STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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** 46537 Based on observation, interview, and record review, the facility failed to ensure staff treated each resident with respect and dignity during assistance with feeding for one of 11 sampled residents (Resident 89) by failing to sit next to Resident 89 at eye level and feed her without rushing her through the meal. This failure had the potential to result in feelings of decreased self-esteem and self-worth for Resident 89. Findings: During a review of Resident 89's Admission Record, the Admission Record indicated, Resident 89 was initially admitted to the facility on [DATE] and last readmission was on 11/13/2024 with diagnoses including developmental disorder (a group of conditions due to an impairment in physical, learning, language, or behavior areas) and dysphagia (difficulty swallowing). During a review of Resident 89's History and Physical (H&P), dated 11/14/2024, the H&P indicated, Resident 89 had no capacity (ability) to understand and make decisions. During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 89 required set-up or clean-up assistance (Helper sets up or cleans up) from one staff for toileting hygiene, bed mobility, supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating, and oral hygiene. During a concurrent observation and interview on 12/16/2024, at 12:24 p.m., with Certified Nurse Assistant (CNA) 6 in the dining room, CNA 6 was standing over Resident 6 and telling Resident 6 to open her mouth, while assisting Resident 6 eat her meal. Resident 6 shook her head left to right and closed her lips tightly. CNA 6 was constantly telling Resident 6 to open her mouth and eat more. CNA 7 came and advised CNA 6 to sit down on the chair and not to rush or force Resident 6 to eat, but CNA 6 continued. CNA 6 stated, she did not have any bad intention, but she wanted to make sure Resident 6 ate more food. CNA 6 stated, she should have sat next to Resident 6 at eye level, and she should have not rushed or forced her to eat. CNA 6 stated, she realized that Resident 6 might feel disrespected. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Studebaker Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13226 Studebaker Rd Norwalk, CA 90650	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024, at 12:35 p.m., with CNA 7, CNA 7 stated, she offered the chair to CNA 6, because staff should sit down next to the resident at eye level to show respect. CNA 7 stated, the staff should have never rushed or forced the resident while assisting with meals because this would affect the resident's dignity negatively. During an interview on 12/20/2024, at 12:11 p.m., with the Director of Nursing (DON), the DON stated, all staff should treat residents respectfully. The DON stated, the staff should have sat next to the resident to show respect and should have not rushed the resident to finish her meal for resident safety. The DON stated this would lower the residents' self-esteem and self-worth. During a review of Resident 89's Order Summary Report (OSR), dated 12/18/2024, the OSR indicated, Consistent Carbohydrate Diet (CCHO diet- eating the same amount of carbohydrates every day to control blood sugar) with pureed texture (all food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) was ordered on 11/26/2024. The OSR indicated, assist with meal was ordered on 11/11/2024. During a review of the facility's Policy and Procedure (P&P) titled, Assistance with Meal, Revised 7/2017, the P&P indicated, Policy Interpretation and Implementation: Dining Room Residents .3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. a. Not standing over residents while assisting them with meals. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, implemented 10/1/2023, the P&P indicated, Policy: II. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49573 Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 89 and Resident 2) had a completed advance directive (a written statement of a person's wishes regarding medical treatment) acknowledgement and Physician Orders for Life-Sustaining Treatment ([POLST]- a medical order that helps give people with serious illness more control over their care during a medical emergency) in their medical records as evidenced by: A. Failing to ensure follow-through with the regional center to obtain the completed advance directives form and have a current copy of the advance directive in Resident 89's medical record. B. Failing to ensure Resident 2 or his/her representative had the opportunity to formulate an advance directive. These failures had the potential for delay of care and treatment and/ or inadvertently missed health care wishes/ decisions of the residents during emergency, end of life, and changes in condition. Findings: A. During a review of Resident 89's Admission Record, the Admission Record indicated, Resident 89 was initially admitted to the facility on [DATE] and last readmission was on 11/13/2024 with diagnoses including developmental disorder (a group of conditions due to an impairment in physical, learning, language, or behavior areas) and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). During a review of Resident 89's History and Physical (H&P), dated 11/14/2024, the H&P indicated, Resident 89 had no capacity (ability) to understand and make decisions. During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 89 required set-up or clean-up assistance (Helper sets up or cleans up) from one staff for toileting hygiene, bed mobility, supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating, and oral hygiene. During an interview on 12/18/2024, at 11:33 a.m., Social Service Director (SSD) 1, SSD 1 stated, Resident 89 was from the regional (nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities) center and all forms should be sent to the Regional Center to be completed. SSD 1 stated, the Medical Records Department should have the Advance Directives and the POLSTs. SSD 1 stated, she asked the Medical Record Director (MRD) to fax the forms to the Regional Center Care Coordinator. SSD 1 stated, she had no documentation to prove she followed up with the Regional Center. SSD 1 stated, incomplete Advance Directive Acknowledgement forms and POLSTs would delay treatment and life saving measures and should be available in the chart for immediate access. (continued on next page)

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F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a concurrent interview and record review on 12/18/2024, at 12:57 p.m., with the MRD, Resident 89's partially filled Advance Directives Acknowledgement and POLST forms that were faxed to the Regional Center were reviewed. The fax confirmation indicated, they were faxed to the Regional Center on 10/29/2024, at 4:19 p.m. The MRD stated, she did not hear anything from the Regional Center yet. The MRD stated, she was waiting for a response, and she did not have any documents to prove regarding following up with the Regional Center. The MRD stated, it was important to ensure Advance Directives and POLSTs were in residents' medical records to honor the resident's wishes during a medical emergency.

B. During a record review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of mild intellectual disability (deficits in intellectual functions pertaining to abstract/theoretical thinking), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cerebral infarction due to thrombosis (a serious condition that occurs when blood flow to the brain is blocked, causing an area of brain tissue to die).

During a record review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was severely cognitively (ability to think, understand, learn, and remember) impaired. The MDS indicated Resident 2 was dependent (helper does all the effort and resident does none of the effort to complete the activity. Or assistance of 2 or more helpers is required for the resident to complete the activity) for self-care abilities such as eating, oral hygiene, toileting, shower/bathe, and dressing. The MDS also indicated Resident 2 was dependent for functional abilities such as rolling left and right, sit to lying position, lying to sitting at edge of bed and sit to stand position.

During a record review of Resident 2's H&P dated 10/11/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions about his care.

During a record review of Resident 2's electronic chart, there was no Advance Directive Acknowledgment form in the chart.

During a concurrent interview and record review on 12/18/2024 at 10:42 a.m., SSD 1 stated an Advance Healthcare Directive (AHCD) give someone else, like an agent, the decisions on healthcare needs. SSD stated this agent makes the decision on behalf of the resident when a resident does not have the capacity to makes decisions. SSD stated Resident 2 belonged to the Regional Center (agency that provide assessments, determine eligibility for services, and offer case management services for individuals with developmental disabilities) so she faxed over the paperwork to the Regional Center to have the case worker fill out the Advance Healthcare Directive acknowledgement form. SSD stated there are a few residents who are under the Regional Center, so a packet of paperwork was sent to the Regional Center to be signed by their perspective case worker. SSD stated the facility does not have a record of when the fax was sent out to Regional Center for Resident 2.

During an interview on 12/20/24 at 12:13 p.m. with DON, the DON stated every resident should have an Advance Directive acknowledgement form offered to the residents. The DON stated the SSD should have followed up with the Regional Center to make sure the facility had the forms back in a timely manner and if not, to follow up with the case managers at the Regional Center. The DON stated the importance of an Advance Directive was, so the facility knows exactly how to treat the resident in case of an emergency.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, implemented 10/1/2023, the P&P indicated, Purpose: To provide residents with the opportunity to make decisions regarding their health care. Policy: I. At the time of admission, Admission Staff or designee will inquire about the existence of an Advance Directive, including whether the resident has requested or is in possession of an aid-in-dying drug. The Admission Staff will inform and provide written information to residents concerning the right to accept or refuse medical treatment . VI. A copy of the Advance Directive is maintained as part of the resident's medical record. Procedure: Upon admission, Admission Staff or designee will inform the resident of their right to execute an Advance Directive Form, if one does not already exist . III. If the resident is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an Advance Directive, the Facility may give Advance Directive information to the resident's representative in accordance with state law . V. The Advance Directive is reviewed annually, or more frequently as indicated by changes in the resident's condition, with the resident to ensure that the selections still reflect the wishes of the resident .VI. A copy of the Advance Directive is provided to emergency personnel if the resident is transferred from the Facility via ambulance. VI II. Inquiries concerning Advance Directives are referred to the Director of Social Services. During a review of the facility's Policy and Procedure (P&P) titled, Job Description: Social Service Designee, updated 5/2017, the P&P indicated, Position Responsibilities: a. Educates patients/residents and families/significant others regarding their rights and responsibilities, health care decision making/advance directives, effective problem solving and the extent of community, health and social services that is available to them, including those necessary for effective discharge planning . w. Conducts open, timely and professional communication and relationships with residents/family, team members, supervisors, and others in order to facilitate team work, to assure resident self-determination, and to update on any significant changes or concerns .dd. Maintains resident dignity, quality of life, confidentiality of information and serves as advocate for the resident at all times.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to assess mental capacity before providing information for signing Notice of Medicare Non-Coverage (NOMNC- a notice that indicates when the care is set to end from skilled nursing facility. It includes information for how to appeal the provider's decision.) and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN- a notice that lists the items or services that your doctor or health care provider expects Medicare will not pay for, along with an estimate of the costs for the items and services and the reasons why Medicare may not pay) for one of three sampled residents (Resident 13) and the responsible party. This failure had the potential to result in Resident 13 and responsible party not being able to exercise their right to file an appeal. Findings: During a review of Resident 13's Admission Record, the Admission Record indicated, Resident 13 was initially admitted to the facility on [DATE] and last readmission was on 8/8/2024 with diagnoses including dementia (a progressive state of decline in mental abilities) and metabolic encephalopathy (a change in how the brain functions). During a review of Resident 13's History and Physical (H&P), dated 8/9/2024, the H&P indicated, Resident 13 had no capacity (ability) to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/31/2024, the MDS indicated Resident 13 required supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating, roll left and right, sit to lying, and lying to sitting on side of bed. During a review of Resident 13's Notice of Medicare Non-Coverage (NOMNC), dated and signed 10/29/2024, the NOMNC indicated, the coverage of the skilled services were ended 10/31/2024 and Resident 13 signed the NOMNC on 10/29/2024. During a review of Resident 13's Advance Beneficiary Notice of Non-Coverage (SNF ABN), dated and signed 10/29/2024, the SNF ABN indicated, skilled services would not be covered by Medicare and there would be estimated cost of 40 dollars per unit for physical /occupational therapy. The SNF ABN indicated, it was signed by Resident 13 on 10/29/2024. During an interview on 12/18/2024, at 11:42 a.m., the Business Office Manager (BOM) stated she did not know Resident 13 did not have capacity to sign the NOMNC and SNF ABN. The BOM stated, she did not have any clinical background and should have checked with the nursing staff before she asked the resident to acknowledge and sign the forms. The BOM stated, it was important to make sure that the resident and the responsible party understood what they were singing because they might lose their right to appeal in a timely manner. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/20/2024, at 7:47 a.m., Resident 13's Family Member (FM) 1 she did not know that Resident 13 had signed the NOMNC and SNF ABN. FM 1 stated, no one informed her regarding those documents. FM 1 stated, this bothered her a lot, because the facility staff should have known that Resident 13 was confused, and he did not even speak English fluently. FM 1 stated, she started worrying about receiving a shared cost bill. FM 1 stated, she felt like she was cheated because she lost the time to appeal, and this made her anxious about this situation. During an interview on 12/20/2024, at 12:11 p.m., the Director of Nursing (DON) stated if the resident had no capacity to understand acknowledge and sign a form, the staff should reach out to the responsible party. The DON stated, it was important that the resident and the resident's family fully understood about their rights. The DON stated, the NOMNC should have been explained to the Resident's responsible party before they signed it because the Resident might lose their right to appeal. During a review of Resident 13's untitled Care Plan (CP), revised on 9/15/2024, the CP Focus indicated, Resident 13 had impaired cognitive function (Problems with a person's ability to think, learn, remember, use judgement, and make decisions) and impaired thought process (an individual with altered perception and cognition that interferes with daily living) related to dementia. The CP interventions indicated, communicate with the resident/family/caregivers regarding resident's capabilities and needs. During a review of the facility's Policy and Procedure (P&P) titled, Change in Health Care Coverage, implemented 10/1/2023, the P&P indicated, Purpose: To ensure action taken to change a resident's health care coverage is in compliance with regulations regarding enrollment/disenrollment and resident rights. Procedure .III. Documentation . A. The facility will utilize AP-03-Form (Notice to Beneficiary-Change in Health Care Coverage to ensure regulatory requirements for assisting with disenrollments are met and documented. B. The facility must ensure a signature of acknowledgement is obtained from the beneficiary or his/her legal representative. C. If a legal representative is signing on behalf of the Medicare beneficiary, the facility staff member assisting must verify that the legal representative has the necessary authority to make both financial and health care decisions. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, implemented 10/1/2023, the P&P indicated, Policy: The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source .Procedure: I. State and federal laws guarantee certain basic rights to all residents of the facility .A. Right to be informed about what rights and responsibilities they have .II. Designate a personal representative to make financial and/or healthcare related decisions on their behalf.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50978 Based on observation, interview, and record review, the facility failed to follow their admission process by not itemizing one of three sampled resident's (Resident 71), personal belongings upon admission, and not returning the resident's clothing after being processed from the laundry. This failure resulted in Resident 71's unaccounted for and lost belongings. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted Resident 71 on 4/4/2024 with diagnoses of end stage renal disease (irreversible kidney failure) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), limitation of activities due to disability, major depressive disorder, and unspecified psychosis (severe mental disorder in which a person loses the ability to recognize reality or relate to others). During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 71 was cognitively (ability to think, understand and make daily decisions) intact and required partial/moderate assistance from staff with activities of daily living. During a review of Resident 71's medical record on 12/16/2024, indicated Resident 71 did not have an itemized list upon admission. During an interview on 12/16/2024 at 12:19 p.m., in Resident 71's room, Resident 71 stated, missing items included blanket and clothes, that went to the laundry and never came back. Resident 71 stated, I asked social services for a grievance form and I have not received one. During an interview with the Social Services Director (SSD), on 12/18/2024 at 9:26 a.m., the SSD stated, she was not aware of Resident 71's missing items. The SSD stated when there are missing items, the itemized list is checked to see what items were missing. The SSD stated, not having an itemized list of belongings places the Resident 71 at risk for their belongings to not be accounted for and lost. During an interview on 12/18/2024 at 2:59 p.m., with Registered Nurse Supervisor (RNS) 1, The RNS stated she does not know why Resident 71 did not have an itemized belongings list. RNS 1 stated staff are supposed to do resident's inventory on admission. RNS 1 stated not following the facility's admission procedure led to Resident 71's missing items. RNS 1 stated, for Resident 71, the Administrator should be notified and interview Resident 71 if the resident would like monetary reimbursement or to have items replaced. During an interview on 12/18/2024 at 3:05 p.m., with the SSD, the SSD stated staff failed to make an inventory list for Resident 71'2 belongings, therefore the facility will owe the resident reimbursement for the loss. The SSD stated, On admission the charge nurse should do inventory of belongings, so we do not misplace items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure dated January 1, 2024, titled, Admission and Orientation of Residents, indicated, A. Items brought to the Facility will be documented on the resident inventory. During a review of the facility's P&P dated, October 1, 2023 , titled, Resident Rights-Personal Property, indicated, V. The resident's personal belongings and clothing are inventoried and documented upon admission. VI. The Facility promptly investigates any complaints of misappropriation, theft, or mistreatment of resident property.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Cross reference F744 Based on interview and record review the facility did not protect two of three sampled resident (Resident 20 and 75) from abuse when the facility failed to: 1) Ensure Resident 75, who had a history of aggressive behavior, did not aggressively approach Resident 20, who also had a history of aggressive behavior. 2) Ensure Resident 75 was close to the nursing station as indicated in the care plan intervention, initiated 11/2/2024, to ensure closer monitoring of Resident 75 for aggression manifested by hitting staff. As a result of the deficient practices, Residents 75 and 20 had a physical altercation in Resident 20's room and Resident 75 sustained scratches on the face. Findings: During a review of Resident 20s Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). During a review of Resident 20's Minimum Data Set (MDS), a resident assessment tool, dated 10/18/2024, the MDS indicated Resident 20's cognitive (ability to think and reason) skills for daily decision-making was severely impaired. The MDS indicated Resident 20 had physical behavioral symptoms directed toward others (for example hitting, kicking, scratching, grabbing) that occurred 1 to 3 days. The MDS indicated Resident 20 had verbal aggression symptoms toward others (for example threatening, screaming, or cursing) that occurred 4 to 6 days, but less than daily. The MDS indicated Resident 20 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, showering, and personal hygiene. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including Dementia, major depressive disorder, generalized anxiety disorder, and psychotic disorder (serious mental illness that causes a person to lose touch with reality) not due to a substance or known condition. During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision-making was intact. The MDS indicated Resident 75 required set up assistance when eating, supervision (helper provides verbal cues) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and toileting hygiene. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 75's care plan (untitled), initiated on10/31/2024, the care plan focus indicated Resident 20 was involved in a resident-to-resident altercation of hitting another resident and claiming to be hit by another resident. The care plan goal indicated other resident (Unidentified) will feel safe through review date 3/3/225. The care plan intervention included to administer medications as ordered, intervene as needed to protect the rights and safety of others; approach in a calm manner, divert attention, remove from situation, and take to another location. During a review of Resident 75's care plan (untitled), initiated 11/2/2024, the care plan focus indicated to monitor aggressive behavior such as hitting staff. The care plan goal indicated resident would not show aggressive behavior. The care plan intervention indicated to keep the resident closer to the nursing station and encourage resident to express feelings without getting aggressive and disrespectful. During a record review of Resident 20's Care Conference Interdisciplinary (IDT Resident's health care team consisting of various specialties) Meeting notes, dated 12/2/2024 and timed at 4:17 p.m., the notes indicated on 12/2/2024 Resident 20 was involved in an altercation with another resident (unidentified) and caused minor injuries to the other resident (unidentified). During a review of a facility document titled, Interviews conducted by the DON (Director of Nursing), on 12/2/2024, the DON's Interview document indicated Resident 75 stated he (Resident 75) went to the bathroom and heard someone saying Pendejo (Spanish slang term like someone calling someone an idiot or a dummy) so Resident 75 stated he wheeled himself over to Resident 20's bedside and stated, What's up?. The DON's Interview document indicated Resident 20 stated, Pendejo again. Resident 75 stated he (Resident 75) got up from his wheelchair and walked over to Resident 20 and Resident 20 scratched Resident 75. The DON's Interview document indicated Resident 75 stated he was unsure if he was able to hit Resident 20 and that he just felt Resident 20 scratch him and then staff came inside the room and separated Resident 75 from Resident 20. During an interview on 12/17/2024 at 2:56 p.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 75 went to the restroom and heard Resident 20 calling him Pendejo. RNS 1 stated Resident 75 went to Resident 20's bedside and there was a physical altercation that resulted in Resident 75 sustaining scratches on the face. RNS 1 stated it was physical abuse that's why it was reported. During an observation and interview on 12/18/2024 at 12:13 p.m., with RNS 1, in the hallway, Resident 75's room was not noted to be adjacent to the nursing station. RNS 1 stated Resident 75's room was four rooms down from the nursing station and not close to the station. During the continued interview and record review on 12/18/2024 at 12:15 p.m. with RNS 1, Resident 75's care plans were reviewed. Resident 75's care plan (untitled), initiated 11/2/2024, the care plan focus indicated to monitor aggressive behavior such as hitting staff. The care plan intervention indicated to keep the resident closer to the nursing station and encourage resident to express feelings without getting aggressive and disrespectful. RNS 1 stated this care plan intervention was not implemented on 11/2/2024 like it should have been. It was implemented after a resident-to-resident altercation involving the resident on 12/2/2024. RNS 1 stated Resident 75's room should be closer to the station so after the incident on 12/2/2024 he was moved closer so we can monitor him closer. During an interview on 12/20/2024 at 12:30 p.m., with the DON, the DON stated residents have the right to be free from abuse and abuse should be prevented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Studebaker Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 13226 Studebaker Rd Norwalk, CA 90650	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse, Prevention and Prohibition Program, implemented 7/9/2024, the P&P indicated residents have the right to be free from abuse. The facility has zero tolerance for abuse and staff must not permit anyone to engage in verbal, mental, or physical abuse or mistreatment. The facility was committed to protecting residents from abuse by anyone including other residents.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to document a transfer form for one of two sampled residents (Resident 47) when resident got transferred to the general acute care hospital ([GACH, to a medical facility that provides short-term, active treatment for a wide range of sudden and severe illnesses or injuries) for vomiting (involuntary expulsion of stomach contents through the mouth or nose). This deficient practice had the potential to delay care due to inadequate information from the sending facility. During a record review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of congestive heart failure ([CHF], a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), acute respiratory failure (a life-threatening condition that occurs when the lungs and blood are unable to exchange gases properly), cerebral palsy (a group of neurological disorders that cause permanent problems with movement, balance, and posture), mild intellectual disabilities (deficits in intellectual functions pertaining to abstract/theoretical thinking), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a record review of Resident 47's Minimum Data Set ([MDS], a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 47 was moderately impaired in cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 47 was dependent (helper does all the effort and resident does none of the effort to complete the activity. Or assistance of 2 or more helpers is required for the resident to complete the activity) for self-care abilities such as oral hygiene, toileting, shower/bathe, and lower body dressing but maximal assist with upper body dressing. The MDS also indicated Resident 47 was dependent for functional abilities such as rolling left and right, sit to lying position, and lying to sitting at edge of bed position. During a record review of Resident 47's history and physical (H/P) dated 8/4/2024, the H/P indicated Resident 2 had the capacity to understand and make decisions about his care. During a record review of Resident 47's Change in Condition Evaluation dated 12/13/2024, the Change in Condition Evaluation indicated Resident 47 had shortness of breath (SOB) and vomiting. During a record review of Resident 47's Nurses Progress Notes dated 12/13/2024, the Nurses Progress Notes indicated around 7:30 p.m., was noted resident with repetitive emesis. Medication for nausea and vomiting given and noted not effective. The Nurses Progress Notes indicated; Resident 47 was noted with SOB. Emergency medical transfer were called, and Resident 47 was transferred to the GACH. Doctor notified. During a record review of Resident 47's medical records, there was no transfer form dated 12/13/2024 when Resident 47 was transferred out the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 12/19/2024 at 10:48 a.m. with Registered Nurse Supervisor (RNS) 1, the Change in Condition Evaluation and Nurses Progress Notes were reviewed. RNS 1 stated Resident 47 was transferred out to the hospital for emesis (throwing up). RNS 1 stated the staff was supposed to complete a transfer form when Resident 47 was transferred out to the hospital. RNS 1 stated the importance of the transfer form was to communicate accurate information with the staff at the receiving facility. RNS 1 stated since the transfer form was not done when Resident 47 was being transferred out, the receiving facility had to call the facility because the receiving facility lacked the information needed for Resident 47 being sent out to their facility. During an interview on 12/20/24 at 12:28 p.m. with Director of Nursing (DON), DON stated the transfer form is a communication form that goes with the resident to the receiving facility. The DON stated it was a summary of the resident and the care that was done in our facility. The DON stated the transfer form should have been done when Resident 47 was transferred out to the receiving facility and that the importance of doing the transfer form was to let the receiving facility know our facility was transferring the resident out and this was what we have done for this resident already. During a review of the facility's policy and procedure (P/P) titled Transfer and Discharge, dated 10/2023, indicated, documentation of written or telephone acknowledgement of the resident's transfer by the resident's representative may occur after the transfer in an emergency situation .documentation relating to resident's transfer/discharge will be maintained in the resident's medical record .a temporary transfer to an acute care facility is considered a Facility-initiated discharge and notice must be provided to the resident/resident representative as soon as practicable before the transfer. The Ombudsman must also be notified as soon as practicable.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 49573

Based on observation, interview and record review, the facility failed to implement a comprehensive care plan for two of four sampled residents (Resident 2 and Resident 50) by failing to ensure:

1.Resident 2 had a comprehensive care plan for a person with an intellectual/developmental disability ([IDD], a group of conditions that impact a person's intellectual, physical, and emotional development).

2.Resident 50 had a comprehensive care plan for a person that wears a bipap (help push air into your lungs, supplies pressurized air into your airways by helping open your lungs with pressured air at night) machine.

This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 2 and Resident 50 and to prevent them from achieving their highest practical well-being.

Findings:

1.During a record review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of mild intellectual disability (deficits in intellectual functions pertaining to abstract/theoretical thinking), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral infarction due to thrombosis (a serious condition that occurs when blood flow to the brain is blocked, causing an area of brain tissue to die).

During a record review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 2 was severely impaired in cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 2 was dependent (helper does all the effort and resident does none of the effort to complete the activity. Or assistance of 2 or more helpers is required for the resident to complete the activity) for self-care abilities such as eating, oral hygiene, toileting, shower/bathe, and dressing. The MDS also indicated Resident 2 was dependent for functional abilities such as rolling left and right, sit to lying position, lying to sitting at edge of bed and sit to stand position.

During a record review of Resident 2's history and physical (H/P) dated 10/11/24, the H/P indicated Resident 2 did not have the capacity to understand and make decisions about his care.

During a record review of Resident 2's Preadmission Screening and Resident Review (PASRR) Individualized Determination Report dated 10/1/2024, the PASRR Individualized Determination Report indicated Level 1 screening was positive for possible Intellectual Disability (ID)/Development Disability (DD), and Related Conditions (RC). The PASRR Individualized Determination Report indicated a significant medical condition with mental stressors that require nursing care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 2's undated comprehensive care plans, the comprehensive care plans did not indicate a care plan focus and goals addressing Resident 2's IDD, likes and dislikes. During a concurrent interview with record review on 12/19/2024 at 10:57 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 2's undated comprehensive care plans were reviewed. There was no comprehensive care plan addressing Resident 2's IDD. RNS 1 stated the importance of a comprehensive care plan for an individual with a IDD was having a care plan tailored to their needs. RNS 1 stated the focus of a care plan for someone with IDD such as a focus on communication, was how staff can communicate with the resident to provide the care needed for that resident. RNS 1 stated it was important to have care plans focused areas such as assisting with activities of daily living ([ADL]s, tasks that people perform to stay healthy and alive, such as eating, using the bathroom, and moving around) was important to have so each staff caring for the resident knows how to care for that resident based on their needs. RNS 1 stated a care plan focused on psychosocial was also important because residents with IDD enjoy participating in activities such as bingo, dancing, and music. RNS 1 stated Resident 2 enjoyed bingo and Zumba dancing activities and socializing with other residents. During a concurrent interview with record review on 12/20/2024 at 12:26 p.m. with Director of Nursing (DON), the comprehensive care plan, no date, was reviewed. The comprehensive care plan did not address Resident 2's IDD. DON stated the importance of person-centered care plan for someone who was not able to verbalize what they want was to let staff know what the staff can do for the resident. DON stated a resident should still be able to do activities and be able to do things they enjoy like any other resident. DON stated someone with an IDD would need certain care and a care plan would let the staff know how to care for that resident. 2.During a record review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses of paraplegia (a chronic condition that causes the loss of motor or sensory function in the lower half of the body, including the legs, feet, and toes), acute (symptoms or signs that begin and worsen quickly) and chronic (a disease or condition that usually lasts for 3 months or longer and may get worse over time) respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately provide oxygen to the body, resulting in a low level of oxygen in the blood), hypertension ([HTN]-high blood pressure), and amyotrophic lateral sclerosis ([ALS], a progressive neurodegenerative disorder that affects the motor neurons in the brain and spinal cord). During a record review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 had intact cognitive status. The MDS indicated Resident 50 needed setup or clean up assistance (helper sets up or cleans up but resident completes the activity, helper assists only prior to or following the activity) with functional ability such as eating and needed moderate assistance (helper does less than half the effort, helper lifts or hold trunks or limbs and provides more than half the effort) for oral hygiene and dependent on staff for shower/bathe, and dressing. The MDS also indicated Resident 50 was dependent on functional ability such as rolling left and right, sit to lying position, lying to sitting on the side of the bed and bed to chair transfer. During a record review of Resident 50's H/P dated 11/12/2024, the H/P indicated Resident 50 had the capacity to understand and make decisions. During a record review of Resident 50's Order Summary Report dated 11/19/2024, the Order Summary Report indicated bipap at night with heated humidifier (provides moisture to prevent dryness). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/16/2024 at 11:30 a.m., with Resident 50 in her room, Resident 50 was resting in bed with the head of the bed up. Resident 50 had her Bipap machine at the bedside. Resident 50 stated she wears the bipap every night and during the day for naps. Resident 50 stated the staff does not replace the humidifier for her bipap machine and that she would get panicked at night when the humidifier runs out of water. Resident 50 stated she tried to get the staff to change out the humidifier by pushing the call light button, but staff would come, turn off the call light and did not ask her if she needed anything. Resident 50 stated she would put on an alarm on her phone in the middle of the night to wake up, check to see if the humidifier was running low on water and then call staff when the humidifier was running low. During a concurrent interview and record review on 12/18/2024 at 11:15 a.m., with the MDS Coordinator (MDSC), Resident 50's undated comprehensive care plan was reviewed. There was no care plan for bipap use. The MDSC stated there should have been a care plan for bipap use for Resident 50. The MDSC stated the importance of a care plan was to determine how the care will be provided and the interventions needed for the residents. The MDSC stated if the interventions were not working, staff would revise the care plan as needed. The MDSC stated staff should be doing rounds on the residents to see what the residents have at the bedside. Staff should be replacing the humidifier before it gets empty. The MSDC stated if there was a care plan and interventions in place, Resident 50 should not have to put an alarm to wake up in the middle of the night to check the humidifier to make sure the water did not dry out, The MDSC stated staff should be doing their rounds and checking to make sure the humidifier was not empty. During an interview on 12/20/24 at 11:54 a.m. the Director of Nursing stated the importance of a care plan was, so the staff know what to do for the plan of care for residents. The DON stated not every resident was the same so the care plans are in place so staff can meet the needs of each individual residents. The DON stated the humidifier would need to be checked to make sure it does not run out of water and that staff should be checking every 4 hours to make sure humidifier does not run out of water and change it as needed if it was running low. The DON stated each resident should have interventions tailored to each resident's needs. During a review of the facility's policy and procedure (P/P) titled Care Planning, dated 10/1/23, the P/P indicated the purpose of care planning was to ensure that a comprehensive person centered care plan is developed for each resident based on their individual assessed needs .the care plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's attending physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs .the facility will develop a person-centered baseline care plan for each resident within 48 hours of admission the baseline care plan will be updated to reflect changes in the resident's condition or needs occurring prior to the development of the comprehensive care plan .the IDT will revise the comprehensive care plan as needed at the following intervals such as to address changes in behavior and care and other times as appropriate or necessary.

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	056425	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50978 Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 71) who received required hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially though a machine when the kidney(s) have failed) services was provided adequate care by not: a. Updating Resident 71's medical records for hemodialysis schedule since 9/5/2024, when the order was changed by the hemodialysis center. b. Documenting Resident 71's refusal to go to HD, follow up appointment and notifying the medical doctor (MD). c. Reporting out of range Hemoglobin (Hgb) A1C (a test that indicates the average level of blood sugar control over the last couple of months) to the MD on 4/19/2024 and 11/21/2024. d. Providing Resident 71 snacks while out of the facility on hemodialysis days. This deficient practice placed Resident 71 at risk for a lapse in ongoing assessment and oversight before, during and after dialysis treatments, and resulted in a breakdown of ongoing communication and collaboration with the dialysis facility regarding dialysis care and services and not addressing the resident's high blood sugar test results in a timely manner. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted Resident 71 on 4/4/2024 with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 71 was cognitively (ability to think, understand and make daily decisions) intact and required partial/moderate assistance from staff with activities of daily living. During a review of history and physical dated 4/2024, the history and physical indicated, Resident 71 had the capacity to make own decisions. a. During a telephone interview on 12/18/24 at 4:44 p.m. with Dialysis Nurse (DN) 1, the DN 1 stated, Resident 71's order for hemodialysis was twice a week, Tuesdays and Thursdays since 9/2024. The DN 1 stated the frequency of visits decreased because of patient preference. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a interview and record review on 12/19/2024 at 8:21 a.m. with Licensed Vocational Nurse (LVN) 4 , Resident 71's SNF: Pre-Dialysis Assessment/Dialysis Unit, dated 9/5/2024 was reviewed. The SNF (Skilled Nursing Facility): Pre-Dialysis Assessment/Dialysis Unit indicated, per physician, patient will have 2x/week HD treatment, Tues and Thurs. LVN 4 stated, on 9/5/2024 out-patient HD center notes indicated hemodialysis changed to Tuesdays and Thursdays. LVN 4 stated the order for schedule change was not carried out. LVN 4 stated, I knew and just forgot, physician knows, I just didn't chart it. I should have charted it. b. During a review of Resident 71's progress notes, dated October 2024, the progress notes indicated, missed hemodialysis dates: 10/22/2024, 10/24/2024, 10/29/2024. On 10/22/2024, Resident 71 refused hemodialysis, no make-up appointment was documented, the progress notes did not indicate to whom endorsements were made and was not monitored post HD. On 10/23/2024 the resident was scheduled for appointment at 4:00 p.m., Resident 71 did not go to HD. There was no progress notes, no COC or refusal documented. On 10/24/2024 the progress notes indicated Resident 71 did not go to HD, refusal was not documented, no COC, no monitoring post HD, and MD was not notified. On 10/29/2024 the progress notes indicated no document of refusal, no monitoring post HD, no follow up appointment was scheduled, and the MD not notified. During a review of Resident 71's progress notes dated November 2024, indicated on 11/5/2024, there was no refusal documented, no monitoring post HD, no make-up scheduled and MD was not notified. During a interview and record review on 12/19/2024 at 8:21 a.m. with Licensed Vocational Nurse (LVN) 4 , LVN 4 stated, staff needs to make sure the resident goes to dialysis, if the resident refuses, staff will monitor and assess, write a change of condition (COC), schedule a make-up appointment day notify the physician. LVN 4 stated on missed HD days, staff should have documented refusals, should have done COC, performed an assessment, notified physician, monitored for 72 hours- post refusal, make up days should be rescheduled. LVN 4 stated, missed hemodialysis can be dangerous life threatening. During a concurrent interview and record review on 12/18/2024 at 4:34 p.m., with the Director of Nursing, the DON, Resident 71's dialysis order dated 9/2024 was reviewed. The DON stated, for the process of HD orders, the facility receives orders from dialysis physician, communication comes from hemodialysis center, then goes to registered nurse supervisor and/or charge nurse. The DON stated the systemic failure was a breakdown of communication. The DON stated, there was no documentation for missed hemodialysis days, however the nurses are supposed to document when residents missed dialysis. If residents miss due to transportation issue or if missed dialysis due to refusal, the possible outcomes could be fluid retention, effects on the heart, confusion and a COC. c. During an interview and record review on 12/19/24 at 11:33 a.m. with RNS 1, Resident 71's progress notes dated 4/16/2024 and laboratory report dated 4/18/2024 were reviewed, the progress notes indicated, to have Laboratory for Complete Metabolic Panel and Hgb A1C. Record review of the laboratory report dated 4/18/2024 indicated A1C 8.6 % (percent) (normal value: A1C below 5.7%), and on 11/21/2024 indicated A1C was 8.5%. RNS 1 stated the physician should have been called and notified to get orders and recommendations. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During an interview on 12/16/2024 at 12:19 p.m. with Resident 71, stated going to HD, from 3 a.m. to 7 a. m. Resident 71 stated I know I am supposed to get snacks, but no snacks given, I only get a protein drink. The dialysis center said I need bars to limit my fluid instead this place gives me drinks. During a record review of SNF Pre-Dialysis assessment dated ,d+[DATE], 11/2024, 12/2024, the Pre-Dialysis Assessments indicated, sack lunch and nourishment marked provided = yes. No documentation of what snack was given to the resident. During an interview on 12/18/2024 at 9:26 a.m. with Social Service Director (SSD), the SSD stated the Dietary Supervisor (DS) handles snacks for dialysis residents. SSD stated, We document here in social services any notes for communication between dialysis center and us. During an interview on 12/18/24 at 12:18 p.m. with Licensed Vocational Nurse (LVN) 2 , LVN 2 stated there is a dialysis book per station and each resident has a binder. In the binder are where vital signs and where it states snacks were provided. During an interview on 12/18/24 at 12:29 p.m. with DS, the DS stated dialysis residents are provided with snacks on dialysis days but did not having a system in the kitchen for tracking what type of snacks are provided nor confirming if dialysis residents have received prepared snacks/meals. During a phone interview on 12/18/2024 at 2:17 p.m. with Registered Dietician (RD), the RD stated, typically send off the sandwich or breakfast, but not that early, the kitchen is closed at that time. We should have provided Resident 71 with snacks and have a system in place to document what has been given to the resident and where to store snacks for residents who leave for dialysis when the kitchen is closed and who will be responsible to do this. The RD stated the potential outcome when snacks are not given before HD could be low blood pressure or a blood low volume issue. During a review of the facility's P&P titled, Refusal of Treatment, dated 10/1/2023, indicated, The Facility will honor a resident's request not to receive medical treatment as prescribed by his/her Attending Physician, as well as services outlined on the resident assessment and Care Plan. When a resident refuses or discontinues treatment, the Charge Nurse or DON interviews the resident to determine why the resident is refusing or discontinuing treatment .The Charge Nurse or DON will document information relating to the refusal/discontinuance in the resident medical record .The Interdisciplinary Team will assess the resident's needs and offer the resident alternative treatments while continuing to provide other services in the Care Plan. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, dated 10/01/2023, indicated, The Facility will promptly . consult with the resident's Attending Physician . when there is a significant change in their condition that is caused by, but not limited to C. A significant change in treatment .i. The licensed Nurse will notify the resident Attending Physician when there is a: F. Need to alter treatment significantly (e.g. based on lab/ .results, a need to discontinue an existing form of treatment due to change of condition). During a review of the facility's P&P titled, Dialysis Care, dated 10/1/2023, indicated, A. Diet iii.A sack lunch to be provided .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44055

Cross Reference F600

Based on observation, interview, and record review the facility failed to implement the dementia (a progressive state of decline in mental abilities) care plan for two of three sampled residents (Resident 20 and 75). The facility failed to:

a) Ensure Resident 75's, who had a history of aggression and resident to resident altercation, room was close to the nursing station and monitored closely to protect safety of others.

b) Ensure Resident 20, who had a history of aggression since 6/27/2023, did not scratch Resident 75's face.

c)Ensure Resident 75 did not aggressively approach Resident 20 while Resident 20 was in bed and engage in a physical altercation with Resident 20.

d) Ensure Resident 75 received all scheduled doses of Memantine (medication for dementia). There were three missed doses in October 2024.

As a result, Residents 75 and 20 had a physical altercation in Resident 20's room and Resident 75 sustained scratches on the face.

Findings:

During a review of Resident 20s Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia.

During a review of Resident 20's Minimum Data Set (MDS), a resident assessment tool, dated 10/18/2024, the MDS indicated Resident 20's cognitive (ability to think and reason) skills for daily decision-making were severely impaired. The MDS indicated Resident 20 had physical behavioral symptoms directed toward others (for example hitting, kicking, scratching, grabbing) that occurred 1 to 3 days. The MDS indicated Resident 20 had verbal aggression symptoms toward others (for example threatening, screaming, or cursing) that occurred 4 to 6 days, but less than daily. The MDS indicated Resident 20 required set up assistance with eating, partial assistance (helper does less than half the effort) with oral hygiene, showering, and personal hygiene.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's care plan (untitled), initiated on 6/27/2023, the care plan focus indicated Resident 20 had an episode of being physically aggressive to staff. The goal indicated Resident 20 would not injure self or others by next review date on 3/2/2025. The care plan intervention indicated when Resident 20 became agitated: intervene before agitation escalates, guide away from, destress, engage calmly in conversation. The care plan intervention indicated intervene as needed to protect rights and safety of others, approach calmly, divert attention, remove from situation. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including Dementia, major depressive disorder, generalized anxiety disorder, and psychotic disorder (serious mental illness that causes a person to lose touch with reality) not due to a substance or known condition. During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision-making were intact. The MDS indicated Resident 75 required set up assistance when eating, supervision (helper provides verbal cues) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and toileting hygiene. During a review of Resident 75's care plan (untitled), initiated on 10/31/2024, the care plan focus indicated Resident 75 was involved in a resident-to-resident altercation of hitting other resident and claiming to be hit by another resident. The care plan goal indicated other resident (Unidentified) will feel safe through review date 3/3/2025. The care plan intervention included to administer medications as ordered, intervene as needed to protect the rights and safety of others; approach in a calm manner, divert attention, remove from situation, and take to another location. During a review of Resident 75's untitled care plan, initiated on 7/16/2024, the care plan focus indicated resident had a potential to demonstrate physical behaviors (hitting staff) related to dementia. The care plan goal indicated resident would not harm others or self through review date 3/3/2025 and that Resident 75 would have no more episodes of physical aggression. During a review of Resident 75's care plan (untitled), initiated 11/2/2024, the care plan focus indicated to monitor aggressive behavior such as hitting staff. The care plan goal indicated Resident 75 would not show aggressive behavior. The care plan intervention indicated to keep the resident closer to the nursing station and encourage resident to express feelings without getting aggressive and disrespectful. During a review of a facility document titled, Interviews conducted by the DON (Director of Nursing), on 12/2/2024, the DON's Interview document indicated Resident 75 stated he (Resident 75) went to the bathroom and heard someone saying Pendejo (Spanish slang term like someone calling someone an idiot or a dummy) so Resident 75 stated he wheeled himself over to Resident 20's bedside and stated, What's up?. The DON's Interview document indicated Resident 20 stated, Pendejo again. Resident 75 stated he (Resident 75) got up from his wheelchair and walked over to Resident 20 and Resident 20 scratched Resident 75. The DON's Interview document indicated Resident 75 stated he was unsure if he was able to hit Resident 20 and that he just felt Resident 20 scratch him and then staff came inside the room and separated Resident 75 from Resident 20. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 2:56 p.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 75 had dementia and had behavior issues and aggression. RN 1 stated Resident 75 went to the restroom and heard Resident 20 calling him (Resident 75) Pendejo. RNS 1 stated Resident 75 went to Resident 20's bedside and there was a physical altercation that resulted in Resident 75 sustaining scratches on the face. During an observation and interview on 12/18/2024 at 12:13 p.m., with RNS 1, in the hallway, Resident 75's room was not noted to be adjacent to the nursing station. RNS 1 stated Resident 75's room was four rooms down from the nursing station and not close to the station. During the continued interview and record review on 12/18/2024 at 12:15 p.m., with RNS 1, Resident 75's care plans were reviewed. Resident 75's care plan (untitled), initiated 11/2/2024, the care plan focus indicated to monitor aggressive behavior such as hitting staff. The care plan intervention indicated to keep the resident closer to the nursing station and encourage resident to express feelings without getting aggressive and disrespectful. RNS 1 stated this care plan intervention was not implemented on 11/2/2024 like it should have been. It was implemented after a resident-to-resident altercation involving the resident on 12/2/2024. RNS 1 stated Resident 75's room should be closer to the station so after the incident on 12/2/2024 he was moved closer so we can monitor him closer. During the continued interview and record review on 12/18/2024 at 12:15 p.m. with RNS 1, Resident 75's care plans were reviewed. Resident 75's care plan (untitled), initiated 10/31/2024, the care plan focus indicated Resident 20 was involved in a resident-to-resident altercation of hitting other resident and claiming being hit by another resident. The care plan intervention included to administer medications as ordered, intervene as needed to protect the rights and safety of others. RNS 1 stated these care plan interventions were not implemented because Resident 75 was able to approach Resident 20's bed and had a physical altercation with Resident 20. During a continued interview and record review on 12/18/2024 at 12:20 p.m. with RNS 1, Resident 75's Medication administration record (MAR) for 11/2024 was reviewed and the MAR indicated Memantine 5 milligrams (medication for dementia) orally twice a day was not administered as ordered. There were 3 doses that were not administered in the month of 11/2024. RNS 1 stated there were missed doses for the medication and it should have been administered as ordered for resident safety. During a continued interview and record review on 12/18/2024 at 12:25 p.m. with RNS 1, Resident 20's care plan (untitled), initiated on 6/27/2023, the care plan focus indicated Resident 20 had an episode of being physically aggressive to staff. The goal indicated Resident 20 would not injure others by next review date on 3/2/2025. The care plan intervention indicated when resident becomes agitated: intervene before agitation escalates, guide away from, destress, engage calmly in conversation. The care plan intervention indicated intervene as needed to protect rights and safety of others, approach calm, divert attention, remove from situation. RNS 1 stated this care plan was not implemented because Resident 75 was able to approach Resident 20 and the residents had a physical altercation where Resident 75 sustained scratches in the face. During an interview on 12/20/2024 at 11:53 a.m., with the DON, the DON stated residents' medications need to be administered as ordered. The DON stated residents with dementia need personalized care plans addressing dementia with personalized interventions to make sure the residents were safe. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Dementia - Clinical Protocol, revised 11/2018, the P&P indicated For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. Direct care staff will support the resident in initiating and completing activities and tasks of daily living activities will be supervised and supported throughout the day as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44055 Based on interview and record review the facility failed to administer prescription medications as ordered for two out of two residents (Resident 20 and 75) in November 2024. The deficient practices had the potential to result in poor physical and psychological outcomes. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia. During a review of Resident 20's Minimum Data Set (MDS), a resident assessment tool, dated 10/18/2024, the MDS indicated Resident 20's cognitive skills (ability to think and reason) for daily decision-making was severely impaired. The MDS indicated Resident 20 required set up assistance with eating, partial assistance (helper does less than half the effort) with oral hygiene, showering, and personal hygiene. During a review of Resident 20's Order Summary report, active orders as of 12/18/2024, the orders indicated: 1) Ascorbic Acid (supplement) 500 milligrams by mouth one time a day. 2) Colace (stool softener) 100 milligrams one time a day orally for bowel management. 3) Mirtazapine (medication for depression)7.5 milligrams orally, at bedtime for poor appetite. 4) Multivitamin-Minerals (supplement) one tablet orally daily. 5) Vitamin D (supplement)3000 unit orally one time a day. 6) Quetiapine (medication for schizophrenia) 25 milligrams orally two times a day. 7) Sucralfate (medication for stomach ulcer [sore])1 gram oral four times a day. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including Dementia, major depressive disorder, generalized anxiety disorder, and psychotic disorder (serious mental illness that causes a person to lose touch with reality) not due to a substance or known condition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision-making were intact. The MDS indicated Resident 75 required set up assistance with eating, supervision (helper provides verbal cues) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and toileting hygiene. During a review of Resident 75's Order Summary report, active orders as of 12/17/2024, the orders indicated: 1) Atenolol (medication for high blood pressure [force it takes for heart to pump is higher than normal]) 25 milligrams by mouth once a day. 2) Buspirone (medicine for anxiety) 10 milligrams by mouth two times per day for physical restlessness manifested by constantly moving. 3) Fluoxetine (medication for depression) 20 milligrams one time a day oral manifested by inability to sleep. 4) Memantine (medication for dementia) 5 milligrams two times daily orally, for psychosis manifested by anger outburst with no apparent reason. 5) Olanzapine (medication treats mental disorders) 2.5 milligrams orally at bedtime for psychosis manifested by anger outburst for no apparent reason. During an interview and record review on 12/18/2024 at 4 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 75's Medication administration record (MAR) for 11/2024 was reviewed. Resident 75's MAR indicated not all ordered doses for atenolol, buspirone, fluoxetine, memantine, and olanzapine were documented as given. RNS 2 stated there was one dose each for atenolol, fluoxetine, and olanzapine that documented not given for Resident 75 in November 2024. RNS 2 stated there were 2 doses each for buspirone, and Memantine that were documented as not administered for Resident 75 in November. During an interview and record review on 12/18/2024 at 4:06 p.m. with RN) 2, Resident 20's MAR for 11/2024 was reviewed and the MAR indicated not all ordered doses for medications were documented as administered. RNS 2 stated in November 2024, 2 doses of Mirtazapine were not documented, and one dose each of Vitamin C, Vitamin D, Colace, multivitamin, Sucralfate, and quetiapine was not documented as administered. During an interview on 12/20/2024 at 11:53 a.m., with the Director of Nursing (DON), the DON stated physician orders should always be implemented as ordered including medication administration. During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, implemented 10/1/2023, the P&P indicated the time and dose of the drug or treatment ad ministered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment, Recording will include the date, the time and the dosage of the medication or type of the treatment.

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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. 50978 Based on interview and record review, the facility failed to ensure one of three residents (Resident 71) pharmacy recommendation to repeat the Resident 71's Hemoglobin A1C (Hgb-a test that indicates the average level of blood sugar control over the last couple of months) was followed through with the medical doctor (MD). This failure resulted in Resident 71's repeat Hgb A1c not being ordered, placing Resident 71 at risk for having continued high blood sugar and diabetes complications such as heart disease and stroke. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted Resident 71 on 4/4/2024 with diagnoses including of end stage renal disease (ESRD-irreversible kidney failure) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 71 as cognitively (ability to think, understand and make daily decisions) intact and required partial/moderate assistance from staff with activities of daily living. During a review of Resident 71's Lab Results Report dated, 4/29/2024, indicated a laboratory test was taken on 4/18/2024, resulted on 4/19/2024, with Hgb A1C of 8.6% (percent) (normal value: A1C below 5.7%). During a review of Resident 71's Progress Notes, dated 5/30/2024 at 12:06 p.m., indicated Pharmacy recommendation for blood sugars discussed with MD with order to check patients Hgb A1C. Pt is aware and ok with order. During a concurrent interview and record review on 12/19/2024 at 4:01 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 71's Lab Results Report dated, 4/29/2024, and Progress Report dated 4/16/2024 were reviewed. RNS 1 stated Resident 71's progress notes indicated the pharmacy consultant made recommendation to do an Hgb A1C test, but was not done. RNS 1 stated, the results were not relayed to the medical doctor (MD). Staff need to follow orders and report results to the MD to ensure the resident does not have complications. During a concurrent interview and record review on 12/20/24 at 11:54 a.m. with the Director of Nursing (DON), Resident 71's progress notes were reviewed. The DON stated she was aware of the pharmacy consultant's recommendations to redo Resident 71's HgBA1C test. The DON stated not following pharmacy recommendation to repeat the Resident 71's Hemoglobin A1C was an oversight and should have been done, because possible outcome to the resident are effects on the heart. (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 review of the facility's policy and procedure (P/P), dated October 1, 2023, titled, Laboratory, Diagnostic and Radiology Services, indicated III. The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner.

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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** 44055 Based on interview and record review the facility failed to develop nonpharmacological measures to address combative behavior for two out of two residents (Resident 20 and 75) who were on an as needed (PRN) use of psychotropics (medications that alter perception, mood, consciousness, cognition --ability to think, or behavior). The deficient practice had the potential to result in use of unnecessary medications placing Resident 20 and Resident 75 at risk of medication side effects. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia. During a review of Resident 20's Minimum Data Set (MDS), a resident assessment tool, dated 10/18/2024, the MDS indicated Resident 20's cognitive (ability to think and reason) skills for daily decision-making were severely impaired. The MDS indicated Resident 20 had physical behavioral symptoms directed toward others (for example hitting, kicking, scratching, grabbing) that occurred 1 to 3 days. The MDS indicated Resident 20 had aggressive verbal symptoms toward others (for example threatening, screaming, or cursing) that occurred 4 to 6 days, but less than daily. The MDS indicated Resident 20 required set up assistance with eating, partial assistance (helper does less than half the effort) with oral hygiene, showering, and personal hygiene. During a review of Resident 20's Order details (active orders), dated on 11/10/2024 and timed at 2:45 p.m., the Order details indicated to administer Lorazepam (medication to help a person relax) inject (administration of medication through a needle into the body) 1 milligram (mg) intramuscularly (in the muscle) every 6 hours as needed for anxiety for 14 days manifested by combative behavior towards staff. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including Dementia, major depressive disorder, generalized anxiety disorder, and psychotic disorder (serious mental illness that causes a person to lose touch with reality) not due to a substance or known condition. During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision-making were intact. The MDS indicated Resident 75 required set up assistance with eating, supervision (helper provides verbal cues) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and toileting hygiene. (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 20's Order details, dated on 11/21/2024and timed at 8:30 p.m., the Order details indicated to administer Xanax (medication to help a person relax) oral 0.5 milligram orally every 24 hours as needed for anxiety for 6 days manifested by aggressive behavior. During an interview and record review on 12/18/2024 at 12:30 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 20's Medication administration record (MAR) for 11/2024 was reviewed and the MAR indicated Lorazepam was ordered as needed but there were no nonpharmacological measures to implement prior to trying to administer the PRN psychotropic. RNS 1 stated nonpharmacological measures should have been ordered prior to attempting to use PRN psychotropic medications for resident safety. During a continued interview and record review on 12/18/2024 at 12:30 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 75's Medication administration record (MAR) for 11/2024 was reviewed and the MAR indicated Xanax was ordered as needed but there were no nonpharmacological measures ordered to implement prior to trying to administer the PRN psychotropic. RNS 1 stated nonpharmacological measures should have been ordered prior to attempting to use PRN psychotropic medications for resident safety. During an interview on 12/20/2024 at 11:53 a.m., with the DON, the DON stated the residents need nonpharmacological measures prior to using psychoactive medications so there are no unnecessary medications. During a review of the facility's policy and procedure (P&P) titled, Behavior management, implemented 10/1/2023, the P&P indicated the facility will ensure pharmacological interventions are only used when nonpharmacological interventions are ineffective.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview and record review, the facility failed to administer medications appropriately for two out of four residents (Residents 9 and 16) as observed during the medication pass. During medication pass, there were five medication errors for Resident 16, and one medication error for Resident 9 for a total of 6 medication errors out of 26 opportunities. These medication administration errors resulted in a medication error rate of 23.08%. Findings: During a review of Resident 9's Admission Record, the record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including personal history of transient ischemic attacks (temporary blockage of blood flow to the brain) and cerebral infarction (blood flow to brain is blocked resulting in brain tissue death). During a review of Resident 9's Minimum Data Set (MDS), a resident assessment tool, dated 10/16/2024, the MDS indicated Resident 9's cognitive (ability to think and reason) skills for daily decision-making were intact. The MDS indicated Resident 9 required set up assistance with eating, partial assistance (helper does less than half the effort) with showering, and toileting hygiene. During a review of Resident 9's Order Summary as of 12/17/2024, the summary indicated, starting 10/14/2024, Chewable aspirin (medication that can reduce the risk of heart attack) once a day for stroke (blood flow to brain is cut off and can damage brain cells) prophylaxis (prevention). During a review of Resident 16's Admission Record, the record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to substance or known physiological condition. During a review of Resident 16's MDS, a resident assessment tool, dated 10/21/2024, the MDS indicated Resident 16's cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 16 required supervision with eating, and oral hygiene, substantial assistance (helper does more than half the effort) with showering, and toileting hygiene. During a review of Resident 16's Order Summary as of 12/17/2024, the summary indicated: a) Starting 10/19/2024, metoprolol (medication for HTN) 25 milligram, orally, hold if Systolic (blood pressure when the heart is contracting) Blood Pressure (SBP) below 110. b) Starting 10/18/2024, Valsartan (medication for HTN) 160 milligrams orally twice a day hold if SBP below 110. c) Starting 10/19/2024, Quetiapine (medication for psychosis) 25 milligrams oral one time a day manifested by mood swing. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) Starting 10/18/2024, Docusate Sodium (stool softener) 100 milligrams orally two times a day hold if loose stools e) Starting 10/19/2024, Escitalopram (medication for depression [mood disorder that causes a persistent feeling of sadness and loss of interest])5 milligrams once a day manifested by verbalization of sadness. During an observation and interview on 12/17/2024 at 8:26 a.m., at Resident 16's room, with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed crushing five medications (metoprolol, Valsartan, Quetiapine, Docusate sodium, Escitalopram) together, mixing the medications in apple sauce, and administering the medications at the same time to Resident 16 orally. During an observation and interview on 12/17/2024 at 8:26 a.m., at Resident 9's room, with LVN 2, LVN 2 stated she was administering enteric (protecting the lining of the stomach) coated aspirin and showed me the bottle. LVN 2 was observed administering Enteric coated Aspirin 81 milligrams to Resident 9 and not the chewable aspirin. During an interview on 12/17/2024 at 3:38 p.m., Registered Nurse Supervisor (RN)1 stated licensed staff need to follow physician orders and administer chewable aspirin not enteric coated aspirin if that was the order. RN 1 stated each crushed medication should have been administered separately and not all mixed together with applesauce, for resident safety and to ensure the correct medication was administered. During an interview on 12/20/2024 at 11:53 a.m., with the Director of Nursing (DON) the DON stated crushed medications administer by mouth should be administered individually in case the resident spits out a medication the administering staff would know which one was administered and which one was not. The DON stated medications should be administered as ordered. During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, implemented 10/1/2023, the P&P indicated the facility will practice standards for safe administration of medications for residents in the facility. The P&P indicated the Right medication will be administered as ordered. During a review of the facility's P&P titled, Crushing Medication, revised 4/2018, the P&P indicated, Crushing each medication separately and administering each with food is considered best practice.

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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** 44055 Based on observation, interview and record review, the facility failed to: 1. Ensure bubble pack (medication dispensed by the pharmacy in a single use dose compartments) medications were labeled with parameters (guidelines to assess the resident for before administering the medication) for two of two sampled residents (Resident 16 and 9) 2. Ensure Insulin (medication to regulate blood sugar levels) vials were labeled with the date it was opened. 3. Ensure saline (saltwater) solution was stored in a secured location inaccessible to unauthorized persons. 4. Ensure Vitamin K (vitamin needed for blot to clot) in the emergency kit (receptacle contains medications that can be dispensed when pharmacy services are not available) was not expired. These deficient practices had the potential to result in medication errors. Findings: During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN - high blood pressure) During a review of Resident 9's Minimum Data Set (MDS), a resident assessment tool, dated 10/16/2024, the MDS indicated Resident 9's cognitive (ability to think and reason) skills for daily decision-making were intact. The MDS indicated Resident 9 required set up assistance with eating, partial assistance (helper does less than half the effort) with showering, and toileting hygiene. During a review of Resident 9's Order Summary as of 12/17/2024, the summary indicated: a) Starting 10/14/2024, Metoprolol (medication for HTN) 50 milligrams one time a day hold if Systolic (force exerted when the heart is contracting) Blood Pressure (SBP) less than 110 and heart rate is less than 60. b) Starting 10/13/2024, Amlodipine Besylate (medication for HTN) oral tablet 5 milligrams two times a day hold if SBP less than 110. During a review of Resident 16's Admission Record, the record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to substance or known physiological condition. (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 16's MDS dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 16 required supervision with eating, and oral hygiene, substantial assistance (helper does more than half the effort) with showering, and toileting hygiene. During a review of Resident 16's Order Summary as of 12/17/2024, the summary indicated: a) Starting 10/19/2024, metoprolol (medication for HTN) 25 milligram, orally, hold if SBP 110. b) Starting 10/18/2024, Valsartan (medication for HTN) 160 milligrams orally twice a day hold if SBP below 110. During an observation and interview on 12/17/2024 at 8:26 a.m., at Resident 16's room, with Licensed Vocational Nurse (LVN) 3, Resident 16's metoprolol and Valsartan bubble packs did not indicate the physician ordered parameters to hold if SBP less than 110. LVN 3 stated the bubble packs were not labeled with instructions to hold the medication if SBP less than 110 and it should have been indicated on the bubble packs. During an observation and interview on 12/17/2024 at 8:26 a.m. at Resident 9's room, with LVN 2, Resident 9's amlodipine bubble pack did not indicate the instructions to hold the medication if SBP less than 110. Resident 9's bubble pack containing the Metoprolol did not indicate to hold medication if SBP less than 110 and heart rate less than 60. LVN 2 stated the bubble packs did not indicate the parameters for administering the medications. During an interview on 12/17/2024 at 3:38 p.m., with Registered Nurse Supervisor (RN)1, RN 1 stated medications dispensed by the pharmacy should indicate instructions or parameters for administering the medication for resident safety. During an observation of medication storage check and interview on 12/17/2024 at 3:43 p.m., with RN 2, the following were noted: a) Two vials of Lantus (medication to treat high blood sugar) 100 units/milliliters and one vial of Humulin R (regular insulin to treat high blood sugar) were observed to have no label indicating the date it was opened. b) Vitamin K in an Emergency kit expired 5/31/2024. RN 2 stated the vials should have had the dates opened to ensure medication was still viable. RN2 stated should not store expired medications for administration, for the safety of residents. During an observation and interview on 12/18/2024 at 10:40 a.m., with the Director of Nursing (DON), Saline solutions were stored in unlocked crash carts. The DON stated it is a facility practice to keep two Saline solutions per cart in case of emergencies. During an interview on 12/20/2024 at 11:53 a.m., with the DON, the DON stated medications should be stored safely and securely so only authorized personnel can access medications. The DON stated the facility should not have or store any expired medications to administer to residents' for resident safety. (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 the facility's policy and procedure (P&P) titled, Storage of Medication, revised 12/2023, the P&P indicated: a) Medications were stored in locked medication carts and/or locked medication rooms. b) All expired medications should be removed from storage and destroyed per policy. During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, revised 12/2023, the P&P indicated: a) Manufacturers specifications regarding the preparation and administration of the drug will be reviewed. b) All expired medications should be removed from storage and destroyed per policy. During a review of the facility's P&P titled, Medication Labeling, revised 12/2023, the P&P indicated the required elements of a prescription label will include directions for use.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

45777

Based on observation and interview, the facility failed to store, handle, and maintain food/food supplies with professional standard for food service safety as evidenced by failing to:

1.Ensure to store food with label and open date.

2.Ensure to label five sack lunches for resident's who go out the facility for dialysis (mechanical removal of waste from the blood for residents with end stage kidney disease) with dates the sack lunches were prepared.

3. Ensure the commercial can opener was free from a black sticky substance on the blade and the base of the can opener.

Theses deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization .

Findings :

During an initial observation tour and interview of the kitchen on 12/16/2024 at 8:30 a.m., with the Dietary Supervisor (DS), the DS verified in the walk-in refrigerator there were five sack lunches that contained one turkey sandwich, one mixed fruit cup, one small can 231millileters (ml - a unit of measure of volume) of juice and crackers in each bag with no date indicating when the lunches were prepared.

During an observation and an interview on 12/16/2024 at 8:30 a.m., with the DS, in the walk-in refrigerator there was one 32 ounce of pasteurized (heat treated to remove harmful bacteria) liquid whole eggs that was open and had no open date. The DS verified there was no open date on the eggs and stated liquid eggs must have the date of when the container was opened for the freshness, and to know when to discard it.

During an interview on 12/17/2024 at 8:29 a.m., with DA 1, DA 1 stated he made the lunches the night before on 12/16/2024 for the residents who go for dialysis in the morning. DA 1 stated when he prepared the lunches the night before, he should have also put the date on the lunches to ensure freshness of the food.

During an observation on 12/17/2024 at 12:17 a.m., the large stationary can opener had a black sticky substance around the knife (a blade that is usually mounted on a shaft that extends for the openers main body) and the base (a mounting system that attaches the can opener to a countertop for stability and security) of the can opener. The DS stated that there was a black sticky substance on the can opener and the can opener needed to be cleaned daily.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Can Opener Use and Cleaning, (dated October 1. 2023) the P&P indicated, The dietary staff will use the can opener according to manufacturer's guidelines. The can opener will be sanitized between uses. During a review of the facility's (P&P) titled , Food Storage , (dated October 1, 2023) the P&P indicated, label and date storage products.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44055 Based on observation, interview, and record review the facility failed to: a. Ensure Licensed Vocational Nurse (LVN) 1 donned (put on) an isolation gown while administering medications through the Gastrostomy tube (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for one of one resident (Resident 19). b. Ensure Certified Nurse Assistant (CNA) 4 performed hand hygiene and wore personal protective equipment (PPE) when providing care for one of two residents (Resident 81) reviewed for G-tubes. c. Ensure Certified Nurse Assistant (CNA) 1 and CNA 2 performed hand hygiene and changed gloves when providing incontinence care to two of two residents (Resident 71 and Resident 395) These deficient practices had the potential to result in the spread of infections in the facility and cause undue harm to the residents' health and well-being. Findings: a. During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted Resident 25 on 3/4/2024 with a G-tube. During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool), dated 11/13/2024, the MDS indicated Resident 19's cognition (ability to think, understand and make daily decisions) was severely impaired. The MDS indicated Resident 19 was dependent on staff with 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 concurrent observation and interview on 12/17/2024 at 9:01 a.m. with LVN 1, an Enhanced Barrier Precaution (EBP) was observed outside Resident 19's room indicating to wear a gown and gloves for high contact resident care activities. LVN 1 was observed touching Resident 19's G-tube and proceeded to administer eight medications through the G-tube without wearing an isolation gown. LVN 1 stated she forgot to put on an isolation gown. During an interview on 12/20/2024 at 11:56 a.m. with the Director of Nursing (DON), the DON stated EBP should be followed, and staff need to wear gloves and isolation gown to prevent spread of infection and to protect the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Standard and Enhanced Precautions revised 10/2023, the P&P indicated Enhanced standard precautions will be implemented for residents with a known Multidrug resistant Organism (MDRO - germs that are resistant to multiple antibiotics) and who are at high-risk for colonization (when a microorganism grows and multiplies on or inside a host without causing disease) and transmission (process by which a germ spreads from one host to another). Resident characteristics that are associated with a high-risk of MDRO colonization and transmission include presence of indwelling devices (feeding tube) and functional disability and total dependence on others for assistance with activities of daily living .a gown is worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing. 51634 b. During a review of Resident 81's Admission Record, the Admission Record indicated the facility admitted the resident on 06/18/2024 with diagnoses including history of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), gastrostomy tube [(G-tube) a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems] placement, and chronic obstructive pulmonary disease [(COPD-a chronic lung disease causing difficulty in breathing) During a review of Resident 81's physician (MD) orders dated 10/16/2024 indicated an order for enteral feeding (through a tube placed in the stomach or small intestine), every night. During an observation on 12/16/2024, at 10:15 a.m., Certified Nurse Assistant (CNA) 4 exited entered Resident 81's room without performing hand hygiene. CNA 4 was observed adjusting Resident 81's blanket while inside the resident's room without wearing gown or gloves. CNA 4 was observed exiting Resident 81's room without performing hand hygiene. Outside Resident 81's room was a sign indicating the resident was on Enhanced Barrier Protection (EBP). During an interview on 12/18/2024 at 9:26 a.m., Certified Nurse Assistant (CNA) 5 stated, when staff enters a room on EBP and will touch the resident or resident's belongings, staff need to sanitize hands, wear a gown, gloves, and mask to avoid spreading infection between residents. CNA 5 stated the EBP sign was there to let staff know which resident was on isolation. During an interview on 12/18/2024 at 11:15 a.m., Licensed Vocational Nurse (LVN) 1 stated EBP are for residents with a history of infection or a dialysis shunt, (a surgically placed connection between an artery and a vein in the arm). LVN 1 stated, we put on a gown, then gloves before entering the room, then we take off gloves, followed by the gown when we leave the resident's room. During an interview on 12/19/2024, at 3:48 p.m., the Infection Prevention Nurse (IPN) stated, staff must wear gloves and a gown when providing care for the resident on EBP .hand hygiene needs to be performed prior to entry and upon leaving the resident's room. If this process is not followed properly, there is a risk of contaminating other residents with a multidrug-resistant organism (MDRO). The IPN stated EBP are necessary when medical records indicate a wound is healing, for residents on dialysis, residents with central lines, foley catheters and gastrostomy tubes or any MDRO history. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/20/24, at 3:30 p.m., the Director of Nursing (DON), the DON stated staff should wear a gown and gloves when providing care to the residents who are ordered these precautions. Upon entering the resident's room, staff should use the hand sanitizer. If staff do not follow the precautions on the sign, the residents are likely to develop an infection. During a review of the facility's policy and procedure titled, Hand Hygiene Policy No. - IC - 21 Item V. B. i-iii indicated: i. Alcohol-based hand hygiene products can and should be used to decontaminate hands: I. Immediately upon entering a resident occupied area (single or multiple bedrooms, procedure, or treatment room) regardless of glove use; ii. Immediately upon exiting a resident occupied area (e.g., before exiting into a communal area such as a corridor: regardless of glove use; iii. Before moving from one resident to another in a multiple-bed room or procedure area regardless of glove use. 50978 c. During a review of Resident 395's Admission Record, the Admission Record indicated the facility admitted the resident on 12/12/2024 with diagnoses including history of dementia (a progressive state of decline in mental abilities) and other infectious and parasitic diseases, including clostridium difficile [(C. diff) -a highly contagious bacteria that causes severe diarrhea]. During a review of Resident 395's Minimum Data Set (MDS-a resident assessment tool), dated 12/20/2024, the MDS indicated the resident's cognitive (ability to think, understand and make decisions) skills for daily decision making were severely impaired. During a review of Resident 395 History and Physical (H&P), dated 12/13/2024, the H&P indicated the resident had a diagnosis of resolving C. diff colitis .and the resident does not have the capacity to understand and make decisions. During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted Resident 71 on 4/4/2024 with diagnoses including end stage renal disease (irreversible kidney failure) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and limitation of activities due to disability. During a review of Resident 71's Minimum Data Set (MDS-a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 71 was cognitively intact. During a review of Resident 71's Care Plan, dated 8/1/2024, the care plan indicated Resident 71 was on Enhanced Barrier Precautions (EBP -precautions utilized to prevent the spread of multidrug resistant organisms) secondary to a permacath (a special catheter used for short-term dialysis treatment) dialysis site. (continued on next page)

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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 - Some	During an observation on 12/16/2024, at 11:01 a.m., a sign posted outside Resident 395's room, indicated Contact Barrier Precautions (Requires gown and gloves to be worn every time a caregiver enters a resident 's room). Certified Nurse Assistant (CNA) 1 was observed wearing a gown and gloves. Resident 395 was observed lying on the bed, while turned on the left side CNA 1 was observed rolling soiled incontinence brief under Resident 395, wiped perineal area, then placed a clean incontinence brief under the resident, rolled soiled linen under the resident then placed clean linens under the resident. CNA 1 was observed not changing gloves between the dirty and clean incontinence care or performing hand hygiene between dirty to clean areas. During a telephone interview on 12/17/2024, at 4:28 p.m., with CNA 1, the CNA 1 stated not changing gloves during care. CNA 1 stated, she should have changed gloves and performed hand hygiene when going from dirty to clean procedure. CNA 1 stated not changing gloves or performing hand hygiene could possibly cause spread of infection. During a concurrent observation and interview on 12/17/2024 at 4:13 p.m., in Resident 71's room, Certified Nursing Assistant (CNA) 2 was observed providing incontinence care for urine. Resident 71 was observed turned to side when CNA 2 removed the resident's soiled incontinent brief, performed perineal care, and rolled soiled bed linens under the resident. CNA 2 touched and placed clean incontinent brief and linens under Resident 71 then placed soiled linen in soiled linen bin without changing gloves or performing hand hygiene. CNA 2 stated gloves were not changed because she forgot. CNA 2 stated, she should have removed gloves, sanitized hands, put on gloves and performed hand hygiene when handling dirty areas. CNA 2 stated the potential outcome for Resident 71 was spread of infection and cross contamination. During an interview on 12/18/2024 at 2:19 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when incontinent care is provided, CNA should use hand sanitizer, wear gown and gloves, assess the area, provide care, use towels soaked in warm water to clean, remove gown and gloves and hand sanitize, if C. diff, we wash our hands with soap and water. During an interview on 12/18/2024 at 2:38 p.m., with IPN, the IPN stated staff should be re-educated on understanding infection control and incontinence care as possible outcome to Residents 395 and 71 was contamination. During an interview on 12/18/2024 at 3:01 p.m., with DON, the DON stated CNA 1 placed Resident 395 and CNA 2 placed Resident 71 at risk for spread of infection by not providing incontinence care per facility policy. During a review of the facility's policy and procedure (P/P) titled, Perineal Care, dated October 1, 2023, the P/P indicated, VIII. Wash, rinse and dry buttocks and peri-anal area without contaminating perineal area. IX. Remove wet linen. X. Place dry linens or briefs or both underneath resident. XI. Reposition resident. XII. Remove gloves. Wash hands or use alcohol-based hand sanitizer. XIII. Put con clean gloves. XIV. Clean and return all equipment to its proper place. XV. Place soiled linen in proper container. XVI. Remove gloves. XVII. Wash hands. P/P titled, Hand Hygiene, dated October 1, 2023, the P/P indicated, A. Wash hands with soap and water: .vii. in between glove change. B. Alcohol-based hand hygiene products can and should be used to decontaminate hands: .after removing personal protective equipment