (AMS) as follows: 28 times between 10/1/2024 - 10/30/2024 25 times between 11/1/2024 - 11/30/2024 22 times between 12/1/2024 - 12/31/2024 12 times between 1/1/2025 - 1/15/2025 During a review of Resident 79's MAR for monitoring behavior (s) of anxiety m/b restlessness every shift for the months of 10/2024, 11/2024, 12/2024, and 1/2025. Resident 79's MARs indicated by documentation and initialed by licensed nurses across three nursing shifts (7 AM - 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM) that the resident experienced: Zero (0) episodes of restlessness between 10/1/2024 - 10/31/2024, but was administered 28 doses of lorazepam for restlessness. Three (3) episodes of restlessness between 11/1/2024 - 11/302024, and was administered 25 doses of lorazepam for restlessness. Three (3) episodes of restlessness between 12/1/2024 - 12/31/2024, and was administered 22 doses of lorazepam for restlessness. Six (6) episodes of restlessness between 1/1/2025 - 1/15/2025, and was administered 12 doses of lorazepam for restlessness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's MAR for monitoring behavior (s) of psychosis m/b auditory hallucinations every shift for the use of olanzapine for the months of 10/2024, 11/2024, 12/2024, and 1/2025. Resident 79's MARs indicated by documentation and initialed by licensed nurses across three nursing shifts (7 AM - 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM) that the resident experienced, zero (0) behaviors of psychosis m/b auditory hallucinations for the months of 10/2024, 11/2024, and 12/2024; with three behaviors documented on the 1/1/2025 MAR for 1/2/2025, 1/3/2025, and 1/8/2025. During a review of Resident 79's MAR for monitoring behavior (s) of depression m/b inability to sleep every shift for trazodone, for the months of 10/2024, 11/2024, 12/2024, and 1/2025. Resident 79's MARs indicated by documentation and initialed by licensed nurses across three nursing shifts (7 AM - 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM) that the resident experienced, Zero (0) behavioral episodes of inability to sleep for the months of 10/2024, 11/2024, 12/2024, and 1/2025. Resident 79's starting dose of trazodone 25 mg nightly at bedtime, dated 5/7/2025, was increased on 9/1/2024 to trazodone 50 mg nightly at bedtime, and the order was increased again on 12/23/2024 to trazodone 100 mg for the same indication of depression m/b inability to sleep. During a concurrent observation and interview on 1/15/2025 at 9:58 AM, with Resident 79's Sitter (RS) 1 inside of the resident's room, Resident 79 was observed sleeping in bed. RS 1 stated that she was a 1:1 sitter for Resident 79 because the resident was a fall risk. RS 1 stated that the resident sleeps a lot and that she wakes Resident 79 up for meals and snacks. RS 1 stated that she works with Resident 79 daily from 7 AM - 3 PM and the resident sleeps most of the time she is with the resident. RS 1 stated Resident 79 is easy to work with and is cooperative. During an interview on 1/15/2025 at 10:03 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 79 was confused and did not know where she was. LVN 1 stated that Resident 79 slept quite a bit at times and tried to not get out of bed as much. LVN 1 stated Resident 79 used to be an artist and could talk to you about her art, as the resident used to paint. LVN 1 stated that he administered the PRN lorazepam 1 mg to Resident 79 on the morning of 1/15/2025 because the resident was restless. LVN 1 stated after the lorazepam Resident 79 calmed down a lot. LVN 1 stated Resident 79 did not show signs of depression, she was always willing to get up and says, okay, okay. During a concurrent interview and record review on 1/15/2024 at 10:34 AM with LVN 1, Resident 79's progress notes, 1/2025 MAR, and care plan for the use of lorazepam and trazodone was reviewed. LVN 1 stated he did not document nonpharmacological interventions attempted or indicate if the interventions were effective or not prior to administering the PRN medication lorazepam to Resident 79. LVN 1 stated he did not document or describe the behavior he observed that resulted in the resident being administered lorazepam. LVN 1 stated Resident 79's care plan did not include any nonpharmacological interventions to attempt prior to the administration of psychotropic medications for restlessness, depression, or inability to sleep. LVN 1 stated Resident 79 sleeps quite a bit during the day and was administered trazodone nightly for depression and inability to sleep. LVN 1 stated that there was no documentation that the resident was being monitored or documented hours of sleep daily. LVN 1 stated that Resident 79 was cooperative, talks about her art, and would smile frequently, but was confused and disoriented at times and did not know where she was. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/15/2025 at 10:52 AM, with Registered Nurse (RN) 1, Resident 79's MARs and nursing progress notes were reviewed. RN 1 stated Resident 79's MAR indicated the resident was administered lorazepam on 1/10/2025 and there was no documentation that nonpharmacological interventions was attempted prior to the administration of lorazepam. RN 1 stated there should have been documentation of the nonpharmacological intervention and the effectiveness of the intervention for Resident 79. RN 1 stated there was no documentation that Resident 79 was being monitored for hours of sleep during the day, evening, or nighttime hours. RN 1 stated licensed nurses should have been monitoring Resident 79 for hours of sleep which was the triggered behavior for the use of trazodone, depression m/b inability to sleep, but they were not. During a concurrent an interview on 1/15/2025 at 2:29 PM, with RS 1, inside of Resident 79's room, RS 1 stated Resident 79 was sleeping, and she woke Resident 79 up for lunch and the resident went back to sleep. RS 1 stated that she has not seen Resident 79 talking to herself. RS 1 stated Resident 79 woke up today, 1/15/2025, when Responsible Party (RP) 2, came to visit, but went back to sleep once RP 2 left. During an observation on 1/15/2025 at 2:47 PM, inside of Resident 79's room, Resident 79 was observed sleeping on her back. During a concurrent observation and interview on 1/16/2025 at 11:10 AM, with RS 1, inside of Resident 79's room, Resident 79 was observed sleeping. RS 1 stated Resident 79 was sleeping. During an interview on 1/16/2025 at 11:11 AM with RP 2, RP 2 stated Resident 79 usually have her eyes closed when he arrives. RP 2 stated Resident 79 began hallucinating after admission to the facility. RP 2 stated was aware of the medications Resident 79 was on but was not aware of the side effects of the medications. RP 2 stated 79 continues to decline and is getting more confused and forgetful and cannot make a full sentence now. RP 2 stated before Christmas 2024, Resident 79 was able to sing a full verse of Jingle Bells. RP 2 stated Resident 79's physician initially wanted to wean the resident off of olanzapine and start the resident on a different medication for dementia due to Alzheimer's disease, but the medication was too expensive. RP 2 stated when he looks at Resident 79 now, there are times the resident just stares as if she is here, but nobody is home. During a concurrent observation and interview on 1/16/2025 at 2:59 PM, with Certified Nurse Assistant (CNA) 5, Resident 79 was observed sleeping, CNA 5 confirmed and stated, Resident 79 is sleeping now. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/16/2025 at 3:30 PM, with the Director of Nursing (DON) in the presence of the facility's Administrator, Resident 79's clinical records for Resident 79 was reviewed, that included the nursing progress notes, MARs between 10/2024 through 1/2025, MRRs, and resident's psychiatric evaluations for 5/7/2024 and 9/19/2024. The DON stated the licensed nurses should document the specific behaviors observed and the nonpharmacological interventions attempted. The DON reviewed Resident 79's clinical records and stated there was no documentation to describe the behavior exhibited by the resident or documentation to indicate that the resident was evaluated for underlying cause of restlessness. The DON stated there was no documentation of nonpharmacological interventions attempted to alleviate the restlessness prior to the administration of lorazepam for the months of 10/2024, 11/2024, 12/2024, and 1/2025. The DON reviewed the monitoring for trazodone for the month of 12/2024 when trazodone was increased from 50 mg to 100 mg for depression m/b inability to sleep. The DON stated the trazodone dose increase does not correlate with the documentation of monitoring for sleep that indicated zero (0) across three nursing shifts between 10/2024 through 1/2025. The DON stated there was no documentation from the psychiatrist after 9/19/2024 to show that lorazepam 1 mg was reevaluated after 30 days. The DON stated there was no documentation that the facility evaluated the monitoring of behaviors and side effects of all psychotropic medications for Resident 79 as recommended by the facility's Consultant Pharmacist MRRs between 10/2024 through 12/2024. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring revised 3/2019, the P&P indicated Behavioral or Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating the underlying factors, and those that cannot. Current guidelines recommend the use of nonpharmacological interventions for BPSD .Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes . 1. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms. 2. The rationale for the interventions and approaches. 3. Specific and measurable goals for target behaviors. 4. How staff will monitor for effectiveness of the interventions. 5. Nonpharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. 6. The IDT (Interdisciplinary Team (brings together knowledge from different health care disciplines to help people receive the care they need) will monitor for side effects and complications related to psychoactive medications for example, lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 77's Admission Record, the admission record indicated Resident 77 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognition was intact. The MDS indicated Resident 77 required set up assistance with eating, oral hygiene, and upper body dressing. The MDS indicated Resident 77 required supervision with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 77 received an antipsychotic medication (medication to treat symptoms of schizophrenia). During a review of Resident 77's History and Physical Examination (H&P), dated 10/29/2024, the H&P indicated Resident 77 had the capacity to understand and make decisions. During a review of Resident 77's GACH Psychiatric Progress Note, dated 10/26/2024, the Psychiatric Progress Note indicated Resident 77 felt his medication regimen was helpful and continued improvement in his anxiety (feeling of fear, dread, and uneasiness) and depression. During a review of Resident 77's GACH Medication List, dated 10/27/2024, the Medication List indicated to continue taking olanzapine 2.5 milligram (mg, unit of measurement), half a tablet, by mouth, two times a day. During a review of Resident 77's Psychiatric Follow Up Note, dated 11/22/2024, the Psychiatric Follow Up Note indicated Resident 77 was restarted on olanzapine due to having delusional thinking (having false or unrealistic beliefs), increased paranoia (unjustified suspicion and mistrust of other people or their actions), and resistance to care. During a concurrent interview and record review on 1/16/2025 at 10:34 a.m., with Registered Nurse (RN) 1, Resident 77's Order Recap Report, dated 1/1/2024 through 1/31/2025 was reviewed. The Order Recap Report indicated: a. Give olanzapine 1.25mg, by mouth, two times a day for schizophrenia, bipolar mania (a period of extreme mood elevation and increase energy). Order started on 10/27/2024 and discontinued on 11/8/2024. b. Give olanzapine 1.25mg, by mouth, two times a day for schizophrenia. Orders started on 11/8/2024 and discontinued on 11/22/2024. c. Give olanzapine 1.25mg, by mouth, two times a day for schizophrenia as manifested by delusional thinking and poor regards to his health. Order started on 11/22/2024. d. Monitor every shift for depression as manifested by delusional thinking. Order started on 11/27/2024. e. Monitor every shift for behavior(s) of agitation for use of olanzapine. Order started on 12/16/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1 stated Resident 77 received olanzapine because he had behaviors of delusional thinking and had poor regard to his health. RN 1 stated Resident 77 was only monitored for behaviors of agitation and delusional thinking. RN 1 stated Resident 77 was not monitored for any behaviors of poor regard to his health. RN 1 stated because Resident 77 was being treated for specific behaviors, all indicated behaviors had to be monitored by the licensed nurses. During a concurrent interview and record review on 1/16/2025 at 10:36 a.m., with RN 1, Resident 77's Medication Regimen Review (MRR), dated 11/1/2024 through 11/20/2024 and 12/1/2024 through 12/17/2024 were reviewed. The MRR indicated the Pharmacist's Consultant recommended to follow up to evaluate monitoring for all indicated behavior(s) and side effect(s) for olanzapine on the [Medication Administration Record]. RN 1 stated the purpose of the MRR was for the Pharmacist Consultant to review the resident's medication list and make recommendations to better monitor and care for the resident. RN 1 stated in November 2024 and December 2024, the Pharmacist Consultant recommended to follow up to monitor for all of Resident 77's indicated behaviors. RN 1 stated Resident 77's indicated behaviors for the use of olanzapine were delusional thinking and poor regard to his health. RN 1 stated the Pharmacist Consultant recommended the monitoring two times; however, the recommendations were not followed. RN 1 stated there was a discrepancy between Resident 77's orders for monitoring and the indicated behaviors for olanzapine. RN 1 stated Resident 77 was not being properly monitored as his behavior for poor regard to his health was not being monitored every shift. RN 1 stated Resident 77 was not being monitored properly for the effectiveness of olanzapine and Resident 77 was at risk of having his behavior being undetected. During an interview on 1/16/2025 at 12:13 p.m., with the DON, the DON stated Resident 77 was on a psychotropic medication, which required an indication of use for the behaviors the medication was treating. The DON stated all behaviors that were indicated must be monitored. The DON stated monitoring for all the behaviors ensured proper monitoring of the effectiveness of the behavior and to allow Resident 77's physician to adjust the dosage if needed. The DON stated because Resident 77's behavior of poor regard to his health was not being monitored, Resident 77 was at risk of having his behavior mismanaged and undetected. During a review of the facility's P&P titled, Behavioral Assessment, Intervention, and Monitoring revised 3/2019, the P&P indicated Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. The P&P indicated when a medication was prescribed for behavioral symptoms, the documentation would include the rational for use, specific target behaviors and expected outcomes, and monitoring for efficacy and adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation and interview, the facility failed to ensure opened boxes of nebulizer solution (Ipratropium and albuterol combination, is used to treat chronic obstructive pulmonary disease (COPD, a condition that blocks airflow and make it hard to breathe) and other lung conditions, such as asthma [wheezing, difficulty breathing], chronic bronchitis [swelling of the air passages that lead to the lungs], and emphysema [damage to the air sacs in the lungs]) had an open date and was stored in accordance with manufacturer's specification for five of five residents (Residents 15, 35, 74, 19, and 12) inside of two of two Medication Carts (Medcart Station 1 and Medcart Station 2). The deficient practice of failing to label nebulizer solutions, Ipratropium and albuterol combination per the manufacturers' requirements increased the risk that residents with lung diseases could have received ineffective medication necessary to treat or prevent shortness of breath, breathing difficulties, chest pain, and coughing, which could result in health complications or hospitalization . Findings: 1. During a concurrent interview and medication area inspection on 1/15/2025 at 2:48 PM of Medcart Station 1 with Licensed Vocational Nurse (LVN) 3, inside of Medcart Station 1, two boxes of Ipratropium-Albuterol Inhalation Solution labeled for Residents 15 and Resident 35 respectively were observed inside of the medication box with vials of inhalation solution stored outside of the foil pouch. LVN 3 stated there was no open date written or indicated on the boxes for Resident 15 or Resident 35. LVN 3 stated there was 2 vials of Ipratropium-Albuterol Inhalation Solution stored outside of the foil with a prescription fill date of 11/26/2024. LVN 3 stated that she administered a dose of Ipratropium-Albuterol Inhalation Solution to Resident 15, today, 1/15/2025 at 11:15 AM. LVN 3 stated there was four vials of Ipratropium-Albuterol Inhalation Solution stored outside of the foil pouch for Resident 35 and the prescription fill date was 11/8/2024. a. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to COPD and Asthma. During a review of Resident 15's Order Summary Report, the Order Summary Report included an order for Ipratropium-Albuterol Inhalation Solution 0.5-3 (2.5) milligram (mg, unit of measure of weight) per 3 milliliters (ml, unit of measure of volume), instructions indicated to inhale 3 ml orally (by mouth) every 6 (six) hours for SOB (shortness of breath)/ wheezing, order date 11/26/2024. b. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to COPD. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Order Summary Report, the Order Summary Report included an order for Ipratropium-Albuterol Inhalation Solution 0.5 mg -3 (2.5) mg per 3 ml, instructions indicated to inhale 3 ml orally (by mouth) every 6 (six) hours as needed (PRN) for SOB/ wheezing/ Congestion, order date 11/22/2024. 2. During a concurrent interview, medication area inspection, and record review on 1/15/2025 at 3:02 PM of Medcart Station 2, with LVN 2, inside of Medcart Station 2, were three boxes of Ipratropium-Albuterol Inhalation Solution labeled for three individual residents, Resident 74, Resident 19, and Resident 12. The vials of Ipratropium-Albuterol Inhalation Solution was observed poured out and stored loosely inside of the boxes labeled for Resident 74, Resident 19, and Resident 12 and there was no foil pouch inside of the boxes. LVN 2 stated for Resident 74 and Resident 12 that there was no open date on the boxes and the date first stored loosely in the boxes was unknown. LVN 2 counted the vials and stated for Resident 74 there was 24 vials of Ipratropium-Albuterol Inhalation Solution stored outside of the foil pouch and the prescription fill date was 12/2/2024. LVN 2 stated for Resident 19 the open date was 12/27/2024 and there was 10 vials of Ipratropium-Albuterol Inhalation Solution stored outside of the foil pouch. LVN 2 stated for Resident 12 there was 11 vials of Ipratropium-Albuterol Inhalation Solution stored outside of the foil pouch and the prescription fill date was 12/18/2024. LVN 2 stated that Resident 12 was administered three doses of Ipratropium-Albuterol Inhalation Solution today, 1/15/2025, from the vials that was stored outside of a foil pouch for an unknown period of time. LVN 2 stated that he administered a dose of Ipratropium-Albuterol Inhalation Solution to Resident 12 today, 1/15/2025 and should have caught it. LVN 2 stated that he did not know who, when, or why the vials of Ipratropium-Albuterol Inhalation Solution was taken out of the foil pouch. a. During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to COPD, Acute Respiratory Failure (occurs when the lungs cannot release enough oxygen into the blood), and Emphysema. During a review of Resident 74's Order Summary Report, the Order Summary Report included an order for Ipratropium-Albuterol Inhalation Solution 0.5 mg -3 (2.5) mg per 3 ml, instructions indicated to inhale 3 ml orally every 6 (six) hours for SOB/ wheezing, order date 12/2/2024. b. During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to COPD. During a review of Resident 19's Order Summary Report, the Order Summary Report included an order for Ipratropium-Albuterol Inhalation Solution 0.5 mg -3 (2.5) mg per 3 ml, instructions indicated to inhale 3 ml orally every 4 (four) hours for COPD exacerbation (worsening), order date 1/2/2025. c. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to COPD, Acute and Chronic (long-term) Respiratory Failure, Pulmonary Fibrosis (is a lung disease that causes scarring in the lungs, making it difficult to breathe), During a review of Resident 12's Order Summary Report, the Order Summary Report included an order for Ipratropium-Albuterol Inhalation Solution 0.5 mg -3 (2.5) mg per 3 ml, instructions indicated to inhale 3 ml orally every 6 (six) hours related to COPD, order date 10/6/2024. (continued on next page)

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	056415	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/2025 at 3:30 PM with a Registered Nurse (RN) 1, RN 1 stated, the Ipratropium-Albuterol Inhalation Solution should be protected from light and remain in the foil pouch. RN 1 stated the light will effect the potency of the medication. RN 1 stated if the strength of the for Ipratropium-Albuterol Inhalation Solution is altered it may not be as effective for the residents to threat their breathing conditions. During an interview on 1/16/2025 at 3:12 PM with the Director of Nursing (DON), the DON read the manufacturer's package labeling for Ipratropium-Albuterol Inhalation Solution and stated the instructions indicated once the vial was removed from the foil pouch, the vial should be used within two weeks. DON stated the boxes of Ipratropium-Albuterol Inhalation Solution should have been dated with an open date. During a review of the manufacturer's labeling Instruction on the outside of the manufacturer's box for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution 0.5 mg/3mg per 3 ml, the manufacturer's labeling indicated, For Oral Inhalation Only, Storage Conditions: Protect From Light. Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within two weeks.

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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. 47679 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen when: 1. A container of apple sauce and jelly were not labeled with the product name, the open date, and the use-by date. 2. An opened container of chocolate creme pie was not labeled with the open date and the use-by date. These deficient practices had the potential to result in harmful bacteria growth that could lead to foodborne illness (transfer of bacteria from one object to another). Findings: During a concurrent observation and interview on 1/13/2025 at 8:12 a.m., with the Dietary Supervisor (DS), in the kitchen, Refrigerator 5 was observed to have two unlabeled containers of food items. The DS stated one container The DS stated one container contained apple sauce and the second container contained jelly. The DS stated the apple sauce and jelly were transferred from their original packaging and into the kitchen safe containers. The DS stated both containers were not labeled with the product name, the open date, nor the use-by date. The DS stated there was no indication how long the apple sauce and the jelly were in the refrigerator. During a concurrent observation and interview on 1/3/2025 at 8:25 a.m., with the DS, in the kitchen, Freezer 1 was observed to have an opened container of chocolate creme pie. The DS stated the pie was served during lunch the previous day. The DS stated the opened container of chocolate creme pie was not labeled with the open day nor the use-by date. During an interview on 1/3/2025 at 8:30 a.m., with the DS, the DS stated when a food item was transferred to another container, the container must be labeled with the product name, the open date, and the use-by date. The DS stated when a food item was kept in its original packaging and opened, the container must be labeled with the open date and the use-by date. The DS stated proper labeling would ensure the freshness of the food item and would ensure the kitchen staff only used the food item within the correct dates. The DS stated if a food item went beyond its use-by date, the food item could grow bacteria and become a food safety hazard. The DS stated serving food items past its use-by date could cause foodborne illnesses to the residents served. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised 11/2022, the P&P indicated, All foods stored in the refrigerator or freezer are covered, labeled, and dated (us by date). The P&P indicated, Refrigerated food are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for three out of five sampled residents (Resident 1, 143, and 144) by failing to ensure: 1. Licensed nurses documented the dates/times residents left and returned to the facility. 2. The Leave of Absence form (form licensed nurses fill out to clear resident to temporarily leave facility) was completed prior to residents leaving and returning to the facility. These deficient practices had the potential to create a miscommunication of the residents' location, whether the residents were cleared to leave the facility, and also created a safety concern. Findings: During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) and pulmonary edema (condition where fluid accumulates in lung tissues, causing shortness of breath, wheezing and coughing up blood). During a review of Resident 1's History and Physical (H&P) dated 6/8/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS), a mandated resident assessment tool), dated 11/21/2024, the MDS indicated that Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 required setup or clean up assistance for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) for toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of the Leave of Absence form, dated 1/13/2025, the form indicated Resident 1 left the facility at 10:00 a.m., and returned at 12:14 p.m. During a review of Resident 1's electronic medical record, unable to locate nursing progress notes indicating Resident 1 left the facility and returned to the facility on [DATE]. During an interview on 1/15/2025 at 8:28 a.m. with Resident 1, Resident 1 stated he left the facility for appointments and errands. Resident 1 stated the staff did not check on him when he returned. Resident 1 stated he gives the leave of absence form to the receptionist prior to leaving the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 143's Admission Record, the admission record indicated Resident 143 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic obstructive pulmonary disease (COPD, group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs). During a review of Resident 143's H&P dated 12/27/2024, the H&P indicated Resident 143 had the capacity to understand and make decisions. During a review of Resident 143's MDS, dated [DATE], the MDS indicated Resident 143's cognitive skills for daily decision making was intact. The MDS indicated Resident 143 required setup or clean up assistance for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 143's Leave of Absence form, dated 1/6/2025, the form indicated Resident 143 left the facility at 12:50 p.m. and returned at 4:40 p.m. The form did not indicate who Resident 143 left the facility with and what was Resident 143's outing plan. During a review of Resident 143's Leave of Absence form, dated 1/7/2025, the form indicated Resident 143 left the facility at 10:40 a.m. and returned at 4:13 p.m. The form did not indicate who Resident 143 left the facility with and what was Resident 143's outing plan. During a review of Resident 143's electronic medical record, unable to locate nursing progress notes that indicated Resident 143 left the facility and returned to the facility on [DATE] and 1/7/2025. 3. During a review of Resident 144's Admission Record, the admission record indicated Resident 144 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure) and lower extremity (legs) thrombosis (a blood clot within blood vessels that limits the flow of blood). During a review of Resident 144's H&P dated 1/9/2025, the H&P indicated Resident 144 had the capacity to understand and make decisions. During a review of Resident 143's Leave of Absence form, dated 1/6/2025, the form indicated Resident 143 left the facility at 12:50 p.m. and returned at 4:40 p.m. The form did not indicate who Resident 143 left the facility with and what was Resident 143's outing plan. During a review of Resident 144's Leave of Absence form, dated 1/9/2025, the form indicated Resident 144 left the facility at 10:45 a.m. and returned at 5:00 p.m. The form did not have the signature of the nurse that cleared Resident 144 to leave the facility. During a review of Resident 144's electronic medical record, unable to locate nursing progress notes that indicated Resident 143 left the faciity on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/2025 at 1:00 p.m. with the Receptionist, the Receptionist stated residents must talk to the charge nurse prior to leaving the facility and fill out the Leave of Absence form. The Receptionist stated the Leave of Absence form must be completely filled out before residents leave the facility. The Receptionist stated if the Leave of Absence form did not have a nurse signature, it meant the charge nurse did not clear the resident to leave the facility and that resident should have not left the facility. The Receptionist stated he did not know why the form was missing the charge nurse signature. During an interview on 1/16/2025 at 12:44 p.m. with Registered Nurse 1 (RN), RN 1 stated a licensed nurse must sign the Leave of Absence form to indicate the resident was cleared to leave the facility. RN 1 stated if a licensed nurse did not clear a resident to leave the facility it would be an unsafe practice and staff would not know resident's whereabouts. RN 1 stated the Leave of Absence form must be completely filled out to allow the resident to leave the facility. RN 1 stated license nurses must sign the Leave of Absence form and document in the nursing progress notes the resident left the facility. RN 1 stated licensed nurses must document when a resident leaves the facility and when the resident returns to the facility. RN 1 stated licensed nurses must document the condition of the resident when leaving the facility and the condition of the resident when they returned to the facility. During a review of the facility's policy and procedure (P&P) titled Signing Residents Out, dated 8/2006, the P&P indicated all residents leaving the premises must be signed out. The P&P indicated the expected time to return to the facility must be documented on the form. During a review of the facility's P&P titled Charting and Documentation, dated 7/2027, the P&P indicated information to be documented in the resident medical record was all services provided to the resident and objective observations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for five of eight sampled residents (Resident 19, 8, 76, 90, and 15) by: 1. Failing to ensure Resident 19's nasal cannula (device used to deliver supplemental oxygen placed directly on the resident's nostrils) and humidifier (a medical device that adds water vapor to oxygen to help relieve dryness and irritation by oxygen therapy) were changed every seven days. 2. Failing to ensure a multiuse bottle of blood glucose (BG, a type of sugar) test strips used for multiple residents was not taken into and out of each of the following residents rooms (Residents 8, 76, 90, and 15) which increased the risk of cross-contamination, infection, and the spread of disease between residents whose blood was being tested during BG level checks (a test that measures the amount of glucose in the blood). These deficient practices had the potential to place Residents 19, 8, 76, 90, and 15 at risk for infection. Findings: 1. During a review of Resident 19's Admission Record (a document containing medical and demographic information), the admission record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness (loss of muscle strength), and dysphagia (difficulty swallowing). During a review of Resident 19's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/17/2024, the MDS indicated Resident 19's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 19 required maximal (helper does less more than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 19's care plan with a focus of Oxygen Therapy related to (r/t) COPD, dated 11/8/2024, the care plan interventions indicated to administer oxygen as ordered. During a review of Resident 19's order summary report, dated 12/26/2024, the order summary report indicated to administer oxygen at two (2) liter (a metric unit) per minute (2 liter/min) as needed (PRN) for shortness of breath. During an observation on 1/13/2025 at 10:26 a.m., in Resident 19's room, observed Resident 19's oxygen humidifier was dated 12/14/2024. Resident 19's oxygen tubing and nasal cannula were touching the floor and undated by Resident 19's bedside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/16/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated the oxygen humidifier on Resident 19's oxygen concentrator was dated 12/14/2024. The DON stated the tubing and nasal cannula were undated. The DON stated the oxygen tubing and nasal cannula should be changed and dated every seven days. The DON stated the oxygen humidifier should be changed every seven days and/or as needed. The DON stated the licensed staff were responsible for changing the oxygen tubbing, nasal cannula, and humidifier every seven days. The DON stated the oxygen supplies might accumulate dirt, dust, and not work properly. The DON stated not changing the oxygen tubing, nasal cannula, and humidifier placed Resident 19 at risk for a respiratory infection. The DON stated the purpose of changing the oxygen supplies every seven days was for infection control purposes and it was a standard of nursing practice. During a review of the facility's policy and procedure (P&P) titled Cleaning and Disinfection of Environmental Surfaces, revised 8/2019, the P&P indicated respiratory therapy equipment should be free from all microorganisms. During a review of the facility's' P&P titled Policies and Practices-Infection Control, revised 10/2018, the P&P indicated facility would maintain a sanitary environment to help prevent and manage transmission of diseases and infections. During a review of the facility's P&P titled Oxygen Administration, revised 2/2024, the P&P indicated the facility would provide safe oxygen administration. 2. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to DM with hyperglycemia (high blood glucose [BG]/blood sugar [BS]). During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was sometimes able to be understood and understand others. The MDS indicated Resident 8 cognition was severely impaired. The MDS indicated Resident 8 required set up assistance with eating. The MDS indicated Resident 8 required substantial assistance for oral hygiene and upper body dressing. The MDS indicated Resident 8 was dependent upon facility staff assistance for bathing, toileting, and lower body dressing. During a review of Resident 8's undated care plan with a focus of Diabetes Mellitus, potential for hypoglycemia (low blood glucose), hyperglycemia (high blood glucose), the care plan indicated the interventions indicated to blood sugar check as ordered and to administer insulin per sliding scale. During a review of Resident 8's Order Summary Report, the Order Summary Report included an order for Insulin Lispro (medication used to treat high blood glucose) Injection Solution 100 units (unit of measurement) per milliliter ([ml] - a unit of measure for volume), indicated, inject subcutaneously (just under the skin) as per sliding scale if 70 milligrams (mg, unit of measure of weight) per deciliter (dL, unit measure of volume) - 150 = 0 If BS<70 to give glucose gel if able to swallow and Notify MD.; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 If BS>400 give 12 units of insulin and Notify MD., subcutaneously before meals and at bedtime related to Type 2 diabetes mellitus with hyperglycemia, administration times 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM, order date 12/6/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a blood glucose monitoring observation on 1/14/2024 at 11:54 a.m. with Licensed Vocational Nurse (LVN) 4 on Nursing Station/Medication Cart 1, LVN 4, put on personal protective equipment (PPE, that include a gown, gloves, and mask) to enter Resident 8's room that had a sign on the door that indicated, Enhanced Barrier Precautions (EBP is an approach to the use of PPE to reduce transmission of Multidrug-Resistant Organisms (MDROs) between residents). LVN 4 took a multiuse bottle of Assure Platinum Blood Glucose (BG) Test Strips with an open date of 1/13/2025 into Resident 8's room placed the multiuse bottle of test strips on Resident 8's bedside table opened the container removed a test strip, pricked Resident 8's finger to obtain a blood sample and tested the resident's BG level. LVN 4 collected all the supplies, disposed of the lancet used to prick the resident's finger, and the used test strip and then returned the unused portion of the multiuse bottle of BG test strips to the medication cart. 3. During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to DM. During a review of Resident 76's MDS dated [DATE], the MDS indicated Resident 76 was sometimes able to be understood and understand others. The MDS indicated Resident 76 cognition was intact. The MDS indicated Resident 76 was able to be understood and understand others. The MDS indicated Resident 76 required set up or supervision for ADLs. During a review of Resident 76's undated care plan with a focus of Diabetes Mellitus, potential for altered blood sugar level - at risk for skin breakdown due to insulin administration and blood sugar monitoring, the care plan indicated the interventions indicated to administer diabetes medications as ordered by doctor and monitor/document for side effects and effectiveness. During a review of Resident 76's Order Summary Report, the Order Summary Report included an order for Insulin Lispro (0.5 Unit Dial) Subcutaneous Solution Pen-injector (a medical device used to administer individualized doses of insulin) 100 UNIT/ML, indicated to Inject as per sliding scale: if 201 mg/dL - 250 = 2 units BS less than 201= No insulin; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units BS greater than 400 = Give 6 units and Call MD, subcutaneously before meals and at bedtime for DM, administration times 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM, order date 10/22/20244 During a concurrent blood glucose monitoring observation and interview on 1/14/2024 at 12:07 PM with LVN 4 on Nursing Station/Medication Cart 1, LVN 4 stated the EBP sign outside of Resident 76's door was for a different resident inside the same room and she was not required to put on a gown to check Resident 76's BG level. LVN 4 took the multiuse bottle of Assure Platinum BG Test Strips into Resident 76's room placed the multiuse bottle of test strips on Resident 76's bedside table opened the container removed a test strip, pricked Resident 76's finger to obtain a blood sample and tested the resident's BG level. LVN 4 collected all the supplies, disposed of the lancet used to prick the resident's finger, and the used test strip and then returned the unused portion of the multiuse bottle of BG test strips to the medication cart. 4. During a review of Resident 90's Admission Record, the Admission Record indicated Resident 90 was admitted to the facility on [DATE] with diagnoses that included but not limited to DM with hyperglycemia. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 90's MDS dated [DATE], the MDS indicated that Resident 90 was sometimes able to be understood and understand others. The MDS indicated Resident 90 cognition was moderately impaired. The MDS indicated Resident 90 was able to be understood and understand others. The MDS indicated Resident 90 required set for eating and partial to substantial assistance for the ADLs, that included bathing or showering, dressing, getting in and out of bed or a chair, walking, and toileting. During a review of Resident 90's undated care plan with a focus of Diabetes Mellitus, potential for hypoglycemia and hyperglycemia, the care plan indicated the interventions indicated to administer diabetes medications as ordered by doctor and monitor/document for side effects and effectiveness. During a review of Resident 90's Order Summary Report, the Order Summary Report included an order for Insulin Regular Human (medication used to treat high blood glucose) Injection Solution 100 units per ml, indicated, inject subcutaneously as per sliding scale: if 151 mg/dL - 200 = 0 units, if BS is less than 60=Give juice or oral glucose gel; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 399 = 9 units; 400+ = 12 [NAME] if BS is greater than 400, give 12 units and notify MD, subcutaneously before meals and at bedtime for DM, administration times 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM, order date 1/2/2025 During a concurrent blood glucose monitoring observation and interview on 1/14/2024 at 12:14 PM with LVN 4 on Nursing Station/Medication Cart 1, LVN 4 stated Resident 90 was under EBP, after putting on PPE (a mask, gown, and gloves), LVN 4 took the multiuse bottle of Assure Platinum BG Test Strips into Resident 90's room placed the multiuse bottle of test strips on Resident 90's bedside table opened the container removed a test strip, pricked Resident 90's finger to obtain a blood sample and tested the resident's BG level. LVN 4 collected all the supplies, disposed of the lancet used to prick the resident's finger, and the used test strip and then returned the unused portion of the multiuse bottle of BG test strips to the medication cart. 5. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to DM and pressure ulcer (a localized area of skin damage caused by prolonged pressure on the skin) of sacral region (lower spine), Stage III (sore deepens and looks like a crater). During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15 was sometimes able to be understood and understand others. The MDS indicated Resident 15 cognition was moderately impaired. The MDS indicated Resident 15 was usually understood and usually able to understand others. The MDS indicated Resident 15 required set for eating and partial assistance for oral hygiene. The MDS indicated Resident 15 substantial assistance to total dependency on facility staff for bathing or showering, dressing, getting in and out of bed or a chair, walking, and toileting. During a review of Resident 15's undated care plan with a focus of Diabetes Mellitus, potential for altered blood sugar, the care plan indicated interventions indicated to administer diabetes medications as ordered by doctor and monitor/document for side effects and effectiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's Order Summary Report, the Order Summary Report included an order for Insulin Lispro, indicated, inject subcutaneously as per sliding scale: if 0 - 200 = 0 units, if BS is less than 201, no insulin; 201 - 250 = 2 units ; 251 - 300 = 3 units ; 301 - 350 = 4 units; 351 - 400 = 5 units if bs greater than 400 give 6 units and call MD, subcutaneously before meals and at bedtime for diabetes, administration times 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM, order date 11/26/2024. During a concurrent blood glucose monitoring observation and interview on 1/14/2024 at 12:22 PM with LVN 4 on Nursing Station/Medication Cart 1, LVN 4 took the multiuse bottle of Assure Platinum BG Test Strips into Resident 15's room placed the multiuse bottle of test strips on Resident 15's bedside table opened the container removed a test strip, pricked Resident 15's finger to obtain a blood sample and tested the resident's BG level. LVN 4 collected all the supplies, disposed of the lancet used to prick the resident's finger, and the used test strip and then returned the unused portion of the multiuse bottle of BG test strips to the medication cart. LVN 4 stated the Assure Platinum BG Test Strips inside the bottle are used for multiple residents and should not go into the room with the residents because of infection control. During an interview with the Director of Nursing on 1/16/2025 at 3:12 PM, the DON stated the multiuse bottle of BG/BS test strips used for multiple residents should stay at the medication cart for infection control. The DON stated the licensed nurse should only carry the supplies that they need into the resident's room and not take additional material or equipment because the supplies become unclean and increase the risk of infection toward other residents. According to Center for Disease Control for Injection Safety under, Considerations for Blood Glucose Monitoring and Insulin Administration dated 8/2024, indicated, Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment .Hand hygiene indicated . Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. Discard gloves in appropriate receptacles (containers). Perform hand hygiene immediately after removing gloves and before touching other medical supplies intended for use on other persons . If healthcare providers use blood glucose testing or insulin administration devices on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, HIV, and other infections. During a review of the facility's P&P titled, Policies and Practices - Infection Control, revised 10/2018, the P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission or diseases and infections. During a review of the facility's P&P tiled, Obtaining a Fingerstick Glucose Level, revised 10/2021, the P&P indicated, the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Assemble equipment and supplies needed. During a review of an undated P&P Titled, Charge Nurse, the P&P indicated, Assist in training department personnel in identifying tasks that involve potential exposure to blood/body fluids . Monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies.