STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056433	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review, the facility failed to complete a Change of Condition (COC) and notify physician for two of three residents (Resident 48 and Resident 362) when Resident 48 verbalized he wanted to die, and when Resident 362 missed a scheduled thyroid (a small gland in your neck) medication. This failure resulted in the lack of necessary care and treatment and had the potential to result in Resident 48 harming himself and Resident 362 developing hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs). Findings: During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought with intense paranoia, leading to false beliefs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) During a review of Resident 48's Minimum Data Set ({MDS}- a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 48 was moderately cognitively (ability to think, understand, learn, and remember) impaired and required substantial assistance with showering/bathing, dressing, and personal hygiene. During a review of Resident 361's Admission Record, the Admission Record indicated Resident 361 was admitted to the facility on [DATE] with diagnoses including hypothyroidism, hypertension ({HTN}- high blood pressure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 361's MDS dated [DATE], the MDS indicated Resident 361's cognition (ability to think, understand, learn, and remember) was intact and required substantial assistance (helper does more than half the effort) with toileting, bathing, and dressing. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/12/2025 on 11:37 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there was no change of condition (COC) or physician notified for Resident 48's verbalization of wanting to die. LVN 1 stated Resident 48's physician should have been notified and a COC should have been done so he could get seen by the psychologist and closely monitored to prevent him from potentially committing suicide. During a concurrent interview and record review on 3/12/2025 at 12:53 p.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated if a medication dose is missed, the doctor should be notified, and a COC should be completed so the resident could receive 72-hour monitoring. RNS confirmed Resident 361 missed her thyroid medication on both 3/1/2025 and 3/6/2025 and a COC was not completed, and the doctor was not notified. RNS 2 stated Resident missing her thyroid medication could affect her thyroid levels and potentially cause hypothyroidism. During a subsequent interview on 3/12/2025 at 1:19 p.m., with LVN 1, LVN 1 stated when she missed Resident 361's thyroid medication, she should have notified the doctor and done a COC so the licensed staff caring for Resident 361 would know to monitor her more closely. During an interview on 3/4/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON when there is change in condition of a resident such as verbalization of wanting to die or a resident misses a medication dose, the staff are expected to complete a COC and notify the doctor. The DON stated when Resident 48 verbalized he wanted to die, a COC is important to do because it's a communication tool between the staff and will trigger closer monitoring of the resident. The DON stated missing a thyroid medication dose is unacceptable and should have been immediately communicated to the doctor because it can cause a significant change in the body's system for Resident 361 who takes the medication regularly. During a review of the facility's policy and procedure (P&P) titled, Behavior Assessment, Intervention, and Monitoring undated, the P&P indicated, New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. During a review of the facility's P&P titled, Physician Notification Policy undated, the P&P indicated, The attending physician shall be notified immediately when there is a significant change in the resident's physical, mental, or psychosocial status. Nurses and licensed staff are responsible for recognizing significant changes and promptly notifying the physician. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, undated, the P&P indicated, Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been a significant change in the resident's physical/emotional/mental condition.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review, the failed to ensure a preadmission screening resident review (PASARR) level II was completed for one of two sampled residents (Resident 22). This deficient practice had the potential to result in an inappropriate placement and delay of needed services for Resident's 22. Findings: During a review of Resident 22's Admission Record, dated 3/14/2025 Resident 22's admission record indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (depressed mood causing significant impairment in daily life) schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) . During a review of Resident 22's Minimum Data Set ({MDS}- a resident assessment) the MDS dated [DATE], indicated Resident 22 has moderate cognitive impairment (difficulty with thinking, remembering, making decisions, and understanding things). The MDS also indicated Resident 22 was taking a antipsychotic medication (brain altering medications used to reduce delusions). During a review of Resident 22's History & Physical (H&P) dated 4/5/24, the H&P indicated Resident 5 had the capacity to understand and make decisions. During review of Resident 22's Order summary Report, dated 3/14/25, the order summary report indicated, Resident 22 was taking abilify 15 mg (a medication used to treat mental illness) in the morning for schizoaffective disorder manifested by paranoid delusions (having false or unrealistic beliefs) about staff disparaging her, auditory hallucinations (hearing things when no one is talking) the devil is talking about and laughing at her. During review of Resident 22's PASARR Level 1 screening dated 8/13/24 , the PASARR level 1 screening indicated Resident 22 had a serious mental illness and a PASRR level II was required. No PASARR level II found. During a concurrent interview and record review on 3/14/2025, at 9:28 a.m. with the MDS coordinator (MDSC) , Resident 22's PASRR Level 1 results dated 8/13/24. The MDSC stated Resident 22's PASARR Level 1 was positive for mental illness and a PASARR Level II was indicated. The MDSC stated Resident 22 has a diagnoses schizoaffective disorder and major depression and does take antipsychotic medication. The MDSC stated she could not find a PASARR Level II for Resident 22 and that Resident 22 could have missed out on specialized mental health services. During a interview on 3/14/2025, at 2:30 p.m. with the Director of Nursing (DON) , the DON stated Resident 22 did have a Positive level1 screening and should have had a PASARR Level II evaluation done. The DON stated Resident 22 could miss out on specialized services and programs. (continued on next page)

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F 0644 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 Admission Criteria dated 3/2019, indicated, all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities(ID) or related disorders (RD) per Medicaid Pre- Admission Screening and Resident Review (PASARR) process. a. If the level 1 screen indicates that the individual may meet the criteria for the MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. The admitting nurse notifies the social services department when a resident is identified as having a possible or evident MD, ID, RD. b. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to implement a care plan for one of three sampled residents (Resident 48). This failure had the potential to place Resident 48 at risk for a delay of care and treatment. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought with intense paranoia, leading to false beliefs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cerebral infarction (loss of blood flow to the brain). During a review of Resident 48's Minimum Data Set ({MDS}- a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 48 was moderately cognitively (ability to think, understand, learn, and remember) impaired and required substantial assistance with showering/bathing, dressing, and personal hygiene. During an observation on 3/11/2025 at 9:48 a.m., Resident 48 yelled out that he wanted to die in the presence of Licensed Vocational Nurse (LVN) 4. LVN 4 stated she would notify her charge nurse immediately. During an interview on 3/12/2025 at 11:37 a.m., with LVN 1, LVN 1 stated there is no care plan for Resident 48's verbalization of wanting to die but should be because Resident 48 could potentially commit suicide. During an interview on 3/12/2025 at 3:11 p.m., with Registered Nurse Supervisor (RNS) 1, RNS stated a care plan is a guideline for the residents care with interventions for the staff to follow when providing care to the residents. RNS 1 stated Resident 48 should have a care plan for his verbalization of wanting to die so the staff are aware and the resident could be monitored more closely to prevent Resident 48 from potentially committing suicide. During an interview on 3/14/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON indicated Resident 48 should have a care plan for his verbalization of wanting to die because it is a guideline for how to care for the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans- Comprehensive, undated, the P&P indicated, Each resident's comprehensive care plan is designed to: incorporate identified problem area, incorporate risk factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and/or functional levels; Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of four reviewed residents (Resident 218) had a Interdisciplinary Team (a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated patient care) meeting scheduled within 72 hours after Resident 218 was admitted to the facility on [DATE] to discuss Resident 218's plan of care. This failure resulted in Resident 218 not aware of his plan of care and not being involved and unable to participate his plan of his care. Findings: During a review of Resident 218's Admission Record, the Admission Record indicated Resident 218 was admitted to the facility on [DATE] with diagnoses including motor-vehicle accident, right humerus upper arm bone) fracture (broken bone) , left tibia lower leg bone) fracture, and scalp (skin covered area on the top of the head) contusion (also known as a bruise, occurs when blood vessels break under the skin, causing blood to leak and become trapped). During a review of Resident 218's Minimum Date Set (MDS - a resident assessment tool), dated 3/11/25, the MDS indicated Resident 218 was able to make self understood and had the ability to express wants and ideas. The MDS indicated Resident 218 had the ability to understand others with clear comprehension. The MDS indicated Resident 218 was dependent on staff for lower body dressing, showering, rolling from left to right, sitting, lying, and standing. The MDS indicated Resident 218 was dependent on nursing staff for transferring to a chair and transferring to a toilet. The MDS indicated Resident 218 needed substantial to maximal assistance from nursing staff with upper body dressing. The MDS indicated Resident 218 needed supervision or touching assistance from nursing staff with eating, oral hygiene, and toileting. The MDS indicated Resident 218 needed partial to moderate assistance from nursing staff with personal hygiene. The MDS indicated Resident 218 did not attempt to walk due to medical condition or safety concerns. During an interview on 3/11/25 at 10:50 a.m., with Resident 218, Resident 218 stated he wants to know about the plan for surgery on his left leg. Resident 218 stated he has not spoken to a physician or facility staff about his plan of care. During an interview on 3/14/25 at 11:43 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 218 was hit by a car and had a left leg fracture with a cast (treatment for fractures, used to immobilize injured bones and promote healing) in place and a right shoulder fracture. LVN 1 stated four attempts were made to schedule an IDT meeting on 3/14/25 at 11 a.m., with Resident 218 representative. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/25 at 3:10 p.m., with Registered Nurse Supervisor (RNS)1, RNS 1 stated after 72 hours of admission to the facility, an IDT meeting should be scheduled and the plan of care discussed with the resident. RNS 1 stated it was a policy to have IDT meeting within 72 hours of admission. RNS 1 stated there was no documentation or notes from an IDT and no documentation of an IDT meeting scheduled 72 hours after Resident 218 was admitted on [DATE]. RNS 1 stated the Social Services Director (SSD), was responsible for scheduling the IDT meetings. RNS 1 stated the IDT meetings were done to inform the resident of the plan of care, to help the resident get better. RNS 1 stated the IDT meetings informs the residents of the discharge plan. RNS 1 stated the IDT meetings informs the resident that they are receiving the correct treatment. RNS 1 stated if the resident does not know the plan of care the resident could possibly refuse care if the care was not explained. During an interview on 3/14/25 at 5:48 p.m., with SSD, SSD stated IDT was done to discuss information regarding the plan of care while the resident was in the facility with the resident, physician, nursing staff , social services, dietary staff, activities staff, rehabilitation staff and case management. SS stated IDT meetings should be done within 72 hours after the resident was admitted to the facility. SSD stated failed to schedule the IDT meeting for Resident 218 and made a call to Resident 218's family on 3/14/25 to schedule an IDT meeting. SSD stated there was no other prior documentation noted to indicate Resident family was notified of an IDT meeting. During an interview on 3/14/25 at 6:26 p.m., with the Director of Nursing (DON), the DON stated Resident 218 was alert and oriented to name, place, time and an IDT meeting should be done within 7 days after admission to the facility with the resident and family member. The DON stated Resident 218 can get mad and depressed and may want to leave the facility early if care and services were not explained. The DON stated Resident 218 needs to know what was going on with the care and services the facility was going to provide. During a review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, date revised 3/2022, the P&P indicated, The IDT includes but is not limited to the resident's attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of the food and nutrition services staff, to the extent practicable, the resident and/or the resident's representative, and other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. During a review of the facility's P&P titled, Care Plans-Comprehensive, undated, the P&P indicated, Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. During a review of the facility's P&P titled, Facility Assessment, date revised 2/19/2025, the P&P indicated the IDT members were responsible for Person-centered care (PCC-an approach to healthcare that focuses on the individual patient's needs, preferences, and values) and for the , Education of resident and family/ resident representative about treatments and medications, documentation of resident treatment preferences, end- of-life care, and advance care planning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Quality of Life Policy, undated, the P&P indicated, Residents shall be involved in care planning and have the right to refuse care in accordance with regulatory guidelines.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 154) who was dependent with activities of daily living ([ADL's]- activities such as bathing, dressing and toileting a person performs daily) received the necessary care and services to maintain good grooming, and personal hygiene. These deficient practices resulted in Resident 154 to experience pressure injury (is damage to the skin and underlying tissues caused by prolonged pressure, friction, or moisture, often leading to open sores or wounds) and had the potential to delay wound healing. Findings: During a review of Resident 154's Admission Record, the Admission Record indicated Resident 154 was admitted to the facility on [DATE], with diagnoses including Stage 4 (wound that penetrate all layers of skin exposing muscles, tendons [tissue that unites a muscle with a bone] cartilage {tissue that lines a joint}, and bones caused by prolonged pressure on the skin) pressure injury on her sacrococcyx ([sacrum]-a large, triangular bone at the base of the spine and the [coccyx]-also known as the tailbone, a small bone at the very end of the spine), Stage 4 pressure injury on the right and left ear lobe. cerebral infarction (damage to the brain from interruption of its blood supply), chronic respiratory failure (a long-term condition where there is not enough oxygen in your body), and functional quadriplegia (complete immobility due to severe disability requiring total assistance with daily activities). During a review of Resident 154's History and Physical (H&P), dated 1/28/25, the H&P indicated, Resident 154 did not have the capacity to understand and make decisions. During a review of Resident 154's Minimum Data Set ([MDS], resident assessment tool), dated 2/1/25, the MDS indicated, Resident 154 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with toileting hygiene, shower/bath self, and personal hygiene. The MDS indicated Resident 159 was always incontinent of bowel (no episodes of continent bowel movements) The MDS indicated Resident 159 was at risk of developing pressure injuries, had three unstageable pressure injuries (a type of pressure ulcer where the depth of the wound cannot be accurately assessed due to the presence of slough [yellow gray dead tissue]or eschar {thick hard crust that covers the wound}), on skin and pressure injury treatment and on turning and repositioning program. During a review of Resident 154's shower record, titled Subacute Shower (undated) record indicated, Resident 154's shower days was Tuesday and Friday. During a review of Resident 154's Care Plan titled Alteration in skin integrity due to actual presence of abrasions, pressure ulcers dated 1/25/25, the Care Plan indicated interventions including to bath/shower resident as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/12/25 at 8:39 a.m. in Resident 154's room, observed Resident 154 in bed lying on her left side, with eyes open, and non-verbal (unable to communicate using spoken words), non-responsive to verbal and tactile stimuli (any form of touch or physical contact that is perceived by the skin). During a concurrent interview and record review on 3/13/25 at 9:20 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated that he was responsible for assisting residents with their activities of daily living, turning and repositioning the residents in bed. Reviewed Resident 154's Skin Inspection Sheets, dated 2/7/25 and 2/11/25. CNA 3 stated Resident 154 did not have skin inspection sheets for the month of 1/25 and 3/25. CNA 3 stated the missing skin inspection sheets for Resident 154 indicated Resident 154 did not receive a shower on her scheduled shower days (Tuesdays and Fridays) and skin inspections was not done. CNA 3 stated that he was responsible for doing skin inspections when Resident 154 receive shower or bed bath, and must report any skin changes he observed to the charge nurse or treatment nurse immediately. CNA 3 stated on the days that residents were not scheduled for shower, resident should receive a bed bath. CNA 3 stated after resident shower or provided bed bath, he documents on the Skin Inspection Sheets and the treatment nurse reviews the Skin Inspection Sheets and signs the sheet after it was reviewed. CNA 3 stated residents may feel sad, depressed, and felt unclean when they do not receive a shower or bed bath. CNA 3 stated that all the residents deserve and have the right to received shower or bed bath. During a concurrent interview and record review on 3/13/25 at 9:44 a.m. with the Director of Staff Development (DSD), Skin Inspection Sheets, the month of 1/25, 2/25, and 3/25 were reviewed. The Skin Inspection Sheets indicated Resident 154 did not receive a shower for the following days: On 1/28/2025 (Tuesday) On 1/31/2025 (Friday) On 2/7/2025 (Friday) On 2/14/2025(Friday) On 2/25/2025 (Tuesday) On 2/28/2025 (Friday) On 3/4/2025 (Tuesday) On 3/7/2025 (Friday) The DSD stated that according to the Skin Inspection Sheets reviewed, Resident 154 was only showered by the CNA on 2/7/2025 and 2/11/2025 since her admission on 1/25/2025. The DSD stated residents should be showered according to their shower schedule and if the residents do not receive a shower they should receive a bed bath. The DSD stated showering residents that have pressure injuries helps maintain healthy skin by keeping the area clean and dry, and removing potential irritants (is a substance that directly damages the skin's surface when it comes into contact) like stool and urine which could cause pressure injuries. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/25 at 11:39 a.m. with License Vocational Nurse (LVN 2) LVN 2 stated the CNAs are responsible for providing shower and bed baths. LVN 2 stated all residents are showered twice weekly by the CNA's depending on their shower days. LVN 2 stated providing shower or bed bath was part of the residents' hygiene and opportunity to assess residents skin condition. LVN 2 stated it was the residents right to have a shower, and they deserve to be cleaned. Reviewed Resident 154's Skin Inspection Sheet dated 2/7/2025 and 2/11/2025. LVN 2 stated that Resident 154 did not have any other Skin Inspection Sheets which confirm that Resident 154 did not received a shower on Tuesday and Fridays as per her showering schedule or bed bath. During interview on 3/13/25 at 2:00 p.m. with Registered Nurse Supervisor (RNS 5), RNS 5 stated CNAs were responsible for showering/bathing the residents. RNS 5 stated all residents should be showered as scheduled and receive bed baths when they are not showered because regular bathing helps to keep the residents skin clean and dry, which was essential for preventing further skin breakdown and the development of new pressure injury. RNS 5 stated moisture and dirt can irritate the skin and make it more susceptible to pressure injury, so removing these irritants (a substance or factor that, upon contact, causes inflammation, irritation, or discomfort to the skin) through bathing was important. RNS 5 stated residents can feel a lower sense of self-esteem due to having malodorous smell. During an interview on 3/14/25 at 4:17 p.m. with Director of Nursing (DON), the DON stated CNAs were responsible for showering/bathing the residents. The DON stated CNAs do skin inspections during scheduled shower and bed baths. The DON stated residents are showered twice weekly and the CNAs use Skin Inspection Sheets to document once the resident was showered. The DON stated if a resident does not have a Skin Inspection Sheet, it would be an indication that the resident did not receive a shower. The DON stated it was residents right to receive showers and bed baths. The DON stated bathing helps residents feels clean and refreshed, which can improve their overall comfort and well-being. During a review of the facility's policy and procedure (P&P) titled, Bath, Shower/Tub, dated 2018, the P&P indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. During a review of the facility's P&P titled, Assistance with ADL Care, [undated], the P&P indicated, Provide assistance with activities of daily living depending on the level of assistance needed and the number of person (s) needed to assist resident. During a review of the Certified Nursing Assistant (CNA) Job Description, [undated], the CNA Job Description indicated, Assist residents with bath functions (i.e., bed bath, tub or shower bath, etc.) as directed. Cross reference F686

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 49145 Based on interview and record review, the facility failed to assist resident who receive proper assistive devices to maintain hearing abilities for one of three sample residents (Resident 20). This failure resulted in a delay in services and Resident 20 not being able to hear adequately during a conversation. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility 12/27/2024 with diagnoses including hyperlipidemia (high cholesterol) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 20's Minimum Data Set ({MDS}- a resident assessment tool) dated 1/3/2025, the MDS indicated Resident 20's cognition (ability to think, understand, learn, and remember) was intact and was dependent (helper does all the effort) with toileting and bathing. During a review of Resident 20's care plan initiated 12/26/2024, the care plan indicated Resident 20 has a communication deficit, hearing impaired with goals that included. During a review of Resident 20's Psychosocial Note, dated 1/28/2025 at 2:29 p.m., the Psychosocial Note indicated Resident 20 went to the Social Services Director (SSD) and reported her hearing aids were missing. During an interview on 3/11/2025 at 10:26 a.m., with Resident 20, Resident 20 stated her hearing aides were missing and feels irritated because others must repeat themselves when speaking with her. Resident 20 stated she told the staff, but no one followed up and she would like to have hearing aids. During a concurrent interview and record review on 3/14/2025 at 7:50 a.m., with the SSD, the SSD stated he spoke with Resident 20 about her hearing aids but did not follow up. The SSD stated he should have followed up with Resident 20's hearing aids and made an appointment for her to be seen. During an interview on 3/14/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON stated hearing aides are important to have because not having them can affect the delivery of care and makes it hard for the resident to communicate. During an interview on 3/14/2025 at 1:19 p.m., with the Administrator (ADM), the ADM stated a resident not having their hearing aides can affect their dignity and it would benefit Resident 20 to have them so others would not have to constantly repeat themselves when speaking to her. (continued on next page)

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F 0685 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, Hearing Impaired Resident, Care of, undated, the P&P indicated, Staff will assisting hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. Staff will help residents who have lost or damaged hearing devices in obtaining serves to replace the devices. During a review of the facility's P&P titled, Accommodation of Needs, revised 3/2021, the P&P indicated, In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. For example, maintaining hearing aids, glasses, and other adaptive devices for residents.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview and record review, the facility failed to ensure the resident did not develop a deep tissue skin injury ([DTI] (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) on the right lateral (side) foot and the right buttock for one of four reviewed residents (Resident 154). The facility failed to: 1.Ensure Resident 154 was turned and repositioned every two hours per physician order and a care plan titled, Risk for Skin breakdown dated 1/27/25 2. Ensure Resident 154 skin assessment was done during shower days and/or bed bath (a wash that you give to someone who cannot leave their bed). 3. Ensure Certified Nursing Assistant (CNA- in general) inspected Resident 154's skin daily and the licensed nurses assessed the resident 's skin weekly as indicated in the resident's care plan titled, Risk for Skin Breakdown dated 1/2025. These failures resulted in Resident 154 in developing a DTI on 2/25/25 measured 2.5 centimeter ([cm] a unit of measurement) in length by 2.0 cm in width, on the right lateral foot and on 3/11/25 developing DTI on a right buttock measured 3.5 cm in length by 1.5 cm in width and with undetermined depth. Findings: a. During a review of Resident 154's Admission Record, the Admission Record indicated Resident 154 was admitted to the facility on [DATE], with diagnoses of cerebral infarction (damage to the brain from interruption of its blood supply), chronic respiratory failure (a long-term condition where there is not enough oxygen in your body), and functional quadriplegia (complete immobility due to severe disability requiring total assistance with daily activities). During a review of Resident 154's History and Physical (H&P), dated 1/28/25, the H&P indicated, Resident 154 did not have the capacity to understand and make decisions. During a review of Resident 154's Minimum Data Set ([MDS], resident assessment tool), dated 2/1/25, the MDS indicated, Resident 154 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) on staff for toileting hygiene, shower/bath self, and personal hygiene. The MDS indicated Resident 154 was always incontinent of bowel (no episodes of continent bowel movements) The MDS indicated Resident 154 was at risk of developing pressure injuries. During a review of Resident 154's Braden Scale (tool used to assess a patient's risk of developing pressure injury) dated 1/25, the Braden Scale indicated, Resident 154's total score of 10 (High Risk: Total Score 10-12) which indicated Resident 154 was a high risk for developing a pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 154's care plan titled, Risk for Skin breakdown, dated 1/27/25 the care plan indicated the goal for Resident 154's was to have an intact skin as evidence by no redness over bony prominences (areas where bones are close to the skin's surface) and other pressure area. The care plan interventions included to turn and reposition resident at least every two hours, reassess skin daily by CNA and weekly by licensed nurses/treatment nurse and notify a physician and resident or resident representative for significant change in skin condition. During a review of Resident 154's Physician Order Summary, dated 1/27/25, the Physician Order Summary indicated to elevate the resident's left and right lower extremity with a pillow when in bed daily for 14 days. During a review of Resident 154's Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Conference, dated 1/29/25, the IDT Conference indicated interventions for skin breakdown included repositioning the resident as often as needed. During a review of Resident 154's undated IDT Notes for Pressure Ulcer and Other Wounds Recommendations/Comments, the IDT notes indicated, Resident at risk for further skin breakdown from multiple medical contributing factors; severely contracted, generalized edema (swelling), limited positioning, total dependent with two persons assist in bed mobility and positioning. During a review of Resident 154's Skin Inspection dated 2/7/25 Resident 154's right buttock and right lateral foot had intact skin. During a review of Resident 154's Physician Order Summary dated 2/25/25, the Physician Order Summary indicated to apply Prevalon Boots (help reduce the risk of pressure injury by keeping the heel floated) to bilateral feet while in bed to reduce/prevent further pressure damage every day and night shift. During a review of Resident 154's Skin Integrity Report, dated 2/25/25, the Skin Integrity Report indicated the resident had a DTI to a right buttock measured 3.5 cm in length, 1.5 cm in width, with undetermined depth and DTI to a right lateral foot measured l 2.5 cm in length, 2.0 cm in width with undetermined depth. During a review of Resident 154's Treatment administration Record (TAR) dated 2/25/25, the TAR indicated a physician's order to apply Prevalon Boots, to relieve pressure to bilateral feet while in bed to reduce/prevent further damaged due to pressure, on day shift (7a.m. to 7 p.m.) and on night shift (7 p.m. to 7 a.m.). During a review of Resident 154's undated shower record, titled Subacute Shower, the record indicated, Resident 154's shower days were Tuesday and Friday. During an observation on 3/12/25 at 8:39 a.m. in Resident 154's room, Resident 154 was observed in bed lying on a left side with eyes open, non-verbal (unable to communicate using spoken words), and non-responsive to verbal and tactile stimuli (any form of touch or physical contact that is perceived by the skin). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 3/12/25 at 1:21 p.m. with Treatment Nurse (TN) 1, in Resident 154's room, Resident 154 was observed in bed lying on a left side with open eyes and non-verbal. Resident 154 was observed lying on a low loss air mattress ([LAL] a type of medical mattress designed to prevent and treat pressure injury by constantly circulating air through tiny holes, keeping the skin cool and dry and reducing moisture buildup) with a sheet under the resident. During the observation Resident 154's was observed to have a pressure injury located on her right lateral foot which appeared with intact skin and black discolored area without a drainage. Also, Resident 154 was observed to have an open skin on the right buttock, red in color and without a drainage. TN 1 stated the Registered Nurse (RN) and TN were responsible for performing skin assessments upon admission, weekly, and as needed. TN 1 stated CNA's will inform TN of any changes in residents skin condition. TN 1 stated during shower and resident bed bath, CNAs would do a residents (in general) skin inspections and document on the Skin Inspection sheet of any changes to a residents' skin. TN 1 stated any changes to a residents' skin will be reported immediately to the charge nurses and TN. TN 1 stated residents were showered twice weekly and received bed baths on remaining days of the week. TN 1 stated CNA 3 reported to TN 1 Resident 154's newly developed pressure injury to the right buttock on 3/11/25 (documented 2/25/25). TN 1 stated it started as a blister that progressed to a DTI. TN 1 stated Resident 154 also developed a DTI to her right lateral (side) foot that was observed on 2/25/25 during TN 1 weekly wound assessment. TN 1 stated Resident 154 should be turned and repositioned every two hours and as needed in order to prevent pressure injuries and to prevent Resident 154 pressure injuries on her sacrococcyx, left and right ear from getting worse. TN 1 stated turning and repositioning residents helps with blood circulation (the movement of blood throughout the body) and helps to decrease the chances of developing a pressure injury. TN 1 stated Resident 154's pressure injury to the right lateral foot and right buttock could have been avoided if the resident was turned every two hours and if Prevalon boots were applied on admission on 1/25/25. TN 1 stated he did not order Prevalon boots to Resident 154, instead he used pillows to help relieve the pressure from Resident 154's heels. During a concurrent interview and record review on 3/12/25 at 1:30 p.m. with TN 1, Resident 154's Turn and Reposition Turning Schedule for the month of 2/2025, was reviewed. The Turn and Reposition Turning Schedule indicated Resident 154 had not been turned and repositioned every two hours per Resident 154's care plan. TN 1 stated that Resident 154 had not been turned and repositioned every 2 hours for several days (from 2/11/25 through 2/28/25). During an observation on 3/12/25 at 3:30 pm in Resident 154's room, Resident 154 remains in bed lying on her left side. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/25 at 9:20 a.m. CNA 3 stated that he was responsible for assisting residents with their activities of daily living and turning and repositioning the residents in bed. Resident 154's Skin Inspection Sheets dated 2/7/25 and 2/11/25 were reviewed with CNA 3. CNA 3 stated Resident 154 right buttock and right heel skin were intact. CNA 3 stated Resident 154 did not have Skin Inspection sheets for the month of 1/25 and 3/25. CNA 3 stated missing Resident 154's Skin Inspection sheets indicated Resident 154 did not receive a shower on her scheduled shower days (Tuesdays and Fridays) and the resident's skin was not inspected. CNA 3 stated that he was responsible for doing skin inspection when Resident 154 received a shower or a bed bath. CNA 3 stated he must report any observed skin changes to the charge nurse or treatment nurse immediately. CNA 3 stated on the days that residents (in general) were not scheduled for shower; residents should receive a bed bath. CNA 3 stated skin changes would be considered open areas, redness, blisters, discoloration, and swelling of the skin. CNA 3 stated after resident shower or bed bath he documents on the Skin Inspection Sheets and the treatment nurse reviews the Skin Inspection Sheets and signs the sheet after it was reviewed. CNA 3 stated residents should be turned and repositioned every two hours and as needed. CNA 3 stated when the residents were turned and repositioned it should be documented on the residents Turn and Reposition Turning Schedule form. CNA 3 stated if there was no documentation on the Turn and Reposition Turning Schedule form it means that Resident 154 was not turned and repositioned. CNA 3 stated if residents were not turned and repositioned every two hours it had the potential to result in pressure injury. During a concurrent interview and record review on 3/13/25 at 9:44 a.m. with the Director of Staff Development (DSD), Resident 154's Skin Inspection Sheets for the month of 1/25, 2/25, and 3/25 were reviewed. The Skin Inspection Sheets indicated Resident 154 did not receive a shower and her skin was not inspected on the following days: On 1/28/2025 (Tuesday) On 1/31/2025 (Friday) On 2/7/2025 (Friday) On 2/14/2025(Friday) On 2/25/2025 (Tuesday) On 2/28/2025 (Friday) On 3/4/2025 (Tuesday) On 3/7/2025 (Friday) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DSD stated that CNAs were responsible for checking the residents' skin on the residents' shower days and to document it on the Skin Inspection Sheet. The DSD stated the purpose of the Skin Inspection Sheet was to document any skin changes including open areas, redness, blisters, discoloration, and swelling and inform the charge nurse and treatment nurse, so that charge nurse and or TN could intervene in a timely manner and implement the necessary interventions. The DSD stated that according to the reviewed Skin Inspection Sheets , Resident 154 was only showered on 2/7/2025 and 2/11/2025 since her admission on 1/25/2025. The DSD stated residents (in general) should be showered according to their shower schedule and if the residents do not receive a shower they should receive a bed bath. The DSD stated showering residents that have pressure injuries helps maintain healthy skin by keeping the area clean and dry, and removing potential irritants (is a substance that directly damages the skin's surface when it comes into contact) like stool and urine which could cause pressure injuries. During a concurrent interview and record review on 3/13/25 at 10:30 a.m. with CNA 3, Resident 154's Turn and Reposition Turning Schedule, dated February 2025 was reviewed. The Turn and Reposition Turning Schedule indicated Resident 154 should be turned and repositioned every two hours. CNA 3 stated there was no documentation that indicated Resident 154 was turned every two hours as ordered by Resident 154 physician. The Turn and Reposition Schedule for the following dates and times were documented as follows: On 2/11/2025 6:02 a.m.,14:20 p.m., and 9:23 p.m. On 2/12/2025 6:00 a.m.,12:24 p.m.,1:01 p.m., and 8:38 p.m. On 2/13/2025 6:59 a.m., 12:10 p.m.,1:15 p.m.,3:51 p.m., and 9:54 p.m. On 2/14/2025 1:05 a.m.,6:36 a.m.,1:50 p.m.,3:54 p.m., and10:11 p.m. On 2/15/2025 3:11 a.m., and 6:57 a.m. On 2/16/2025 2:30 a.m.,6:50 a.m.,2:50 p.m.,4:20 p.m., and 9:37 p.m. On 2/17/2025 2:31 a.m.,6:37 a.m.,12:34 p.m.,1:56 p.m., 4:20 p.m., and 10:06 p.m. On 2/18/2025 6:00 a.m.,12:51 p.m.,1:44 p.m.,6:20 p.m., and 9:13 p.m. On 2/19/2025 6:00 a.m.1:26 p.m.6:34 p.m., and 9:25 p.m. On 2/20/2025 6:00 a.m.,12:42 p.m.,1:57 p.m.,4:15 p.m., and 10:18 p.m. On 2/21/2025 6:00 a.m., 2:40 p.m.,5:40 p.m., and 10:00 p.m. On 2/22/2025 6:00 a.m., 1:46 p.m., 3:57 p.m., and 10:35 p.m. On 2/23/2025 1:16 p.m.4:21 p.m.9:48 p.m. On 2/24/2025 3:26 a.m.6:09 a.m.2:44 p.m. 6:43 p.m.10:16 p.m. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/25/2025 6:44 a.m.,11:40 a.m.,2:04 p.m.10:10 p.m. On 2/26/2025 2:00 p.m.7:52 p.m. On 2/27/2025 5:32 a.m.10:39 a.m.11:38 a.m.1:48 p.m., and 7:57 p.m. On 2/28/2025 6:00 a.m.,2:37 p.m., and 8:53 p.m. CNA 3 stated, Resident 154 should have been turned and repositioned every two hours and as needed to prevent pressure injuries from developing and prevent Resident 154 pressure injuries on her sacrococcyx and right and left ear from getting worse. CNA 3 stated Resident 154 could have developed the pressure injuries on her right lateral foot and right buttocks from not being turned every two hours. CNA 3 stated that he discovered Resident 154's right buttock pressure injury on 3/11/2025 and informed the License Vocational Nurse (LVN) 2 and the TN (unknown) about Resident 154's pressure injury on right buttock. CNA 3 stated Resident 154 had not been turned and repositioned every two hours on several days as ordered (from 2/11/25 through 2/28/25). During a concurrent interview and record review on 3/13/25 at 11:39 a.m. LVN 2 stated CNAs were responsible to provide residents a shower and bed baths. LVN 2 stated CNAs were responsible for doing skin inspections when giving a shower and bed baths and to report any skin changes to the charge nurse and treatment nurse. LVN 2 stated the RN (in general) and the TN (in general) were responsible for assessing the residents' skin upon admission and weekly. LVN 2 stated skin changes would be considered open wounds, redness, bruising, blisters, and drainage. LVN 2 stated all residents should receive a shower twice weekly by the CNA's depending on their shower schedule. LVN 2 stated providing a shower was part of the residents' hygiene and a way to assess the residents skin integrity. LVN 2 stated residents should be turned and repositioned every two hours and as needed, especially for residents that are dependent for care and have pressure injuries, to prevent developing pressure injuries and aid in healing their current pressure injuries. LVN 2 stated Prevalon boots were important intervention for residents that were high risk for developing pressure injuries because they decrease the pressure under residents' feet. LVN 2 reviewed Resident 154's Skin Inspection sheet dated 2/7/2025 and 2/11/2025 and validated that Resident 154 did not have any other Skin Inspection sheets. LVN 2 stated the lack of Skin Inspection sheets confirms that Resident 154 did not have skin inspections and was not showered on Tuesday and Fridays as per her showering schedule. During an interview on 3/14/25 at 4:17 p.m. with the Director of Nursing (DON), the DON stated the RN Supervisor (RNS) and TN were responsible for doing skin assessments upon a resident admission, weekly and as needed. The DON stated CNAs were responsible for doing skin inspections when providing a shower and bed baths and report any findings to the charge nurse and TN. The DON stated residents were showered twice weekly and the CNA's use Skin Inspection Sheets to document resident skin condition once the resident received a shower or bed bath. The DON stated if a resident does not have a Skin Inspection Sheet completed, it would be an indication that the resident did not receive a shower and did not have a skin inspection done by the CNA's. The DON stated it was imperative that residents receive showers and bed baths as this their right, and good hygiene practices, can help prevent or reduce the risk of pressure injury infection. The DON stated residents that are total dependent need to be repositioned and turned every two hours, because it helps to maintain their skin integrity, improves circulation, and relieves pressure which could cause pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the Certified Nursing Assistant (CNA) Job Description, [undated], the CNA Job Description indicated, Special Nursing Care Functions .Turn bedfast residents at least every two (2) hours. During a review of facility's P&P titled Wound and Ulcer Protocol undated, the P&P indicated, CNA's will complete body checks on resident shower days and report findings to the charge nurses. The P&P indicated the treatment nurse will ensure if the treatment plan is appropriate for the current status and if changes are needed , the treatment nurse will obtain needed treatment from the physician. 45269

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide services to five of 11 reviewed residents (Resident 62, 109, 112, 40, and 121) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) by failing to: 1.Provide Resident 62 with passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both arms in accordance with the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Discharge Summary, dated 4/10/2023. 2.Provide Resident 62 with active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) exercises to both legs, five times per week, from 9/2024 to 3/2025 in accordance with Resident 62's physician orders. 3.Provide Resident 109 with PROM to both arms and legs, five times per week, from 9/2024 to 12/2024, in accordance with Resident 109's physician orders. 4.Apply both of Resident 109's elbow extension (straightening) splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), both wrist-hand-finger orthoses ([WHFO] splint secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures), the left knee extension splint, and both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position), seven times per week, from 9/2024 to 12/2024 in accordance with Resident 109's physician orders. 5.Perform an accurate Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in both arms and both legs), dated 2/21/2025, for Resident 109's shoulders. 6.Apply both of Resident 109's elbow extension splints, both WHFOs, the left knee extension splint, and both PRAFOs on 3/9/2025 in accordance with Resident 109's physician orders. 7.Perform PROM exercises on Resident 109's forearms during OT treatment on 3/12/2025. 8.Provide Resident 112 with Omni-cycle exercises (motorized therapeutic exercise system to assist with limited strength, endurance, or muscle control) for both arms and legs, three times per week, from 9/2024 to 1/2025, in accordance with Resident 112's physician orders. 9.Continue to provide Resident 112 with Omni-cycle exercises for both arms and legs, three times per week, from 2/2025 to 3/2025. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10.Provide Resident 112 with ambulation (the act of walking) using a front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) and left leg ankle foot orthosis ([AFO] brace to hold the foot and ankle in the correct position), three times per week, from 11/2024 to 3/2025, in accordance with Resident 112's physician orders. 11.Provide Resident 40 with PROM to the left arm and left leg, five times per week, from 11/2024 to 3/2025, in accordance with Resident 40's physician orders. 12.Provide Resident 40 with sit to stand activities using the siderails or parallel bars, five times per week, from 11/2024 to 3/2025, in accordance Resident 40's physician orders. 13.Apply Resident 40's left WHFO, seven times per week, from 11/2024 to 2/2025 in accordance with Resident 40's physician orders. 14.Provide Resident 121 with AAROM on both arms, five times per week, from 11/2024 to 3/2025, in accordance with Resident 121's physician orders. 15.Provide Resident 121 with ambulation using a FWW, three times per week, from 11/2024 to 3/2025, in accordance with Resident 121's physician orders. These failures had the potential for Resident 62, 109, 112, 40, and 121 to experience a decline in ROM and mobility, including the development of contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) and pain. Findings: 1. During a review of Resident 62's Admission Record, the Admission Record indicated the facility originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side and dementia (progressive state of decline in mental abilities). During a review of Resident 62's OT Evaluation and Plan of Treatment, dated 3/27/2023, the OT Evaluation indicated Resident 62's ROM in both arms were within functional limits (sufficient joint movement without significant limitation). During a review of Resident 62's OT Discharge Summary, dated 4/10/2023, the OT Discharge Summary indicated recommendations for the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide PROM to both arms. During a review of Resident 62's Physician Orders, dated 5/8/2023, the Physician Orders indicated for RNA to provide AAROM exercises to both legs, five times per week as tolerated. The Physician Orders did not include for RNA to provide Resident 62 with PROM to both arms. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's Care Plan titled, Potential for developing joint mobility limitation/contracture related to disease process, initiated on 3/26/2022 and revised on 5/11/2024, the Care Plan interventions included to notify the physician, resident representative and rehab (therapists) with significant changes in ROM and for rehab to assess and recommend assistive devices and exercises to maintain joint mobility without pain and difficulty. During a review of Resident 62's Documentation Survey Report (record of nursing assistant tasks) for 9/2024, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank (not initialed) for the following dates: 9/2/2024, 9/3/2024, 9/4/2024, 9/9/2024, 9/16/2024, 9/18/2024, 9/20/2024, 9/23/2024, 9/24/2024, and 9/30/2024. During a review of Resident 62's Documentation Survey Report for 10/2024, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank for the following dates: 10/2/2024, 10/16/2024, 10/18/2024, and 10/22/2024. During a review of Resident 62's Documentation Survey Report for 11/2024, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank for the following dates: 11/1/2024, 11/18/2024, 11/21/2024, 11/25/2024, 11/27/2024, and 11/28/2024. During a review of Resident 62's Documentation Survey Report for 12/2024, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank for the following dates: 12/5/2024, 12/6/2024, 12/9/2024, 12/12/2024, 12/16/2024, 12/18/2024, 12/23/2024, 12/24/2024, and 12/30/2024. During a review of Resident 62's Minimum Data Set ([MDS] a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 62 had clear speech, made concrete verbal requests, usually understood others, and had moderately impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 62 did not have ROM limitations in both arms and legs, required substantial/maximal assistance (helper does more than half the effort) assistance with toileting, upper body dressing, rolling to the right and left side in bed, and transfers from lying on the back to sitting at the side of the bed, and was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for bathing and lower body dressing. During a review of Resident 62's JMS, dated 12/18/2024, the JMS indicated Resident 62 had full ROM in both arms and legs. The JMS indicated to continue with current RNA maintenance program. During a review of Resident 62's Documentation Survey Report for 1/2025, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank for the following dates: 1/1/2025, 1/7/2025, 1/8/2025, 1/9/2025, 1/13/2025, 1/20/2025, 1/27/2025, and 1/29/2025. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's Change in Condition (CIC) Evaluation, dated 2/3/2025, the CIC Evaluation indicated Resident 62 complained of two out of ten (2/10) pain (pain scale used to measure the intensity of pain with 0 representing no pain and 10 representing the worst possible pain) in the left shoulder which started on 12/28/2024. The CIC Evaluation indicated Resident 62's Nurse Practitioner assessed the resident who had decreased ROM on the left shoulder and an X-ray (image of the inside of the body) was ordered. During a review of the left shoulder X-ray, dated 2/3/2025, the X-ray indicated Resident 62 had degenerative osteoarthritis (breakdown of the cartilage lining joints that occurs over time) of the left shoulder joint. During a review of Resident 62's Documentation Survey Report for 2/2025, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank for the following dates: 2/6/2025, 2/20/2025, and 2/24/2025. During a review of Resident 62's Documentation Survey Report for 3/2025, the Documentation Survey Report indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. The Documentation Survey Report was blank on 3/3/2025 and 3/10/2025. During an interview on 3/11/2025 at 10:36 a.m. with the Director of Rehabilitation (DOR), the DOR stated the RNAs were trained in a maintenance program after a resident completed their therapy program. The DOR stated the RNA program included ROM exercises, applying splints, and maintaining mobility with walking or sit to stand transfers. The DOR stated ROM exercises maintained a resident's joint mobility and prevented ROM limitations. During an observation on 3/12/2025 at 9:02 a.m. in Resident 62's room, Resident 62's RNA session was observed. Resident 62 laid in bed while Restorative Nursing Aide 4 (RNA 4) stood on the left side of the bed. RNA 4 performed massage on both legs and then provided ROM exercises on both hips, knees, and ankles. During a concurrent observation and interview on 3/12/2025 at 9:13 a.m. with Resient 62 and RNA 4 in Resident 62's room, Resident 62 stated having left arm pain especially when lifting the arm. Resident 62 lifted both arms and observed with limited active ROM in the left shoulder. Resident 62 stated she started to have left shoulder pain after someone (unknown) lifted Resident 62's left arm at the end of December. RNA 4 stated the physician order for RNA was for both legs and did not include ROM to both arms. During an interview on 3/12/2025 at 9:21 a.m. with RNA 4, RNA 4 stated Resident 62 was seen for AAROM of both legs. RNA 4 stated the physician order indicated to provide AAROM to both legs, five times per week. RNA 4 stated she provided Resident 62 with exercises three times per week since RNA 4 was usually pulled from RNA services to provide Certified Nursing Assistant (CNA) care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 8:43 a.m. with the DOR, Resident 62's OT Discharge Summary, dated 4/10/2023, and physician orders for RNA, dated 5/8/2023, were reviewed. The DOR stated the OT Discharge Summary, dated 4/10/2023, included recommendations to provide Resident 62 with PROM to both arms. The DOR reviewed Resident 62's physician orders and stated Resident 62 did not have any RNA orders to provide PROM to both arms. The DOR stated Resident 62 was at high risk for developing ROM limitations due to left arm hemiparesis. The DOR stated Resident 62's left shoulder pain was not reported to the rehab department and could have been prevented with ROM exercises. During a concurrent interview and record review on 3/14/2025 at 12:43 p.m. with the Director of Medical Records (DMR), Resident 62's RNA tasks in the facility's electronic documentation system and Documentation Survey Reports, dated 3/2024 to 3/2025, were reviewed. The DMR stated Resident 62's RNA tasks and Documentation Survey Reports did not include the RNA for AAROM to the right leg. During an interview on 3/14/2025 at 12:49 p.m. with RNA 4, RNA 4 stated the blank dates on Resident 62's Documentation Survey Report indicated Resident 62 was not seen for RNA services. RNA 4 stated she did not work on Sundays and Mondays. RNA 4 stated any other blank dates on the Documentation Survey Report indicated RNA 4 was pulled from RNA services to provide CNA care. During an interview on 3/14/2025 at 3:47 p.m. with the Quality Assurance Nurse (QA) and Director of Staff Development (DSD), the QA stated residents receiving RNA services (in general) had the potential to develop contractures if RNA services were not provided. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents will not experience a reduction in ROM and will receive treatment and services to increase and/or prevent a further decrease in ROM. b. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (complete lack of oxygen to the brain, which results in death of brain cells), epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), and cardiac arrest (heart suddenly and unexpectedly stops beating effectively). During a review of Resident 109's Physician Orders, dated 5/19/2023, the Physician Orders indicated for the RNA to provide PROM exercises on both arms and legs, five times per week or as tolerated. Another physician order, dated 5/19/2023, indicated for the RNA to apply both WHFOs and both PRAFOs for four to six hours or as tolerated, seven days per week. During a review of Resident 109's Physician Orders, dated 12/16/2023, the physician orders indicated for RNA to apply a knee extension splint on the left leg for two to four hours per day or as tolerated, seven days per week. During a review of Resident 109's Physician Orders, dated 2/3/2024, the Physician rders indicated for the RNA to apply both elbow extension splints for two to four hours per day or as tolerated, seven days per week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 109's JMS, dated 8/7/2024, the JMS indicated Resident 109 had minimal ROM limitations (less than or equal to 25 percent [%] loss) in both shoulders, both elbows, the left knee, and both ankles. The JMS also indicated Resident 109 had moderate ROM limitations (26 to 50% loss) in both hands. During a review of Resident 109's Documentation Survey Report for 9/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 9/2/2024, 9/6/2024, 9/9/2024, 9/11/2024, 9/12/2024, 9/13/2024, 9/16/2024, 9/17/2024, 9/18/2024, 9/19/2024, and 9/20/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 9/1/2024, 9/2/2024, 9/6/2024, 9/7/2024, 9/9/2024, 9/11/2024, 9/12/2024, 9/13/2024, 9/16/2024, 9/17/2024, 9/18/2024, 9/19/2024, 9/20/2024, 9/21/2024, and 9/22/2024. During a review of Resident 109's Documentation Survey Report for 10/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 10/1/2024, 10/14/2024, 10/17/2024, and 10/31/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 10/1/2024, 10/5/2024, 10/13/2024, 10/14/2024, 10/17/2024, 10/20/2024, and 10/31/2024. During a review of Resident 109's JMS, dated 10/31/2024, the JMS indicated Resident 109 had minimal ROM limitations in both shoulders, both elbows, the left knee, and both ankles. The JMS also indicated Resident 109 had moderate ROM limitations in both hands. During a review of Resident 109's Documentation Survey Report for 11/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 11/1/2024, 11/21/2024, and 11/22/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 11/1/2024, 11/2/2024, 11/3/2024, 11/9/2024, 11/21/2024, 11/22/2024, 11/24/2024, and 11/25/2024. During a review of Resident 109's Census List, Resident 109 went to the hospital on 11/26/2024 and returned to the facility on [DATE]. During a review of Resident 109's readmission JMS, dated 11/27/2024, the JMS indicated Resident 109 had minimal ROM limitations in both shoulders, both elbows, the left knee, and both ankles. The JMS also indicated Resident 109 had moderate ROM limitations in both hands. During a review of Resident 109's Documentation Survey Report for 12/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/24/2024, 12/25/2024, 12/30/2024, and 12/31/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/21/2024, 12/23/2024, 12/24/2024, 12/25/2024, 12/28/2024, 12/30/2024, and 12/31/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 109's Physician Orders from an outpatient brain injury clinic, dated 1/24/2025, the Physician Orders indicated for Resident 109 to receive Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function), Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]), and Speech Language and Pathology ([SLP] profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) services. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109 had no speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 109 was dependent for toileting, bathing, dressing, rolling to either side while lying in bed, and chair/bed-to-chair transfers. During a review of Resident 109's quarterly JMS, dated 1/30/2025, the JMS indicated Resident 109 had minimal ROM limitations in both shoulders, both elbows, the left knee, and both ankles. The JMS also indicated Resident 109 had moderate ROM limitations in both hands. During a review of Resident 109's JMS, dated 2/21/2025, the JMS indicated Resident 109 had moderate ROM limitations in both shoulders, elbows, and hands. The JMS indicated Resident 109 had minimal ROM limitations in both ankles and no ROM limitations in both hips and knees. During a review of Resident 109's PT Evaluation and Plan of Treatment, dated 2/21/2025, the PT Evaluation indicated both hips and knees had ROM within functional limits (sufficient joint movement without significant limitation). The PT Evaluation indicated Resident 109 had impaired ROM (unspecified) in both ankles. The PT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform activities of daily living [ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility]), and orthotic (splint) management and training, five times per week for four weeks. During a review of Resident 109's OT Evaluation and Plan of Treatment, dated 2/21/2025, the OT Evaluation indicated Resident 109's ROM in both arms were impaired, including right shoulder flexion (lifting the arm upward, normal 0 to 180 degrees) 0 to 70 degrees (0-70 degrees), left shoulder flexion 0-80 degrees, right elbow extension (normal 0 degrees) negative 95 degrees (-95 degrees, positioned in 95 degrees of elbow flexion), and left elbow extension -80 degrees (positioned in 80 degrees of elbow flexion). The OT Evaluation did not include ROM measurements of both wrists and hands. The OT Evaluation indicated Resident 109 had contractures (unspecified), elbow extension splints, and WHFOs. The OT Plan of Care included therapeutic exercises, neuromuscular reeducation, therapeutic activities, self-care management training, and orthotic management and training, five times per week for four weeks. During a review of Resident 109's Physician Orders, dated 3/7/2025, the Physician Orders indicated to discontinue RNA for application of both WHFOs, both elbow extension splints, the left knee extension splint, and both PRAFOs, seven days per week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 109's Physician Orders, dated 3/7/2025, the Physician Orders indicated for RNA to apply both WHFO and both PRAFOs for four to six hours per day or as tolerated, two times per week, every Saturday and Sunday. The physician orders, dated 3/7/2025, also indicated for RNA to apply the left knee extension splint and both elbow extension splints for two to four hours per day or as tolerated, two times per week, every Saturday and Sunday. During a review of Resident 109's Documentation Survey Report for 3/2025, the Documentation Survey Report for RNA to apply both WHFOs, both elbow extension splints, the left knee extension splint, and both PRAFOs was blank for 3/9/2025 (Sunday). During a review of Resident 109's Physician Orders, dated 3/10/2025, the Physician Orders indicated to discontinue RNA on 3/10/2025 for PROM to both arms and legs, five times per week or as tolerated. During a concurrent observation and interview on 3/11/2025 at 10:07 a.m. with Family 1 in Resident 109's bedroom, Resident 109 was observed sitting in a reclining wheelchair. Both of Resident 109's hands had handrolls placed in each palm. Resident 109's handrolls also had fabric placed in-between each finger. Resident 109's right arm was positioned in elbow flexion, neutral forearm (forearm positioned midway between full pronation [palm facing down] and full supination [palm facing up], with the thumb pointing upwards, and the palm facing neither up nor down), slight wrist flexion, and the right fingers were bent in a closed fist over the hand roll. Resident 109's left arm was positioned in elbow flexion, forearm supination, wrist in neutral (straight position with bending), and the left fingers were bent in a closed fist over the hand roll. Family 1 stated the PT and OT started working with Resident 109 but the intervention, including ROM and applying splints, was the same as the RNAs. During an interview on 3/11/2025 at 10:36 a.m. with the DOR, the DOR stated the purpose of PT (in general) included improving a resident's mobility, muscle strength, ROM, balance, activity tolerance, and gait (manner of walking) if possible. The DOR stated the purpose of OT (in general) included improving a resident's activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), muscle strength, ROM, balance, and activity tolerance. The DOR stated the RNA program included ROM exercises, applying splints, and maintaining mobility with walking or sit to stand transfers. The DOR stated ROM exercises maintained a resident's joint mobility and prevented further limitations. The DOR stated the application of splints prevented contractures or prevented existing contractures from worsening. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/12/2025 at 10:47 a.m. in Resident 109's room, Resident 109's OT treatment session was observed. Occupational Therapy Assistant 1 (OTA 1) stood on the left side of the bed to perform PROM exercises on the left arm, including left shoulder flexion, shoulder abduction (lifting the arm up and away from the body), shoulder horizontal abduction (lifting the arm from shoulder level in front of the body toward the side and away from the body), shoulder rotation in clockwise and counterclockwise directions, elbow flexion and extension, and individual finger extension. Resident 109's left forearm position was in supination during the PROM exercises. OTA 1 did not perform left forearm ROM into pronation. OTA 1 and Physical Therapy Assistant 1 (PTA 1) applied the left elbow extension splint and left WHFO. OTA 1 walked to the right side of Resident 109's bed to perform PROM exercises on the right arm, including right shoulder flexion, shoulder abduction, elbow flexion and extension, and individual finger extension. Resident 109's right forearm position was in supination during the PROM exercises. OTA did not perform right forearm PROM into pronation. OTA 1 and PTA 1 applied the right elbow extension splint and left WHFO. During an observation on 3/12/2025 at 11:14 a.m. in Resident 109's room, Resident 109's PT treatment session was observed. PTA 1 performed PROM to both legs, including left hip flexion (bending the leg at the hip joint toward the body) with knee flexion, left hip abduction (moving the leg at the hip joint away from the body), hip rotation in clockwise and counterclockwise directions, and ankle dorsiflexion (bending the ankle toward the body). PTA 1 applied the left knee splint and both PRAFOs. During an interview on 3/12/2025 at 11:36 a.m. with Family 1, Family 1 stated the Resident 109 received therapy in the room and did not leave the room for therapy sessions. Family 1 stated Resident 109 tends to bend the left knee and needs the left knee extension splint. Family 1 stated PTA 1 and OTA 1 spent more time performing the PROM exercises with Resident 109 than usual. Family 1 stated the therapists have never performed forearm pronation exercises to both of Resident 109's arms. During a concurrent interview and record review on 3/13/2025 at 11:15 a.m. with the DOR, Resident 109's OT Evaluation, dated 2/21/2025, and JMS, dated 2/21/2025, were reviewed. The DOR stated the OT Evaluation indicated Resident 109's had 0-80 degrees of left shoulder flexion (normal 0-180 degrees) and 0-70 degrees of right shoulder flexion. The DOR reviewed Resident 109's JMS, which indicated Resident 109 had moderate ROM limitations in both shoulders. The DOR stated Resident 109's JMS was inaccurate for both shoulders and should have been assessed as severe ROM loss (more than 50% loss). During an interview on 3/14/2025 at 11:21 a.m. with OTA 1 and PTA 1, OTA 1 stated forearm pronation muscles were weaker than supination muscles. OTA 1 stated PROM exercises for forearm pronation should have been done, but were not completed with Resident 109 during the treatment session. PTA 1 stated Resident 109 received therapy Monday to Friday in Resident 109's room due to the application of splints. PTA 1 stated Resident 109 was supposed to receive RNA twice per week in addition to PT and OT services. During a concurrent interview and record review on 3/14/2025 at 12:03 p.m. with Restorative Nursing Aide 2 (RNA 2), Resident 109's Documentation Survey Reports for 3/2025 were reviewed. RNA 2 stated Resident 109's Documentation Survey Report for Sunday, 3/9/2025 was blank which indicated Resident 109 did not receive RNA services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 3:47 p.m. with the Quality Assurance and the Director of Staff Development (DSD), the QA stated residents receiving RNA services (in general) had the potential to develop contractures if RNA services were not provided. The DSD stated a blank date in the Documentation Survey Report for RNA tasks indicated the resident did not receive RNA services. During a review of the facility's P&P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. c. During a review of Resident 112's Admission Record, the Admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to stenosis (narrowing) of the right posterior cerebral artery (blook vessel in the brain that supplies oxygen-rich blood to the back part of the brain), diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), and cerebral edema (swelling of the brain). During a review of Resident 112's Care Plan titled, Decline in current ambulatory skills, initiated on 1/5/2024 and revised 9/17/2024, the care plan interventions included for RNA to perform ambulation using a FWW with AFO on the left leg, three times per week as tolerated. During a review of Resident 112's Care Plan titled, At risk for decline in current joint and muscle integrity on both arms and legs, initiated on 3/1/2024 and revised 9/17/2024, the care plan interventions included RNA to perform Omni-cycle exercises on both arms and legs, three times per week as tolerated. During a review of Resident 112's Physician Orders, dated 9/18/2024, the Physician Orders indicated for the RNA to assist Resident 112 with ambulation using a FWW with the AFO on the left leg, three times per week as tolerated, and RNA to assist Resident 112 with Omni-cycle exercises for both arms and legs, three times per week as tolerated. During a review of Resident 112's Physician Orders, dated 11/11/2024, the Physician Orders indicated for the RNA to assist Resident 112 with ambulation using a FWW with the AFO on the left leg, three times per week as tolerated every Monday, Wednesday, and Friday. During a review of Resident 112's Documentation Survey Report for 11/2024, the Documentation Survey Report did not include Omni-cycle exercises on both arms. The Documentation Survey Report for RNA to provide Resident 112 with Omni-cycle exercises on both legs was blank for the following dates: 11/13/2024, 11/21/2024, and 11/26/2024. The Documentation Survey Report for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank for the following dates: 11/13/2024, 11/22/2024, 11/25/2024, and 11/29/2024. During a review of Resident 112's Documentation Survey Report for 12/2024, the Documentation Survey Report did not include Omni-cycle exercises on both arms. The Documentation Survey Report for RNA to provide Resident 112 with Omni-cycle exercises on both legs was blank for the following dates: 12/24/2024, 12/25/2024, and 12/31/2024. The Documentation Survey Report for RNA provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/25/2024, and 12/30/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 112's Documentation Survey Report for 1/2025, the Documentation Survey Report indicated for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg, Omni-cyc [TRUNCATED]

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview and record review the facility failed to ensure one of two sampled residents, Residents 22 intravenous catheter (IV - a flexible tube that's inserted into vein to deliver fluids or medications) was rotated when Resident 22's IV site was not changed for nine days. This deficient practice had the potential to cause an infection at the insertion site. Findings: During a review of Resident 22's Admission Record, dated 3/14/2025 Resident 22's admission record indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (depressed mood causing significant impairment in daily life) schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) . During a review of Resident 22's ({MDS}- a resident assessment tool) the MDS dated [DATE], indicated Resident 22 has moderate cognitive impairment (difficulty with thinking, remembering, making decisions, and understanding things). The MDS also indicated, Resident 22 needs substantial assistance (helper does more than half the work) with activities of daily living (ADL's - activities such as oral hygiene and dressing, a person performs daily). During a review of Resident 22's History & Physical (H&P) dated 4/5/24 indicated Resident 5 has the capacity to understand and make decisions. During review of Resident 22's Intravenous Therapy Medication Record, dated 3/03/25, the intravenous therapy medication record indicated, Resident 22 was on Zosyn 3.375 (antibiotic used to treat bacteria) three times a-day until 3/15/25 and that the IV catheter was placed at the general acute care hospital (GACH) prior to admission . During a review of Resident 22's care plan titled IV Therapy dated 3/3/24 indicated Resident 22 was on Zosyn for urinary tract infection (UTI) and to rotate IV site every 96 hours and as needed, observe IV site frequently for signs and symptoms (S/S) of complications such as swelling, pain, drainage and leakage. During an observation on 3/11/25 at 10:52 a.m. in Resident 22's room Resident 22's IV catheter in her left upper arm (LUA) had no time or date on the dressing and the catheter site appeared to be leaking. During a concurrent interview and record review on 3/11/2025, at 11:07 a.m. with the RNS3, Resident 22's intravenous therapy medication record was reviewed. The RNS3 stated Resident 22 was admitted on [DATE] from GACH with the IV catheter in her LUA and no other documentation was found. The RNS3 stated there was no date or time on the catheter site and the IV catheter should have been rotated every 96 hours. The RNS3 stated without the time and date on the IV site you would not know when it needed to be rotated it is like a form of communication. The RNS3 stated there could be a potential for infection when IV catheters are not rotated. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/25 at 7:43 am with the Director of Nurses (DON), the DON stated IV site needs to have time and date when the IV catheter was placed and that the IV site should have been rotated on the seventh day or when the IV site started leaking. The DON stated there is a potential for phlebitis (inflammation of a vein near the surface of the skin) when IV sites are not rotated. During a review of the facility's policy and procedure (P&P) titled Peripheral Catheter Dressing Change dated 3/2023, the P&P indicated, Transparent dressings are changed with each site rotation and/or at least every seven days or if the integrity of the dressing is compromised (wet, loose or soiled). Label dressing with date, time, and nurse's initial. Condition of the site will be documented at least every shift. Documentation in the medical record includes but is not limited to: Date and time, site assessment, Resident response to procedure, and resident teaching.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview, and record review, the facility failed to ensure resident who were receiving hemodialysis (clinical purification of blood as a substitute for the normal function of the kidney) treatments was provided with an emergency dialysis kit at bedside, in order to respond to a potential medical complication for one of two sampled residents (Resident 5). This deficient practice had the potential to cause a delay in treatment in case of an emergency. Findings: During a review of Resident 5's Admission Record, dated 3/14/2025 Resident 5's admission record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including end stage renal disease (ESRD (End Stage Renal Disease-irreversible kidney failure) dependent on renal dialysis, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing. During a review of Resident 5's ({MDS}- a resident assessment tool) the MDS dated [DATE], indicated Resident 5 has severe cognitive impairment. The MDS also indicated, Resident 10 was dependent on staff (helper does all the work) with activities of daily living (ADL's - activities such as toileting, bathing and dressing, a person performs daily).The MDS also indicated Resident 5 was on hemodialysis. During a review of Resident 5's History & Physical (H&P) dated 12/20/24 indicated Resident 5 was alert and oriented x 3 with normal affect, normal speech, but forgetful. During review of Resident 5's Order Summary Report, dated 2/24/25, the order summary report indicated, Resident 5 was on hemodialysis three times a week. The order summary report also indicated Resident 5 had orders to monitor dialysis access site, permcath (catheter used long term, gives access to the bloodstream) on her left chest and to check for signs of bleeding every shift. During a concurrent observation and interview on 3/13/25 at 3:40 p.m. in Resident 5's room with Registered Nurse Supervisor 2 (RNS2), RNS2 stated she could not find the emergency dialysis kit at Resident 5's bedside and the emergency dialysis kit contains gauze a tourniquet and a bandage. During a concurrent interview and record review on 3/13/2025 at 3:47 p.m., with RNS2, Resident 5's care plan titled Need for Hemodialysis dated 12/20/2024. The care plan indicated Resident 5 was at risk for bleeding secondary to heparin (blood thinner) administration during dialysis. RNS2 stated that Resident 5 was on hemodialysis three times a week and that Resident 5 should have an emergency dialysis kit at her bedside. RNS2 stated there is a chance Resident 5 could start bleeding from her access site. RNS2 stated resident could go into shock and possible death. During an interview on 3/14/25 at 2:18 p.m. with the Director of Nursing (DON), the DON stated she was made aware that Resident 5 did not have an emergency dialysis kit at her bedside. DON stated all residents on dialysis need to have an emergency kit at bedside, DON stated there is the possibility resident could start bleeding from access site and die. (continued on next page)

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F 0698 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 Dialysis Care dated no date indicated, the facility shall ensure provisions for the standards of care for residents on renal dialysis including but not limited to shunt care. Shunt care shall be provided by licensed nurse, upon orders upon orders of the physician. Shunt sites shall be checked for conditions and patency. Notify physicians if shunt presents symptoms of infection or malfunction. After each dialysis, licensed shall evaluate resident and notify physician immediately of any apparent complications from dialysis procedures.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to: 1.Ensure there was sufficient Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) staff to provide treatment to five of 11 reviewed residents (Resident 62, 109, 112, 40, and 121) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move). This failure had the potential for Resident 62, 109, 11, 40, and 121 and other residents with physician orders for RNA to experience a decline in range of motion [ROM, full movement potential of a joint (where two bones meet)] and mobility (ability to move). 2.Ensure there was sufficient licensed nurses in the subacute unit (SAU, a nursing unit that provides a level of medical care that is less intensive than acute care but more specialized than typical skilled nursing care). This failure resulted in late administration of medication for seven (7) of 26 residents in SAU received their morning medications late on 3/12/25, and 3/13/25. This failure had the potential of not meeting residents' needs in the SAU. Findings: 1.During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 3/3/2025 (Monday) for the 7:00 a.m. to 3:00 p.m. shift, the Nursing Staffing Assignment and Sign-in Sheet indicated Restorative Nursing Aide 6 (RNA 6) was assigned to Nursing Stations A1 and A2 and RNA 1 was assigned to Nursing Stations C1 and C2. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 3/9/2025 (Sunday) for the 7:00 a.m. to 3:00 p.m. shift, the Nursing Staffing Assignment and Sign-in Sheet indicated RNA 7 was assigned to Nursing Stations A1, A2, C1, and C2. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 3/10/2025 (Monday) for the 7:00 a.m. to 3:00 p.m. shift, the Nursing Staffing Assignment and Sign-in Sheet indicated RNA 6 was assigned to Nursing Stations A1 and A2 but did not call or show to work. The Nursing Staffing Assignment and Sign-in Sheet indicated RNA 7 was assigned to Nursing Stations C1 and C2. During an interview on 3/12/2025 at 8:40 a.m. with the RNA staff, RNA 1 stated his work schedule was from Sundays to Thursdays. RNA 2, 3, and 4 stated their work schedule was from Tuesdays to Saturdays. RNA 2 and 3 stated the part-time RNAs, were RNA 6 and RNA 7, who covers RNA treatment on Sunday and Monday. The RNA staff stated there should be three RNAs each day to provide treatment to residents- one RNA for Nursing Stations A1 and A2, one RNA for Nursing Station C1, and one RNA for Nursing Station C2. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/2025 at 12:03 p.m. with RNA 2 and 3, the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 3/9/2025 and 3/10/2025, were reviewed. Both RNA 2 and 3 stated 3/9/2025 (Sunday) and 3/10/2025 (Monday) were their regular days off. RNA 2 and RNA 3 reviewed the Nursing Staffing Assignment and Sign-in Sheet, dated 3/9/2025, and stated RNA 7 was the only RNA for Nursing Stations A1, A2, C1, and C2. RNA 2 and RNA 3 stated it was not possible for RNA 7 to provide RNA treatment to all the residents. RNA 2 and RNA 3 reviewed the Nursing Staffing Assignment and Sign-in Sheet, dated 3/10/2025, and stated RNA 6 did not call and did not show up to work. RNA 2 and RNA 3 stated RNA 7 was the only RNA for Nursing Stations A1, A2, C1, and C2 and could not provide RNA treatment to all the residents. During a concurrent interview and record review on 3/14/2025 at 3:47 p.m. with the Quality Assurance Nurse (QA) and the Director of Staff Development (DSD), the Nursing Staffing Assignment and Sign-in Sheet, dated 3/9/2025, was reviewed. The QA and DSD stated RNA 6 was assigned to Nursing Stations A1, A2, C1, and C2. The QA and DSD stated it was not possible for RNA 6 to provide RNA treatment to all the residents. The QA stated residents receiving RNA services (in general) had the potential to develop contractures if RNA services were not provided. During a concurrent interview and record review on 3/14/2025 at 4:05 p.m. with the QA and the DSD, the Nursing Staffing Assignment and Sign-in Sheet, dated 3/10/2025, was reviewed. The QA and DSD stated RNA 7 was the only RNA for Nursing Stations A1, A2, C1, and C2. The QA and DSD stated it was not possible for RNA 7 to provide RNA treatment to all the residents. The DSD stated the facility did not have enough staff to provide RNA treatment on 3/9/2025 and 3/10/2025. During a concurrent interview and record review on 3/14/2025 at 4:13 p.m. with the QA and the DSD, the Nursing Staffing Assignment and Sign-in Sheet, dated 3/3/2025, was reviewed. The QA and DSD stated RNA 6 was assigned to Nursing Stations A1 and A2 and RNA 1 was assigned to Nursing Stations C1 and C2. The DSD stated the RNA treatments occurred Monday to Friday and splints were applied Saturday and Sunday. The DSD stated the facility used to have three RNAs to provide treatment on Sunday and Monday and are currently down to two RNAs for Sunday and Monday. The DSD stated the residents with physician orders for RNA services may not receive treatment on Mondays since the facility did not have enough RNA staff to provide the treatment on Mondays. During an interview on 3/14/2025 at 5:30 p.m. with the QA and the DSD, the DSD stated the RNA staff did get pulled from providing RNA services to provide Certified Nursing Assistant (CNA) care when CNA staff called out of work. During a review of the facility's policy and procedure (P&P) titled, Staffing, revised 10/20217, the P&P indicated the facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans. a. During a review of Resident 62's Admission Record, the Admission Record indicated the facility originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side and dementia (progressive state of decline in mental abilities). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's Physician Orders, dated 5/8/2023, the Physician Orders indicated for RNA to provide active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) exercises to both legs, five times per week as tolerated. During a review of Resident 62's Care Plan titled, Requires RNA program for AAROM on both legs, five times per week as tolerated, revised on 11/17/2023, the care plan interventions included to provide the RNA program as ordered by Resident 62's physician. During a review of Resident 62's Documentation Survey Report (record of nursing assistant tasks) for 9/2024, the Documentation Survey Report for the RNA to provide AAROM exercises was blank (not initialed) on the following dates: 9/2/2024, 9/3/2024, 9/4/2024, 9/9/2024, 9/16/2024, 9/18/2024, 9/20/2024, 9/23/2024, 9/24/2024, and 9/30/2024. During a review of Resident 62's Documentation Survey Report for 10/2024, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on the following dates: 10/2/2024, 10/16/2024, 10/18/2024, and 10/22/2024. During a review of Resident 62's Documentation Survey Report for 11/2024, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on the following dates: 11/1/2024, 11/18/2024, 11/21/2024, 11/25/2024, 11/27/2024, and 11/28/2024. During a review of Resident 62's Documentation Survey Report for 12/2024, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on the following dates: 12/5/2024, 12/6/2024, 12/9/2024, 12/12/2024, 12/16/2024, 12/18/2024, 12/23/2024, 12/24/2024, and 12/30/2024. During a review of Resident 62's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 12/18/2024, the MDS indicated Resident 62 had clear speech, made concrete verbal requests, usually understood others, and had moderately impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 62 did not have ROM limitations in both arms and legs, required substantial/maximal assistance (helper does more than half the effort) assistance with toileting, upper body dressing, rolling to the right and left side in bed, and transfers from lying on the back to sitting at the side of the bed, and was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for bathing and lower body dressing. During a review of Resident 62's Documentation Survey Report for 1/2025, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on the following dates: 1/1/2025, 1/7/2025, 1/8/2025, 1/9/2025, 1/13/2025, 1/20/2025, 1/27/2025, and 1/29/2025. During a review of Resident 62's Documentation Survey Report for 2/2025, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on the following dates: 2/6/2025, 2/20/2025, and 2/24/2025. During a review of Resident 62's Documentation Survey Report for 3/2025, the Documentation Survey Report for the RNA to provide AAROM exercises was blank on 3/3/2025 (Monday) and 3/10/2025 (Monday). (continued on next page)

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	056433	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 8:40 a.m. with RNA 4, RNA 4 stated her work schedule was from Tuesday to Saturday. During an observation on 3/12/2025 at 9:02 a.m. in Resident 62's room, Resident 62's RNA session was observed. Resident 62 laid in bed while Restorative Nursing Aide 4 (RNA 4) performed massage on both legs and then provided ROM exercises on both hips, knees, and ankles. During an interview on 3/12/2025 at 9:21 a.m. with RNA 4, RNA 4 stated Resident 62 was seen for AAROM of both legs. RNA 4 stated the physician order indicated to provide AAROM to both legs, five times per week. RNA 4 stated she provided Resident 62 with exercises three times per week since RNA 4 was usually pulled from RNA services to provide CNA care. During an interview on 3/14/2025 at 12:49 p.m. with RNA 4, RNA 4 stated the blank dates on Resident 62's Documentation Survey Report indicated Resident 62 was not seen for RNA services. RNA 4 stated she did not work on Mondays. RNA 4 stated any other blank dates on the Documentation Survey Report indicated RNA 4 was pulled from RNA services to provide CNA care. b. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (complete lack of oxygen to the brain, which results in death of brain cells), epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), and cardiac arrest (heart suddenly and unexpectedly stops beating effectively). During a review of Resident 109's Physician Orders, dated 5/19/2023, the Physician Orders indicated for the RNA to provide passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) exercises on both arms and legs, five times per week or as tolerated. Another physician order, dated 5/19/2023, indicated for the RNA to apply both wrist-hand-finger orthoses ([WHFO] splint secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures) and both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) for four to six hours or as tolerated, seven days per week. During a review of Resident 109's Physician Orders, dated 12/16/2023, the Physician Orders indicated for RNA to apply a knee extension splint on the left leg for two to four hours per day or as tolerated, seven days per week. During a review of Resident 109's Physician Orders, dated 2/3/2024, the Physician Orders indicated for the RNA to apply both elbow extension splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), for two to four hours per day or as tolerated, seven days per week. During a review of Resident 109's Documentation Survey Report for 9/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 9/2/2024, 9/6/2024, 9/9/2024, 9/11/2024, 9/12/2024, 9/13/2024, 9/16/2024, 9/17/2024, 9/18/2024, 9/19/2024, and 9/20/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 9/1/2024, 9/2/2024, 9/6/2024, 9/7/2024, 9/9/2024, 9/11/2024, 9/12/2024, 9/13/2024, 9/16/2024, 9/17/2024, 9/18/2024, 9/19/2024, 9/20/2024, 9/21/2024, and 9/22/2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 109's Documentation Survey Report for 10/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 10/1/2024, 10/14/2024, 10/17/2024, and 10/31/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 10/1/2024, 10/5/2024, 10/13/2024, 10/14/2024, 10/17/2024, 10/20/2024, and 10/31/2024. During a review of Resident 109's Documentation Survey Report for 11/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 11/1/2024, 11/21/2024, and 11/22/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 11/1/2024, 11/2/2024, 11/3/2024, 11/9/2024, 11/21/2024, 11/22/2024, 11/24/2024, and 11/25/2024. During a review of Resident 109's Documentation Survey Report for 12/2024, the Documentation Survey Report for RNA to provide PROM to both arms and legs was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/24/2024, 12/25/2024, 12/30/2024, and 12/31/2024. The Documentation Survey Report for RNA to apply both elbow extension splints, the left knee splint, and both PRAFOs was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/21/2024, 12/23/2024, 12/24/2024, 12/25/2024, 12/28/2024, 12/30/2024, and 12/31/2024. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109 had no speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 109 was dependent for toileting, bathing, dressing, rolling to either side while lying in bed, and chair/bed-to-chair transfers. During a review of Resident 109's Physician Orders, dated 3/7/2025, the Physician Orders indicated to discontinue RNA for application of both WHFOs, both elbow extension splints, the left knee extension splint, and both PRAFOs, seven days per week. During a review of Resident 109's Physician Orders, dated 3/7/2025, the Physician Orders indicated for RNA to apply both WHFO and both PRAFOs for four to six hours per day or as tolerated, two times per week, every Saturday and Sunday. The Physician Orders, dated 3/7/2025, also indicated for RNA to apply the left knee extension splint and both elbow extension splints for two to four hours per day or as tolerated, two times per week, every Saturday and Sunday. During a review of Resident 109's Documentation Survey Report for 3/2025, the Documentation Survey Report for RNA to apply both WHFOs, both elbow extension splints, the left knee extension splint, and both PRAFOs was blank for 3/9/2025 (Sunday). During an interview on 3/11/2025 at 10:07 a.m. with Family 1, Family 1 stated different RNAs provided Resident 109 with treatment, including Restorative Nursing Aide 2 (RNA 2) and RNA 3 and sometimes RNA 7. During an interview on 3/12/2025 at 8:40 a.m. with the RNA staff, RNA 2 and RNA 3 stated their work schedule was from Tuesday to Saturday. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/2025 at 12:03 p.m. with Restorative Nursing Aide 2 (RNA 2), Resident 109's Documentation Survey Reports for 3/2025 reviewed. RNA 2 stated Resident 109's Documentation Survey Report for 3/9/2025 (Sunday) was blank which indicated Resident 109 did not receive RNA services. c. During a review of Resident 112's Admission Record, the Admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to stenosis (narrowing) of the right posterior cerebral artery (blook vessel in the brain that supplies oxygen-rich blood to the back part of the brain), diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), and cerebral edema (swelling of the brain). During a review of Resident 112's Care Plan titled, Decline in current ambulatory skills, initiated on 1/5/2024 and revised 9/17/2024, the Care Plan interventions included RNA to perform ambulation using a FWW with AFO on the left leg, three times per week as tolerated. During a review of Resident 112's Care Plan titled, At risk for decline in current joint and muscle integrity on both arms and legs, initiated on 3/1/2024 and revised 9/17/2024, the Care Plan interventions included RNA to perform Omni-cycle (motorized therapeutic exercise system to assist with limited strength, endurance, or muscle control) exercises on both arms and leg, three times per week as tolerated. During a review of Resident 112's Physician Orders, dated 9/18/2024, the Physician Orders indicated for the RNA to assist Resident 112 with ambulation using a front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) with ankle foot orthosis ([AFO] brace to hold the foot and ankle in the correct position) on the left leg, three times per week as tolerated, and to assist Resident 112 with Omni-cycle exercises for both arms and legs, three times per week as tolerated. During a review of Resident 112's Physician Orders, dated 11/11/2024, the Physician order indicated for the RNA to assist Resident 112 with ambulation using a FWW with the AFO on the left leg, three times per week as tolerated every Monday, Wednesday, and Friday. During a review of Resident 112's Documentation Survey Report for 11/2024, the Documentation Survey Report for RNA to provide Resident 112 with Omni-cycle exercises was blank for the following dates: 11/13/2024, 11/21/2024, and 11/26/2024. The Documentation Survey Report for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank for the following dates: 11/13/2024, 11/22/2024, 11/25/2024, and 11/29/2024. During a review of Resident 112's Documentation Survey Report for 12/2024, the Documentation Survey Report for RNA to provide Resident 112 with Omni-cycle exercises was blank for the following dates: 12/24/2024, 12/25/2024, and 12/31/2024. The Documentation Survey Report for RNA provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank for the following dates: 12/2/2024, 12/9/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/25/2024, and 12/30/2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 112's Documentation Survey Report for 1/2025, the Documentation Survey Report indicated for RNA to provide Resident 112 with Omni-cycle exercises was blank for the following date: 1/1/2025, 1/6/2025, 1/8/2025, 1/13/2025, 1/15/2025, 1/16/2025, 1/21/2025, 1/24/2025, and 1/27/2025. The Documentation Survey Report for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank for the following dates: 1/1/2025, 1/6/2025, 1/8/2025, 1/13/2025, 1/15/2025, 1/24/2025, and 1/27/2025. During a review of Resident 112's MDS, dated [DATE], the MDS indicated Resident 112 had clear speech, had difficulty communicating some words or finishing thoughts, sometimes understood verbal content, and had moderately impaired cognition. The MDS indicated Resident 112 required substantial/maximal assistance (helper does more than half the effort) for toileting and showering and partial/moderate assistance (helper does less than half the effort) for dressing, sit to stand, chair/bed-to-chair transfers, toilet transfers, and walking 50 feet (unit of measure). During a review of Resident 112's Documentation Survey Report for 2/2025, the Documentation Survey Report for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank on 2/24/2025 and 2/28/2025. The Documentation Survey Report for RNA to provide Resident 112 with Omni-cycle exercises was blank on 2/4/2025 and 2/25/2025. During a review of Resident 112's Documentation Survey Report for 3/2025, the Documentation Survey Report for RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg was blank on 3/3/2025 (Monday). During a concurrent observation and interview on 3/11/2025 at 12:29 p.m. in Resident 112's room, Resident 112 was awake and sitting up in a wheelchair after eating lunch. Family 2 stated Resident 112 received RNA for walking three times per week on Mondays, Wednesdays, and Fridays and RNA for the Omni-cycle exercises twice per week on Tuesdays and Thursdays. Family 2 was not sure if Resident 112 received RNA services five times per week. During an interview on 3/12/2025 at 8:40 a.m. with the RNA staff, RNA 2 stated his work schedule was from Tuesday to Saturday. During a concurrent interview and record review on 3/14/2025 at 10:13 a.m. with RNA 2, Resident 112's Documentation Survey Reports for RNA, including 11/2024 to 3/2025, were reviewed. RNA 2 stated blank dates on the Documentation Survey Report indicated Resident 112 did not receive RNA services. RNA 2 stated he did not work on Sundays and Mondays. RNA 2 stated he usually gets pulled from RNA duties to perform CNA care. d. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left non-dominant side and muscle weakness. During a review of Resident 40's Physician Orders, dated 7/10/2024, the Physician Orders indicated for RNA to provide PROM on the left arm and left leg, five times per week as tolerated, RNA to perform sit to stand activities using the siderails or parallel bars, five times per week as tolerated, and RNA to apply the left WHFO for two to four hours, seven days per week as tolerated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Documentation Survey Report for 12/2024, the Documentation Survey Report for the RNA to provide PROM to Resident 40's left arm and left leg and RNA to perform sit to stand activities using the siderails or parallel bars was blank on the following dates: 12/5/2024, 12/6/2024, 12/9/2024, 12/10/2024, 12/13/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/30/2024, and 12/31/2024. The Documentation Survey Report for the RNA to apply Resident 40's left WHFO was blank on the following dates: 12/5/2024, 12/6/2024, 12/7/2024, 12/9/2024, 12/10/2024, 12/13/2024, 12/16/2024, 12/20/2024, 12/21/2024, 12/23/2024, 12/30/2024, and 12/31/2024. During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40 had clear speech, had difficulty communicating some words or finishing thoughts, usually understood verbal content, and had moderately impaired cognition. The MDS indicated Resident had ROM limitations in one arm and one leg and was dependent for toileting, lower body dressing, sit to stand transfers, and chair/bed-to-chair transfers. During a review of Resident 40's Documentation Survey Report for 1/2025, the Documentation Survey Report for the RNA to provide PROM to Resident 40's left arm and left leg and RNA to perform sit to stand activities using the siderails or parallel bars was blank on the following dates: 1/1/2025, 1/6/2025, 1/13/2025, 1/24/2025, 1/27/2025, and 1/28/2025. The Documentation Survey Report for the RNA to apply Resident 40's left WHFO was blank on the following dates: 1/1/2025, 1/6/2025, 1/12/2025, 1/13/2025, 1/19/2025, 1/24/2025, 1/27/2025, and 1/28/2025. During a review of Resident 40's Documentation Survey Report for 2/2025, the Documentation Survey Report for the RNA to provide PROM to Resident 40's left arm and left leg, RNA to perform sit to stand activities using the siderails or parallel bars, and RNA to apply Resident 40's left WHFO was blank on the following dates: 2/5/2025, 2/6/2025, 2/7/2025, 2/12/2025, 2/19/2025, 2/24/2025, and 2/25/2025. During a review of Resident 40's Documentation Survey Report for 3/2025, the Documentation Survey Report for the RNA to provide PROM to Resident 40's left arm and left leg and RNA to perform sit to stand activities using the siderails or parallel bars was blank on 3/3/2025 (Monday). The Documentation Survey Report for the RNA to apply Resident 40's left WHFO was blank on 3/2/2025 (Sunday) and 3/3/2025 (Monday). During an observation on 3/11/2025 at 11:26 a.m., Resident 40 was sitting in a wheelchair and using the right arm and right leg to propel the wheelchair from the bedroom to the hallway. Resident 40 was wearing a left WHFO while seated in the wheelchair. During a concurrent interview and record review on 3/11/2025 at 11:39 a.m. in the hallway, Resident 40 was sitting in the wheelchair and removed the left WHFO. Resident 40 stated he received RNA for exercises three times per week but was supposed to receive RNA services five times per week. Resident 40 stated he wanted RNA five times per week because he led a very active lifestyle and played sports prior to having a stroke. During an interview on 3/12/2025 at 8:40 a.m. with the RNA staff, RNA3 stated his work schedule was from Tuesdays to Saturdays. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/2025 at 10:32 a.m. with RNA 3, Resident 40's Documentation Survey Report for RNA, including 11/2024 to 3/2025, were reviewed. RNA 3 stated he consistently documented RNA sessions. RNA 3 stated the blank dates on Resident 40's Documentation Survey Report indicated Resident 40 did not receive RNA services. RNA 3 stated he did not work on Sundays and Mondays and was pulled from RNA to perform CNA care. RNA 3 stated RNA 1, RNA 6, or RNA 7 were supposed to provide treatment to Resident 40 on Mondays and when RNA 3 was pulled from RNA to perform CNA care. RNA 3 stated Resident 40 gets mad at RNA 3 when Resident 40 does not receive RNA on Mondays and when RNA 3 gets pulled to perform CNA care. RNA 3 stated the residents (in general) should be provided RNA in accordance with the physician order because the resident can develop contractures or develop pain because they have not been moving. RNA 3 stated residents (unspecified) who did not receive RNA treatment had more pain and limited ROM when RNA 3 returned to providing RNA services. e. During a review of Resident 121's Admission Record, the Admission Record indicated Resident 121 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (disease characterized by a progressive decline in mental abilities), hemiparesis following a cerebral infarction affecting the right dominant side, and dysphagia (difficulty swallowing). During a review of Resident 121's Physician Orders, dated 8/30/2024, the Physician Orders indicated for the RNA to provide ambulation with a FWW, three times per week or as tolerated, and AAROM to both arms, five times per week or as tolerated. During a review of the Documentation Survey Report for 11/2024, the Documentation Survey Report for the RNA to provide Resident 121 with a walking program was blank for the following dates: 11/1/2024, 11/8/2024, 11/18/2024, 11/22/2024, 11/25/2024, and 11/27/2024. During a review of the Documentation Survey Report for 12/2024, the Documentation Survey Report for the RNA to provide AAROM to both of Resident 121's arms was blank for the following dates: 12/4/2024, 12/5/2024, 12/6/2024, 12/9/2024, 12/10/2024, 12/13/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/25/2024, 12/30/2024, and 12/31/2024. The Documentation Survey Report for the RNA to provide Resident 121 with a walking program was blank for the following dates: 12/4/2024, 12/6/2024, 12/9/2024, 12/13/2024, 12/16/2024, 12/20/2024, 12/23/2024, 12/25/2024, and 12/30/2024. During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 had clear speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 121 was dependent for toileting, bathing, lower body dressing, sit to stand transfers and required substantial/maximal assistance to walk 50 feet. During a review of the Documentation Survey Report for 1/2025, the Documentation Survey Report for the RNA to provide AAROM to both of Resident 121's arms was blank for the following dates: 1/1/2025, 1/27/2025, and 1/28/2025. The Documentation Survey Report for the RNA to provide Resident 121 with a walking program was blank for the following dates: 1/1/2025, 1/6/2025, 1/13/2025, and 1/27/2025. During a review of Resident 121's Documentation Survey Report for 2/2025, the Documentation Survey Report for the RNA to provide AAROM to both of Resident 121's arms was blank for the following dates: 2/5/2025, 2/6/2025, 2/25/2025, and 2/26/2025. The Documentation Survey Report for the RNA to provide Resident 121 with a walking program was blank for the following dates: 2/5/2025, 2/12/2025, 2/19/2025, and 2/26/2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 121's Documentation Survey Report for 3/2025, the Documentation Survey Report for the RNA to provide Resident 121 with a walking program was blank on 3/3/2025 (Monday) and 3/10/2025 (Monday). During an interview on 3/12/2025 at 8:40 a.m. with the RNA staff, RNA 3 stated his work schedule was from Tuesdays to Saturdays. During a concurrent interview and record review on 3/14/2025 at 10:32 a.m. with RNA 3, Resident 121's Documentation Survey Reports for RNA, including 11/2024 to 3/2025, were reviewed. RNA 3 stated he consistently documented RNA sessions. RNA 3 stated the blank dates on Resident 121's Documentation Survey Report indicated Resident 121 did not receive RNA services. RNA 3 stated he did not work on Sundays and Mondays and was pulled from RNA to perform CNA care. RNA 3 stated RNA 1, RNA 6, or RNA 7 were supposed to provide treatment to Resident 121 on Mondays and when RNA 3 was pulled from RNA to perform CNA care. RNA 3 stated the residents (in general) should be provided RNA in accordance with the physician order because the resident can develop contractures or develop pain because they have not been moving. RNA 3 stated residents (unspecified) who did not receive RNA treatment had more pain and limited ROM when RNA 3 returned to providing RNA services. During a review of the facility's P&P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents will not experience a reduction in ROM and will receive appropriate services to maintain or improve mobility. Cross reference F688. 2. During a concurrent observation and interview on 3/12/25 at 11:47 a.m., with Licensed Vocational Nurse (LVN 6) in the SAU, LVN 6 stated the SAU had 26 residents in house on 3/12/25 and 12 of 26 residents were assigned to LVN 6. LVN 6 stated 3 out of 12 assigned residents had not receive their morning medications at 11:47 a.m. During an interview on 3/12/25 at 11:58 a.m., with LVN 6 outside of Resident [TRUNCATED]

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 45981 Based interview, and record review the facility failed to ensure staffing information was accurate and current on 1/13/25,2/12/25, 3/9/25 and 3/10/25. This deficient practice had the potential to affect the care of all the residents in the facility and for resident needs to go unmet. Findings: During a concurrent interview and record review on 3/14/25 at 10:24 a.m. with the Director of Staff Development (DSD), the facility's Sub Acute Unit Census (count of the number of people (patients, residents, etc.) who are currently under the care or in residence at a specific facility at a given time) and Nursing Staffing Assignment and Sign-In Sheet (a document used in healthcare facilities to track and verify nursing staff assignments, ensuring accurate documentation of hours worked and verification of presence and duties performed) dated 1/13/25, 2/12/25, 3/9/25 and 3/10/25 were reviewed. The DSD stated she was responsible for the staffing at the facility and ensuring that the daily census was accurate and reflects the Nursing Staffing Assignment and Sign-In Sheets reflect the current licensed staff working on a particular day. The DSD stated in the sub-acute area (designed for individuals who are too ill to return home but no longer require the intensive care of a hospital), staffing was determined by the acuity (the number and stability of a resident's medical conditions and their physical and psychosocial care needs) of the residents, census, and the mandated hours that are required. The DSD stated that it was imperative to post the accurate staffing information in order to know the correct number of staff because it could cause the residents to have a delay in their care. The DSD stated not having the adequate number of staff could cause the call lights not being answered in a timely manner, medications administered late, and the overall care of the residents could be late. The following dates reviewed with the DSD indicated: 1.On 1/13/25 facility's census indicated 26 residents from 7:00 am-7:00 p.m. Number of Staff indicated 2 Registered Nurses (RN's), the facility's Nursing Staffing Assignment and Sign-In Sheet validated 1 RN signed in on 1/13/25. 2, On 2/12/25 facility's census indicated 28 residents from 7:00 am-7:00 p.m. Number of Staff indicated 2 Registered Nurses (RN's), the facility's Nursing Staffing Assignment and Sign-In Sheet validated 1 RN signed in. 3.On 3/9/25 facility's census indicated 26 residents from 7:00 am-7:00 p.m. Number of Staff indicated 4 Licensed Vocational Nurses (LVN's), the facility's Nursing Staffing Assignment and Sign-In Sheet validated 3 LVN's signed in. 4.On 3/10/25 facility's census indicated 26 residents from 7:00 am-7:00 p.m. Number of Staff indicated 3 Licensed Vocational Nurses (LVN's), the facility's Nursing Staffing Assignment and Sign-In Sheet validated 2 LVN's signed in. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DSD validated the posted staffing was inaccurate and should have been updated accordingly, in order to ensure that there was adequate staffing in order to provide proper care and services to the residents in a timely manner. During an interview on 3/14/25 4:30 p.m. with the Director of Nursing (DON), the DON stated the facility census and Nursing Staffing Assignment and Sign-In Sheets should be accurate and updated. The DON stated it was important because it indicates how many staff are providing care to the residents. The DON stated if there was not enough licensed staff the residents will not receive the proper care that they deserve. During a review of the facility's policy ana procedure (P&P) titled, Staffing, dated 2017, the P&P indicated, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 78) was provided necessary behavioral health care and services for the treatment of the residents emotional and mental condition by ensuring: 1.Resident 78 who verbalized feelings of wanting to die was assessed, monitored, and provided interventions to address Resident 78's feelings of wanting to die. 2.Physician, psychiatrist (a physician who specializes in psychiatry, the branch of medicine devoted to the diagnosis, prevention, study, and treatment of mental disorders), psychiatrist nurse practitioner, and interdisciplinary team ([IDT]-comprises professionals from various disciplines who work in collaboration to address a patient with multiple physical and psychological [mental and emotional) needs) were notified when Resident 48 verbalized wanting to die. These failures resulted in Resident 78 not receiving the necessary care, services, and interventions to address Resident 78's emotional, behavioral, and psychosocial (the psychological dimension {internal, emotional, and thought processes, feelings and reactions} and the social dimension {includes relationships, family and community network, social values and cultural practices} of a person) needs. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought with intense paranoia, leading to false beliefs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 48's Minimum Data Set ({MDS}- a resident assessment tool), dated 1/23/2025, the MDS indicated Resident 48 was moderately cognitively (ability to think, understand, learn, and remember) impaired and required substantial assistance with showering/bathing, dressing, and personal hygiene. During a review of Resident 48's care plan initiated 2/16/2024, the care plan focus was, Resident 48's use of antidepressant (medications to treat mental health conditions) medication with goals that included Resident 48 will have decreased episodes of manifested behavior. Interventions for Resident 48 included monitor for changes in condition and report to the medical doctor and to provide a safe, calm environment. During an observation on 3/11/2025 at 9:48 a.m., Resident 48 yelled out that he wanted to die in the presence of Licensed Vocational Nurse (LVN) 4. LVN 4 stated she would notify her charge nurse immediately. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 3/11/2025 at 12:32 p.m., with LVN 4, LVN 4 stated she informed LVN 1 of Resident 48's comment of wanting to die and LVN 1 replied that she was aware of Resident 48's comments and he is being monitored. During an interview on 3/12/2025 at 11:37 a.m., with LVN 1, LVN 1 stated Resident 48 has made comments that he wanted to die in the past she did not document these comments. LVN 1 stated she did inform anyone of Resident 48's comments nor complete a change of condition (COC) or implement a care plan. LVN 1 stated she should have informed Resident 48's doctor so the staff could monitor him more closely because Resident 48 could try to commit suicide. During an interview on 3/12/2025 at 2:01 p.m., with Resident 48, Resident 48 indicated he thinks about dying every day, even dreams about dying. Resident 48 stated he began thinking about dying when he was admitted to the facility and stated I wake up feeling like sh*t everyday and it goes downhill from there. I'm sick of it. This is a miserable existence. During an interview on 3/12/2025 at 3:11 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 indicated she was unaware of Resident 48's verbalization of wanting to die. RNS 1 stated this verbalization of wanting to die is suicidal ideation and Resident 48's doctor should be notified immediately. RNS 1 stated there was no COC, care plan, nursing notes, or monitoring for Resident 48's suicidal ideation but there should be to prevent Resident 48 from potentially committing suicide. During an interview on 3/12/2025 at 4:57 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated she has heard Resident 48 verbalizing he wanted to die and reported it to her charge nurse. During an interview on 3/14/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON stated when Resident 48 verbalized he wanted to die, it should have been immediately reported to the doctor, a COC completed, care plan implemented, monitoring initiated, and the social worker notified immediately so an investigation could be done. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, undated, the P&P indicated, The facility will provide, and residents will receive behavioral health services as needed to attain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The nursing staff will identify, document, and inform the physical about specific details regarding changes in an individual's mental status, behavior, and cognition, including onset, duration, intensity, and frequency of behavioral symptoms.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28851 Based on observation, interview, and record review, the facility: 1.Failed to ensure morning medication administrations were done on time in the subacute unit (SAU, a nursing unit that provides a level of medical care that is less intensive than acute care but more specialized than typical skilled nursing care) for seven (7) of 26 residents on 3/12/25 and 4 of 25 SAU residents on 3/13/25. 2.Failed to ensure medications were checked for accuracy upon delivery receipt and before administration. As a result, the Zosyn (piperacillin sodium and tazobactam sodium, an antibiotic combination that treat certain infections) intravenous (IV, into the vein) medications for 2 of 2 sampled residents (Residents 22 and 44) were not administered in accordance with the physician orders. The facility pharmacy failed to communicate the changes in physician's order with the facility and the prescriber. 3.Failed to ensure the emergency drug usage log was complete with details. These failures had the potentials of medication errors and/or adverse effects. Findings: 1. During an interview on 3/12/25 at 3:48 p.m., with Registered Nurse Supervisor (RNS 5)m RNS 5 stated 7 out of 26 residents in SAU received their morning meds (due at 9 a.m.) after 10 a.m. (Residents 30, 41, 108, 134, 149, 311, and 461). RNS 5 stated residents' doctors were notified of the late administrations of morning meds. During an interview on 3/12/25 at 3:50 p.m., RNS 5 stated most of the residents in the SAU had gastrostomy tube (G-Tube, a feeding tube inserted through a small opening in the abdomen directly into the stomach, used to deliver nutrition, fluids, and medications to individuals who cannot eat or drink safely). RNS 5 stated medication administration process via G-tube would take approximately 20 mins to one hour on average, especially when obstruction with the G tube occurred or other complication. RNS 5 stated it was fair to say medication administration would take 30 minutes on average for a resident with G-tube, from start to finish including obtaining vital signs and performing infection prevention procedures (such as sanitizing equipment and hand hygiene). Using the SAU census on 3/12/25 at 26 residents, with 2 licensed vocational nurses (LVN) on duty, assumed 12 residents per LVN and needs 30 minutes to perform medication administration via G-tube for each resident, then each LVN would need 12 times 30 minutes, or 360 minutes (6 hours) total, to complete morning medication administration duties. RNS 5 then stated there were usually 3 LVNs. Adjusted for three LVN with a census of 24 residents, then each LVN would have 8 residents with 30 minutes each, or 240 minutes (4 hours) total. RNS 5 stated for the medications scheduled at 9 a.m., medications can be given 1 hour before and after scheduled administration time. RNS 5 stated the calculated 4 hours exceeds the regulatory required window of two hours (between 8-10 a.m.). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/13/25 at 2:19 p.m., RNS 5 stated there were four residents (Residents 59, 125, 133, and 147) in the SAU received their 9 AM meds after 10 AM and residents' physicians were notified During an interview on 3/13/25 at 2:42 p.m., with the Director of Nursing (DON), the DON stated licensed nurses had from 8 a.m., to 10 a.m., to pass (administer) the medications scheduled at 9 a.m During a review of the facility policy and procedures (P&P) titled Medication Administration Policy (dated January 2022), indicated . Medications are administered within 60 minutes of schedule time (1) one hour before and (1) one hour after . 2. During a concurrent medication administration observation and interview on 3/13/25 at 9:52 a.m., with RNS 2 outside Resident 22's room, RNS 2 was preparing an intravenous (IV-giving medicines or fluids through a needle or tube inserted into a vein) medications. The label on the IV bag indicated it was Zosyn (piperacillin sodium and tazobactam sodium, an antibiotic combination that treat certain infections) 3.375 milligram (mg-unit of measurement) in 100 milliliter (ml, unit to measure volume) of 0.9% sodium solution (used for fluid replenishment and compound with IV medications), to be infused over four hours. RNS2 stated the rate translated into 25 ml per hour (hr) and administered to Resident 22. During a review of Resident 22's Physician Order, dated 3/3/25 at 5:57 p.m., the Physician Order indicated Piperacillin Sodium-Tazobactam Sodium in dextrose (chemically identical to glucose or blood sugar, a form of parenteral solutions containing various concentrations of glucose in water intended for intravenous fluid replenishment, mix or compound with IV medications) 3-0.375 gm/50ml. During an interview on 3/13/25 at 11:30 a.m., RNS 4 stated Resident 22 received Zosyn in NS at 100 ml and did not match the physician's order dated 3/3/25. During an interview on 3/13/25 at 11:39 a.m., RNS 2 called the facility contracted pharmacy and spoke to a technician who mentioned there was a shortage of dextrose 5% in water (D5W, a common IV fluid containing 5% glucose in water). During an interview on 3/13/25 at 11:41 a.m., the facility pharmacist stated it was their pharmacy's protocol to automatically change the IV fluid in any Zosyn order to NS in 100ml. During a review of the Pharmacy Protocol (dated 2/28/25) indicated . Fluid for Final Product: NS, D5W . and did not indicate the pharmacy will automatically change fluid types and the quantity used. During an interview on 3/13/25 at 11:45 a.m., RNS 2 stated when the nurse receives pharmacy delivery, the nurse should check the receipt and products received against the physician order. RNS 2 stated if there was any discrepancy, licensed nurse should clarify with the pharmacy and/or the prescriber. During an interview on 3/13/25 at 11:48 a.m., the pharmacist stated the pharmacy did not have record of clarifying the original order received or notifying the prescriber the change of IV fluid for Resident 22's Zosyn order. The pharmacist stated there was no record of notifying the facility of the change in order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 3/13/25 at 11:50 a.m., reviewed Resident 22's Progress Notes. RNS 2 stated there was no record regarding the change of fluid and volume between the pharmacy and the facility. During an interview on 3/13/25 at 12:02 a.m., the DON stated the pharmacy should have communicated the change in resident's order to the facility and/or that medical doctor should be inform of the change. During a concurrent interview and record review on 3/13/25 at 12:28 p.m., with the DON, reviewed delivery receipts (dated 3/5/25 and 3/10/25) for Resident 22's Zosyn. The DON stated the licensed nurse did not sign the delivery receipts for facility's record. During a concurrent observation and interview on 3/14/25 at 9:51 a.m., with RNS 4 outside of Resident 44's room, RNS 4 was preparing IV medication for Resident 44. RNS 4 stated Resident 44's Zosyn IV would be held due to the label did not match with Resident 44's physician order. During an interview on 3/14/25 at 10:06 a.m., RNS 4 stated before administration, licensed nurse should check the label of the IV medication against the physician order. RNS 4 stated a complete order includes the type of fluid needed to reconstitute & mix with the medication. During an interview on 3/14/25 at 10:20 a.m., RNS 4 stated Resident 44's IV medication administration record did not contain full order details. RNS 4 stated Resident 44's physician order indicated Zosyn 3.375 mg in Dextrose 50 ml, which did not match with the label and the medication in NS 100 ml sent from the pharmacy. During an interview on 3/14/25 at 10:36 a.m., the DON stated the physician order stated in Dextrose, but the pharmacy sent NS. The DON stated the pharmacy should communicate the change of fluid to mix with the medication. The DON stated the pharmacy did not communicate the change. During an interview on 3/14/25 at 12:59 p.m., the DON stated licensed nurses did not perform the 5 rights of medication administration (right medication, right resident, right dose, right time, right route of administration) for Resident 22 and 44. The IV Zosyn in NS 100 ml did not match with the physician orders on file. During a review of the facility policy and procedures, Medication Administration Policy (dated January 2022), indicated . Medications are administered as prescribed . 3. During a concurrent interview and record review, reviewed the emergency kit (E-Kit, contain a small quantity of emergency drug supplies which can be dispensed when pharmacy services are not available) log. RNS 4 stated one of the pages indicated someone removed a 1000 ml D5/0.45% NS (IV fluid that contains a mixture of 5% dextrose and 0.45% sodium chloride in water for fluid replenishment) for Resident 22, but failed to fill in the date, time, quantity removed, and licensed nurse's initial. During a review of the facility's policy and procedures (P&P) titled Emergency Pharmacy Services and E-Kits (dated August 2014), the P&P indicated . A record of the name, dose of the drug administered, . date, time of administration, and the signature of the person administering the dose shall be recorded in the emergency log book . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross reference F760

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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** 28851 Based on observation, interview, and record review, the facility failed to ensure that medication error rate was less than five percent (%). Two medication errors out of 32 total opportunities contributed to an overall medication error rate of 6.25 % for two residents (Resident 134, and 22) observed during medication administration (MedPass). This deficient practice of medication administration error rate of 6.25 percent (%) exceeded the five (5) percent (%) threshold and had the potential of adversely affecting residents' health condition. Findings: 1. During a medication administration observation on 3/13/25 at 8:59 a.m., outside Resident 134's room, the Licensed Vocational Nurse (LVN 2) was preparing Resident 134's medications. In total, LVN 2 administered eight (8) medications to Resident 134. One of those 8 medications was Mucinex DM (brand name for guaifenesin and dextromethorphan, a combination medication to treat cough and chest congestion) 600/30 milligrams (mg- unit to measure mass) extended-release tablet. LVN 2 crushed one tablet of Mucinex DM, mixed with 10 milliliters (ml, unit to measure volume) of water and administered to Resident 134 via resident's gastrostomy tube (G-tube, a feeding tube inserted through a small opening in the abdomen directly into the stomach, used to deliver nutrition, fluids, and medications to individuals who cannot eat or drink safely). During a review of Resident 134's Admission Record, the Admission Record indicated Resident 134 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancer, an abnormal growth of cells) of hypopharynx (the lowers part of the throat located behind the voice box and above the esophagus, or food pipe), malignant neoplasm of upper third of esophagus, and chronic obstructive pulmonary disease (COPD-a group of lung diseases that cause airflow obstruction and breathing difficulties). During a review of Resident 134's Physician Order dated 12/17/24 timed at 7:14 p.m., the Physician Order indicated, Mucinex Oral Tablet 600 mg (guaifenesin) give 600 mg orally two times a day related to encounter for attention to tracheostomy (a surgical procedure creating an opening in the neck to the trachea, or windpipe, allowing air to reach the lungs, often with a tube inserted to maintain the airway and facilitate breathing or secretion removal). During a concurrent interview and record review 3/14/25 at 11:55 a.m., Licensed Vocational Nurse (LVN) 2, LVN 2 stated the medication cart contained medications for Resident 134. LVN 2 presented the Mucinex DM in the cart and stated there was no other Mucinex or guaifenesin. Reviewed Resident 134's Medication Administration Record (MAR) and Resident 2134's Physician Order. LVN 2 stated the order was to give Mucinex (guaifenesin), without DM. LVN 2 stated Mucinex DM had 2 ingredients guaifenesin and DM. During an interview 3/14/25 at 12:52 p.m., with Director of Nursing (DON), the DON stated guaifenesin was not the same as Mucinex DM and extended-release medication should not be crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent medication administration observation and interview on 3/13/25 at 9:52 a.m., with RNS 2 outside Resident 22's room, RNS 2 was preparing an intravenous (IV-giving medicines or fluids through a needle or tube inserted into a vein) medications. The label on the IV bag indicated it was Zosyn (piperacillin sodium and tazobactam sodium, an antibiotic combination that treat certain infections) 3.375 milligram (mg-unit of measurement) in 100 milliliter (ml, unit to measure volume) of 0.9% sodium solution (used for fluid replenishment and compound with IV medications), to be infused over four hours. RNS2 stated the rate translated into 25 ml per hour (hr.) and administered to Resident 22. During a review of Resident 22's Physician Order, dated 3/3/25 at 5:57 p.m., the Physician Order indicated Piperacillin Sodium-Tazobactam Sodium in dextrose (chemically identical to glucose or blood sugar, a form of parenteral solutions containing various concentrations of glucose in water intended for intravenous fluid replenishment, mix or compound with IV medications) 3-0.375 gm/50ml. During a concurrent observation and interview on 3/13/25 at 11:19 a.m., with RNS 4 at Resident 22 bedside observed Resident receiving the infusion of Zosyn. RNS 4 stated the Zosyn label read piperacillin sodium and tazobactam sodium in 100 ml NS. The volume and the type of fluid used were incorrect. During a concurrent interview and record review on 3/13/25 at 11:30 a.m., reviewed Resident 22's Physician Order (dated 3/3/25). RNS 4 stated the order indicated Zosyn 3.375mg in Dextrose 50 ml. RNS 4 stated Resident 22 received Zosyn in NS at 100 ml which did not match Resident 22's physician's order. During an interview on 3/14/25 at 12:59 p.m., the DON stated licensed nurses did not perform the 5 rights of medication administration (right medication, right resident, right dose, right time, right route of administration) for Resident 22. The IV Zosyn in NS 100 ml did not match with the physician orders on file. The DON stated residents that had a certain condition can be sensitive with certain types of fluids that could cause negative effect to residents. During a review of the facility policy and procedures, Medication Administration Policy (dated January 2022), indicated . Medications are administered as prescribed .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28851 Based on observations, interviews, and record review, the facility failed to ensure two of three reviewed residents were free of significant medication errors as evident by: 1.The facility administered intravenous (into the vein) antibiotic (medication to treat infection) not in accordance with physician's order for two (2) of 2 sampled (Resident 22 received 30 of 36 doses in total and Resident 44 received 19 of 22 doses). These deficient practices had the potentials of worsening residents' health conditions. 2.Failing to administer Resident 361's Liothyronine (a medication used to treat hypothyroidism {when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs}). This failure of failing to administer medications in accordance with the physician orders increased the risk for Resident 361 to potentially experience hypothyroidism symptoms such as constipation (problem with passing stools), feeling weak, and weight gain. Findings: 1.During a review Resident 22's Admission Record, the Admission Record indicated Resident 22 was readmitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancer, an abnormal growth of cells) of cheek mucosa (mouth cavity tissue) and heart failure (a heart condition when the heart cannot pump enough blood to meet the body's needs, leading to symptoms like shortness of breath, and swelling). During a review of Resident 22's Physician Order, dated 3/3/25 at 5:57 p.m., the Physician Order indicated Piperacillin Sodium-Tazobactam Sodium in dextrose (solutions intended for intravenous fluid replenishment, mix or compound with IV medications) 3-0.375 gram (gm, unit to measure mass) in 50 milliliters (ml, unit to measure volume). Use 1 dose intravenously one time only for urinary tract infection (UTI, an infection of the urinary system) until 3/3/25 at 11:59 p.m., infuse at 25 cubic centimeters (CC, unit to measure volume) per hour (hr) for 4 hours, use 1 dose intravenously every 8 hours for UTI until 03/15/2025 23:59, infuse at 25cc/hr for 4 hrs. During a medication administration observation on 3/13/25 at 9:52 a.m., Registered Nurse Supervisor (RNS 2) administer Zosyn 3.375 gm in 100 ml of 0.9% sodium solution (normal saline, NS, a form of IV fluids used for fluid replenishment and compound with IV medications). During a concurrent interview and record review on 3/13/25 at 11:30 a.m., reviewed Resident 22's Physician Order (dated 3/3/25). RNS 4 stated the order indicated Zosyn 3.375 gm in Dextrose 50ml but Resident 22 received Zosyn 3.375 gm in NS at 100 ml which did not match Resident 22's physician's order. During a review of Resident 22's pharmacy delivery receipts indicated the pharmacy sent 11 doses of Zosyn 3.375 gm in 100 ml NS on 3/5/25 and 14 doses of the same medications on 3/10/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 22's IV medication administration record (IV MAR) indicated Resident 22 received 30 of 36 doses of Zosyn in March 2025. During an interview on 3/13/25 at 12:02 p.m., with the Director of Nursing (DON), the DON stated residents that had a certain condition can be sensitive with certain types of fluids that could cause negative effect to residents. During a review Resident 44's Admission Record, the Admission Record indicated Resident 44 was readmitted to the facility on [DATE] with diagnoses including bacterial pneumonia (a lung infection caused by bacteria), epilepsy (a brain disorder characterized by recurrent seizures), hypertension (high blood pressure). During an interview on 3/14/25 at 10:20 a.m., RNS 4 stated Resident 44's physician order indicated Zosyn 3. 375 gm in Dextrose 50 ml, which did not match with the medication label on the medication. During a review of Resident 44's IV MAR indicated Resident 44 received 30 of 36 doses of Zosyn in March 2025. During a review of Resident 44's Care Plan (initiated on 11/6/24) indicated Resident 44 was at risk for fluid volume imbalance and electrolyte imbalance. During an interview on 3/14/25 at 10:42 a.m., with the DON , the DON stated Resident 44 had a history of hypernatremia (high blood sodium levels which can lead to dehydration and potentially causing confusion, seizures, or even coma). The DON stated residents with certain heart diseases such as heart failure, on fluid/sodium restriction, or have contraindication with certain IV fluids, could be at risk for adverse events. During a review of the facility policy and procedures, titled Medication Administration Policy (dated January 2022), indicated . Medications are administered as prescribed . Cross Reference F755 2.During a review of Resident 361's Admission Record, the Admission Record indicated Resident 361 was admitted to the facility on [DATE] with diagnoses including hypothyroidism, hypertension (HTN- high blood pressure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 361's Minimum Data Set (MDS- a resident assessment tool) dated 3/4/2025, the MDS indicated Resident 361's cognition (ability to think, understand, learn, and remember) was intact and required substantial/maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. During a review of Resident 361's Physician Order Summary Report, the Physician Order Summary included, but not limited to the following medications: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.Amlodipine besylate (a medication used to treat high blood pressure) tablet 5 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth two time a day for HTN, hold for systolic blood pressure (SBP - the pressure in arteries when heart is pumping blood into arteries) <110, order date 2/26/2025. b.Levothyroxine sodium (a medication to treat hypothyroidism) tablet 125 micrograms (mcg- a unit of measure for mass), give 1 tablet in the morning. c.Liothyronine sodium (a medication to treat hypothyroidism) tablet 5 microgram (mcg-unit of measurement) by mouth one time a day. During a review of Resident 361's Care Plan titled Resident 361 had thyroid disorder initiated 2/27/2025, the care plan goals included Resident 361 would be free from signs and symptoms of weakness nor tiredness daily for three months. The Care plan interventions for Resident 361 included administering medications as ordered, monitoring for weakness or tiredness and encourage naps as needed. During an interview on 3/11/2025 at 3:04 p.m., with Resident 361, Resident 361 stated she does not always receive her thyroid medications in the morning. During a concurrent interview and medication reconciliation record review on 3/12/2025 at 10:23 a.m., with Licensed Vocational Nurse (LVN) 1, reviewed Resident 361's Medication Administration Record ({MAR}- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) which indicated there were missed doses of Liothyronine on March 1, 2025, and March 6, 2025. LVN 1 stated she was assigned to Resident 361 on March 6, 2025, and not sure how she missed that medication. Reviewed the Liothyronine bubble pack which indicated there were two doses missed. LVN 1 stated missing doses of thyroid medications can result in constipation and hypothyroidism. During a review of the facility's policy and procedure (P&P) titled, Medication Administration Policy, undated, the P&P indicated, Medications must be administered in accordance with the orders including any required time frame.

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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. 28851 Based on observation, interview, and record review, the facility failed to ensure the intravenous (IV, into the vein) antibiotic (medicines that fight bacterial infections) medications had labels in accordance with the physician orders for two (2) of 2 sampled residents (Residents 22 and 44). This failure had the potential of medication error. Findings: During a concurrent observation, interview and record review on 3/13/25 at 11:19 a.m., Registered Nurse Supervisor (RNS 4) was in Resident 22's room at bedside and Resident 22 was receiving an IV medication. The surveyor asked to see the label of the Resident 22's IV medication. RNS 4 stated the label on Resident 22 IV medication read piperacillin sodium and tazobactam sodium (antibiotic combination that treat certain infections, also known as Zosyn) 3.375 gram (gm, unit to measure mass) in 100 milliliter (ml, unit to measure volume) of 0.9% sodium solution (normal saline, NS, a mixture of water and salt, or sodium chloride, with a salt concentration of 0.9%; it is a form of IV fluids used for fluid replenishment and compound with IV medications). During a review of Resident 22's Physician Order, dated 3/3/25 at 5:57 p.m., indicated Piperacillin Sodium-Tazobactam Sodium in dextrose (a form of parenteral solutions intended for intravenous fluid replenishment, mix or compound with IV medications) 3-0.375 gm/50ml. Use 1 dose intravenously one time only for urinary tract infection (UTI, an infection of the urinary system) until 3/3/25 at 11:59 p.m., infuse at 25 cubic centimeters (CC, unit to measure volume) per hour for four hours intravenously every 8 hours for UTI until 03/15/2025 ,infuse at 25cc/hour for four hours. During a concurrent observation and interview on 3/14/25 at 9:51 a.m., outside Resident 44's room, RN 4 was preparing an IV medication for Resident 44. RN 4 stated the medication was Zosyn 3.375 mg in 100 ml NS. RN 4 stated the label on Resident 44's Zosyn did not match with Resident 22's physician the order. During a review of Resident 44's Physician Order dated on 3/7/25 timed at 4:33 p.m., the Physician Order indicated Zosyn Intravenous Solution 3-0.375 gm/50 ml (Piperacillin Sodium-Tazobactam Sodium in Dextrose) use one dose intravenously one time only for pneumonia (an infection in the lung) until 03/07/2025 and use one dose intravenously every 8 hours for pneumonia for 7 Days. Cross Reference F755 and F760

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation interview and record review the facility failed to ensure Resident 10 was provided with lower dentures. This deficient practice had the potential to result in weight loss because of inability to effectively chew foods for Resident 10. Findings: During a review of Resident 10's Admission Record, dated 3/14/2025 Resident 10's admission record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including protein calorie malnutrition, muscle weakness, dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing. During a review of Resident 10's ({MDS}- a resident assessment tool) the MDS dated [DATE], indicated Resident 10 is cognitively intact. The MDS also indicated, Resident 10 needs substantial assistance (helper does more than half the work) with activities of daily living (ADL's - activities such as toileting, bathing and dressing, a person performs daily). During review of Resident 10's Order summary Report, dated 3/14/25, the order summary report indicated, Resident 10 was on a finely chopped mechanical soft texture, thin consistency until her dentures are available. The order summary report also indicated Resident 10 had orders for dental evaluation and follow up treatment. During a review of Resident 10's care plan titled Dental Care dated 3/10/2022 last revised 8/13/2024 indicated Resident 10 had the potential for decreased food intake related to dental problem, Resident 10 has all natural teeth missing with full upper and lower dentures and is at risk for difficulty chewing and weight loss. Intervention to monitor dental condition & refer for dental evaluation if indicated. During an observation and interview on 3/11/2025 at 10:10 a.m. in Resident 10's room, Resident 10 was missing her bottom dentures. Resident 10 stated I don't like the way food tastes without my bottom dentures. During a concurrent interview on 3/14/2025 at 7:50 a.m. and record review of Residents 10's dental records with the Social Services Director (SSD) , The SSD stated that Resident 10 was seen by the dentist on 2/3/2025 for evaluation for full upper and lower dentures. The SSD stated from what he could see there was no follow up appointment. The facility must provide Resident 10 with bottom dentures. The SSD stated Resident 10's quality of life can be affected with missing teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 3/14/2025 at11:17 a.m. with Social Services (SS) and record review with the, Resident 10's dental records. The SS stated that Resident 10's was seen by the dentist on 2/3/2025 for denture replacement but her insurance would not pay for the x-rays or denture fitting. SS stated that she did not followed up with the dentist until yesterday SS stated it is important for residents to have teeth it can affect the way they eat. They could have weight loss. SS stated it can also affect the way they feel about their appearance. During an interview with the Director of Nursing (DON) on 3/14/25 at 2:21 p.m. the DON stated it did not matter if Resident 10's insurance would not pay for her dentures it is the facility's responsibility to make sure Resident 10 has her bottom dentures. The DON stated Resident 10's oral intake could be poor, and it can also affect the way she feels about herself. During a review of the facility's policy and procedure (P&P) titled Dental Services dated 12/2016, the P&P indicated if dentures are damaged or lost, residents will be referred for dental services within three days. If the referral is not made within 3 days, documentation will be provided regarding what will be done to ensure that the resident is able to eat and drink adequately while awaiting the dental services, and the reason for the delay. All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, and interview the facility failed to ensure the ice machine had an air gap for back flow (the unwanted reverse flow of contaminated water) prevention. This failure had the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another). Findings: During an observation on 3/11/25 at 8:14 am in the kitchen. The ice machine pipe leading to the drain had black grime and dirt on it and there was no air gap between pipe and ice machine drain. During a concurrent observation and interview on 3/14/2025, at 7:26 a.m. with Assistant Dietary Supervisor (ADS) in the kitchen ice machine room. The ADS stated there was black dirt on the pipe leading to the drain. The ADS stated he was not aware of the air gap Food Drug Administration (FDA) FDA Food Code 5-202.13. During a concurrent observation and interview on 3/14/2025, at 7:26 a.m. with the Registered Dietician (RD) in the kitchens ice machine room. The RD stated there was dirt and black crud on the pipe leading to the ice machine drain and that she was not aware of the air gap regulation. The RD stated there was a possibility for contaminated water to back flow into the ice machine. During a concurrent observation and interview on 3/14/2025, at 11:05 a.m. in the kitchen ice machine room with the Maintenance Supervisor (MS), the MS stated that he had worked at the facility for [AGE] years and did not know there needed to be an air gap between the ice machine pipe and the ice machine drain. The MS stated that there was dirt and black grime on the pipe and around the ice machine drain. The MS stated there is a possibility for residents to get a sick stomach if the residents would drink contaminated ice. During an interview on 3/14/2025, at 2:23 p.m. with the Administrator (ADM). The ADM stated she was told that there should be a space between the pipe and the drain because it could back flow and that she was aware of the federal regulation. The ADM stated there is a possibility for contaminated water to back flow into the ice machine. ADM stated there is a potential for a water born illness the residents could have stomach issues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the FDA Food Code 2022 # 5-202.13 Backflow Prevention, Air Gap. The FDA Food code # 5-202.13 back flow prevention, air gap indicated, an air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or non-FOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). 5-2022.13 Backflow Prevention, Air Gap. During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. Standing water in sinks, dipper wells, steam kettles, and other equipment may become contaminated with cleaning chemicals or food residue. To prevent the introduction of this liquid into the water supply through back siphonage, various means may be used. The water outlet of a drinking water system must not be installed so that it contacts water in sinks, equipment, or other fixtures that use water. Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility did not provide accurate documentation for five of 11 reviewed residents (Resident 62, 40, 112, 133, and 109) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) by failing to: 1.Ensure Resident 62's Documentation Survey Report (record of nursing assistant tasks) from 3/2024 to 3/2025 (one year) included a task for the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to perform active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) exercises to the right leg in accordance with the physician's order. 2.Ensure Resident 40's Documentation Survey Report from 7/2024 to 11/2024 (5 months) included a task for the RNA to perform left arm passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) in accordance with the physician's order. 3.Ensure Resident 112's Documentation Survey Report from 9/2024 to 12/2024 (3 months) included a task for the RNA to provide Omni-cycle exercises (motorized therapeutic exercise system to assist with limited strength, endurance, or muscle control) to both arms in accordance with the physician's order. 4.Accurately record Resident 133's physician order, dated 7/19/2024, for the RNA to provide PROM to the right leg. 5.Document the application of Resident 109's both elbow extension (straightening) splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), both wrist-hand-finger orthoses ([WHFO] splint secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures), the left knee extension splint, and both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) during Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) treatment sessions. 6.Document attempts to provide Resident 109 with the Speech Language and Pathology ([SLP] professional aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) treatment. These failures resulted in the inaccurate provision of care for Resident 62, 40, 112, 133, and 109 during RNA, PT, OT, and SLP treatment sessions, which could potentially result in the residents' decline in ROM and mobility. Findings: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 62's Admission Record, the Admission Record indicated the facility originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side and dementia (progressive state of decline in mental abilities). During a review of Resident 62's Physician Orders for RNA, dated 5/8/2023, the Physician Orders indicated for RNA to provide AAROM exercises to both legs, five times per week or as tolerated. During a review of Resident 62's Minimum Data Set ([MDS] a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 62 had clear speech, made concrete verbal requests, usually understood others, and had moderately impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 62 did not have ROM limitations in both arms and legs, required substantial/maximal assistance (helper does more than half the effort) assistance with toileting, upper body dressing, rolling to the right and left side in bed, and transfers from lying on the back to sitting at the side of the bed, and was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for bathing and lower body dressing. During a review of Resident 62's Documentation Survey Report (record of nursing assistant tasks), dated 3/2024 to 3/2025, the Documentation Survey Reports indicated for the RNA to provide AAROM exercises on the left leg, five times per week, but did not include AAROM exercises on the right leg. During an observation on 3/12/2025 at 9:02 a.m. in Resident 62's room, Resident 62's RNA session was observed. Resident 62 laid in bed while Restorative Nursing Aide 4 (RNA 4) stood on the left side of the bed. RNA 4 performed massage on both legs and then provided ROM exercises on both hips, knees, and ankles. During an interview on 3/12/2025 at 9:21 a.m. with RNA 4, RNA 4 stated Resident 62 was seen for AAROM of both legs. During a concurrent interview and record review on 3/14/2025 at 12:43 p.m. with the Director of Medical Records (DMR), Resident 62's RNA tasks in the facility's electronic documentation system and Documentation Survey Reports, dated 3/2024 to 3/2025, were reviewed. The DMR stated Resident 62's RNA tasks and Documentation Survey Reports did not include the RNA for AAROM to the right leg. The DMR stated the facility did not have any documented evidence the RNA provided AAROM on the right leg from 3/2024 to 3/2025. b. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left non-dominant side and muscle weakness. During a review of Resident 40's Physician Orders, dated 7/10/2024, the Physician Orders indicated for RNA to provide PROM on the left arm and left leg, five times per week as tolerated, RNA to perform sit to stand activities using the siderails or parallel bars, five times per week as tolerated, and RNA to apply the left WHFO for two to four hours, seven times per week as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40 had clear speech, had difficulty communicating some words or finishing thoughts, usually understood verbal content, and had moderately impaired cognition. The MDS indicated Resident 40 had ROM limitations in one arm and one leg and was dependent for toileting, lower body dressing, sit to stand transfers, and chair/bed-to-chair transfers. During a review of Resident 40's Documentation Survey Report, dated 7/2024 to 11/2024, the Documentation Survey Report included RNA tasks to provide PROM to the left leg, RNA to perform sit to stand activities using the siderails or parallel bars, and RNA to apply Resident 40's left WHFO. The Documentation Survey Reports did not include a task for the RNA to provide PROM to the left arm during the day shift. During an observation on 3/11/2025 at 11:26 a.m., Resident 40 was sitting in a wheelchair and using the right arm and right leg to propel the wheelchair from the bedroom to the hallway. Resident 40 was wearing a left WHFO while seated in the wheelchair. During an observation on 3/12/2025 at 10:18 a.m. in the therapy room, Resident 40 was observed already wearing the left WHFO. During an interview on 3/12/2025 at 10:32 a.m. in the therapy room, Restorative Nursing Aide 3 (RNA 3) stated he provided Resident 40 with PROM to the left arm and leg and applied the left WHFO in the morning. During a concurrent interview and record review on 3/14/2025 at 4:13 p.m. with the Quality Assurance Nurse (QA) and the Director of Staff Development (DSD), Resident 40's Physician Orders, dated 7/10/2024, and Documentation Survey Report, dated 7/2024 to 11/2024, were reviewed. The QA stated the Documentation Survey Report from 7/2024 to 11/2024 did not include the task for the RNA to provide Resident 40 with PROM to the left arm during the day shift. The DSD stated RNA task for PROM to the left arm was inputted for night shift, which was a documentation error. The DSD stated the RNAs work during the day and would not see the task to provide Resident 40 with PROM to the left arm in their electronic documentation system. The DSD stated Resident 40's Documentation Survey Reports did not reflect the provision of PROM to the left arm in accordance with the physician order, dated 7/10/2024. c. During a review of Resident 112's Admission Record, the Admission Record indicated the facility admitted Resident 112 on 7/10/2023 with diagnoses including cerebral infarction due to stenosis (narrowing) of the right posterior cerebral artery (blook vessel in the brain that supplies oxygen-rich blood to the back part of the brain), diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), and cerebral edema (swelling of the brain). During a review of Resident 112's Physician Orders, dated 9/18/2024, the Physician Orders indicated for the RNA to assist Resident 112 with ambulation (the act of walking) using a front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) with the ankle foot orthosis ([AFO] brace to hold the foot and ankle in the correct position) on the left leg, three times per week as tolerated. Another physician order, dated 9/18/2024, indicated for the RNA to assist Resident 112 with Omni-cycle exercises for both arms and legs, three times per week as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 112's Documentation Survey for 9/2024 to 12/2024, the Documentation Survey Reports indicated for the RNA to provide Resident 112 with ambulation using the FWW with AFO on the left leg and RNA to provide Resident 112 with Omni-cycle exercises on both legs. The Documentation Survey Report did not include for RNA to provide Resident 112 with Omni-cycle exercises on both arms. During an observation on 3/11/2025 at 1:23 p.m. in the therapy room, Resident 112's RNA session was observed. Restorative Nursing Aide 2 (RNA 2) placed and secured Resident 112's wheelchair in front of the Omni-cycle machine. Resident 112 required verbal cues to hold onto the machine's handles to cycle both arms forward. Resident 112 pushed and cycled both legs using the Omni-cycle's foot pedals. Both of Resident 112's legs were cycling faster than both arms. During a concurrent interview and record review on 3/14/2025 at 4:45 p.m. with the QA and DSD, Resident 112's Physician Orders for the Omni-cycle exercises, dated 9/17/2024, and the Documentation Survey Report, dated from 9/2024 to 12/2024, were reviewed. The DSD and QA stated the Documentation Survey Reports from 9/2024 to 12/2024 did not include Resident 112's Omni-cycle exercises for both arms. The DSD stated the facility did not have documented evidence the RNA provided the Omni-cycle exercises for Resident 112's arms from 9/2024 to 12/2024 in accordance with the physician's order, dated 9/17/2024. d. During a review of Resident 133's Admission Record, the Admission Record indicated Resident 133 was admitted to the facility on [DATE] with diagnoses including hemiplegia following a cerebral infarction affecting the right dominant side. During a review of Resident 133's Physician Orders, dated 7/19/2024, the Physician Orders indicated for the RNA to provide PROM on the right arm and AAROM on the left arm, left leg, and right leg, five times per week as tolerated. During a review of Resident 133's MDS, dated [DATE], the MDS indicated Resident 133 did not have any speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 133 had ROM impairments in one arm and one leg and was dependent for toileting, bathing, dressing, and rolling to either side while lying in bed. During a review of Resident 133's Physician Orders, dated 3/5/2025, the Physician Orders indicated for the RNA to provide PROM on the right leg, five times per week as tolerated. During an observation on 3/12/2025 at 10:02 a.m. in Resident 133's room, Resident 133 was lying in bed and used the left arm to scratch both sides of the resident's head. During an observation on 3/12/2025 at 12:19 p.m. in Resident 133's room, Resident 133's RNA session was observed. Restorative Nursing Aide 5 (RNA 5) provided ROM exercises to both arms and legs. Resident 133 was observed with active movement in the left hip and knee. During an interview on 3/12/2025 at 12:42 p.m. with RNA 5, RNA 5 stated he provided PROM exercises to Resident 133's right arm and leg and AAROM exercises to the left arm and leg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 8:44 a.m. with the Director of Rehabilitation (DOR), Resident 133's Physician Orders for RNA, dated 7/19/2024 and 3/5/2025, were reviewed. The DOR stated Resident 133's Physician Order for RNA, dated 7/19/2024, to provide AAROM to the right leg was a clinical record error since Resident 133 was unable to move the right side of the body. The DOR stated the Physician Order for RNA was changed on 3/5/2025 (eight months later) to provide PROM to the right leg. The DOR stated incorrect provision of care could have been provided since the physician's order was not accurate. e. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (complete lack of oxygen to the brain, which results in death of brain cells), epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), and cardiac arrest (heart suddenly and unexpectedly stops beating effectively). During a review of Resident 109's Physician Orders from an outpatient brain injury clinic, dated 1/24/2025, the Physician Orders indicated for Resident 109 to receive PT, OT, and SLP services. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109 had no speech, rarely/never expressed ideas and wants, rarely/never understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 109 was dependent for toileting, bathing, dressing, rolling to either side while lying in bed, and chair/bed-to-chair transfers. 1. During a review of Resident 109's PT Evaluation and Plan of Treatment, dated 2/21/2025, the PT Evaluation indicated both hips and knees had ROM within functional limits (sufficient joint movement without significant limitation). The PT Evaluation indicated Resident 109 had impaired ROM (unspecified) in both ankles. The PT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform activities of daily living [ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility]), and orthotic (splint) management and training, five times per week for four weeks. During a review of Resident 109's OT Evaluation and Plan of Treatment, dated 2/21/2025, the OT Evaluation indicated Resident 109's ROM in both arms were impaired, including right shoulder flexion (lifting the arm upward, normal 0 to 180 degrees) 0 to 70 degrees (0-70 degrees), left shoulder flexion 0-80 degrees, right elbow extension (normal 0 degrees) negative 95 degrees (-95 degrees, positioned in 95 degrees of elbow flexion), and left elbow extension -80 degrees (positioned in 80 degrees of elbow flexion). The OT Evaluation did not include ROM measurements of both wrists and hands. The OT Evaluation indicated Resident 109 had contractures (unspecified), elbow extension splints, and WHFOs. The OT goals for Resident 109 included to tolerate wearing both elbow extension splints for four hours to increase ROM and to tolerate wearing both WHFOs for four hours. The OT Plan of Care included therapeutic exercises, neuromuscular reeducation, therapeutic activities, self-care management training, and orthotic management and training, five times per week for four weeks. During a review of the PT Treatment Encounter Notes, Resident 109 received PT treatment on 2/21/2024, 2/26/2025, 2/27/2025, 2/28/2025, 3/3/2025, 3/4/2025, 3/5/2025, 3/6/2025, 3/7/2025, 3/10/2025, and 3/12/2025. The PT Treatment Notes did not include the application of the left knee splint and both PRAFOs to Resident 109's legs on 2/27/2025, 2/28/2025, 3/3/2025, 3/5/2025, 3/6/2025, and 3/10/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the OT Treatment Encounter Notes, Resident 109 received OT treatment on 2/21/2025, 2/26/2025, 2/27/2025, 2/28/2025, 3/3/2025, 3/4/2025, 3/5/2025, 3/6/2025, 3/7/2025, 3/10/2025, and 3/12/2025. The OT Treatment Notes did not include the application of both elbow extension splints and WHFOs to Resident 109's arms on 2/27/2025, 3/3/2025, 3/4/2025, 3/5/2025, 3/6/2025, and 3/7/2025. During an observation on 3/12/2025 at 10:47 a.m. in Resident 109's room, Resident 109's OT treatment session was observed. Occupational Therapy Assistant 1 (OTA 1) performed PROM to both shoulders, elbows, wrists and fingers. OTA 1 and Physical Therapy Assistant 1 (PTA 1) applied both elbow extension splints and both WHFOs on Resident 109's arms. During an observation on 3/12/2025 at 11:14 a.m. in Resident 109's room, Resident 109's PT treatment session was observed. PTA 1 performed PROM to both hips, knees, and ankles. PTA 1 applied the left knee splint and both PRAFOs on Resident 109's legs. During a concurrent interview and record review on 3/15/2025 at 10:49 a.m. with the DOR, Resident 109's PT Treatment Notes were reviewed. The DOR stated the PTs applied Resident 109's left knee and both PRAFO splints every treatment session. The DOR reviewed Resident 109's PT Treatment Notes and stated the therapists did not indicate splints were applied during treatment sessions on 2/27/2025, 2/28/2025, 3/3/2025, 3/5/2025, 3/6/2025, and 3/10/2025. During a concurrent interview and record review on 3/15/2025 at 12:44 p.m. with the DOR, Resident 109's OT Treatment Notes were reviewed. The DOR reviewed Resident 109's OT Treatment Notes. The DOR stated the therapists did not indicate splints were applied during treatment sessions on 2/27/2025, 3/3/2025, 3/5/2025, 3/6/2025, and 3/7/2025. During an interview on 3/14/2025 at 11:21 a.m. with OTA 1 and PTA 1, PTA 1 stated Resident 109's splints to both arms and legs were applied every treatment session but was not included in the PT and OT documentation. PTA 1 stated the facility did not have any documented evidence Resident 109's splints were applied during PT and OT treatment sessions. 2. During a review of Resident 109's SLP Evaluation and Plan of Treatment, dated 2/28/2025, the SLP Evaluation indicated Resident 109 had impaired receptive language skills (ability to understand and comprehend spoken language), impaired expressive language (ability to communicate thoughts, feelings, and needs through verbal or nonverbal means, including words, gestures, writing, and facial expressions), and impaired cognitive-communicative skills (mental processes and abilities we use to effectively communicate and process information, including attention, memory, and problem-solving). The SLP Plan of Treatment included speech, language, voice, and communication, three times per week for four weeks. During a concurrent interview and record review on 3/13/2025 at 12:59 p.m. with the DOR, the SLP Evaluation, dated 2/28/2025, and SLP documentation was reviewed. The DOR stated the treatment plan included SLP intervention three times per week for four weeks. The DOR reviewed Resident 109's SLP electronic documentation and was unable to locate any treatment notes. The DOR stated the facility did not have any documented evidence Resident 109 was seen for SLP treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 3/14/2025 at 11:50 a.m. with Speech Language Pathologist 1 (SLP 1), SLP 1 stated he attempted to provide treatment to Resident 109 at the end February and on the weekend (unspecified date). SLP 1 stated Resident 109 was not alert enough during the attempts to participate in treatment. SLP 1 stated he did not write any notes documenting the attempts for SLP treatment because the therapists did not have access to complete a note with the facility's electronic documentation system. SLP 1 stated he also did not write a hand-written note in Resident 109's clinical record regarding attempts to provide treatment. During a review of the facility's undated policy and procedure (P&P) titled, Medical Records Accuracy Policy, the P&P indicated the facility maintained medical records that are complete and accurately documented. The P&P indicated the medical record must accurately reflect the resident's treatments.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44898 Based on interview and record review, the facility's Quality Assessment and Assurance Committee ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) failed to ensure effective oversight of the facility and implementation of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey. This failure resulted in the facility having repeat deficiencies in the areas of activities of daily living care provided for dependent residents, increase and prevent the decrease in range of motion and mobility, pharmacy services, procedures and pharmacist records, free of medication error rates five percent or more, and labeling and storage of drugs and biologicals. Findings: During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies: activities of daily living care provided for dependent residents, increase and prevent the decrease in range of motion and mobility, pharmacy services, procedures and pharmacist records, free of medication error rates five percent or more, and labeling and storage of drugs and biologicals. During an interview on 3/14/25 at 6:39 p.m., with the Administrator (ADM), the ADM stated deficiencies were identified from the previous recertification survey. The ADM stated the facility will identify and work on the deficiencies. The ADM stated the facility must have accountability and the staff need to know how their actions affect the residents. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance & Performance Improvement ([QAPI] takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) Committee, dated 8/2017, the P&P indicated, The QAPI Committee responsibilities include identifying and responding to quality deficiencies throughout the facility and oversight of the QAPI program when fully implemented, develop and implement corrective action and monitor performance goals or targets are achieved and revising corrective action when necessary. The duties of the QAPI Committee include but are not limited to routine monitoring of the following for all residents nursing care, including medication administration, prevention of pressure ulcers, dehydration and malnutrition, nutritional status and weight loss or gain, accidents and injuries, unexpected deaths, changes in mental or psychological status, and unplanned hospitalization s.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices by: 1.Failing to maintain an appropriate and recommended temperature of one of three linen dryers. 2.Failing to perform hand hygiene between residents. 3. Failed to handle clean linens in a safe and sanitary manner in the laundry room. 4.Failing to clean two of two cloth gait belts (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) used with Resident 134, 143, and 16 in accordance with the manufacturer's recommendations for disinfecting wipes (pre-moistened towelettes that contain a sanitizing or disinfecting formula that kill or reduce germs on surfaces). These failures had a potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for spread of infection. Findings: 1.During a concurrent observation and interview on 3/13/2025 at 7:36 a.m., with the Maintenance Supervisor (MS), dryer #2 had an observed temperature of 130-degrees Fahrenheit ([F] scale for measuring temperature) while drying linens. The MS stated the dryer temperatures were supposed to range between 160-170 degrees F to kill the germs but was unsure as to why dryer #2 was only 130-degrees F. 2.During an observation on 3/11/2025 at 9:44 a.m., Certified Nurse Assistant (CNA) 2 was observed exiting resident room with a water pitcher in hand and entering another resident room without performing hand hygiene. During an interview on 3/11/2025 at 9:48 a.m., with CNA 2, CNA 2 stated she did not perform hand hygiene after leaving resident room and before entering another resident room but should have. CNA 2 stated performing hand hygiene before entering and exiting resident rooms, prevents germs being transmitted from resident to resident. 3.During a concurrent observation and interview on 3/13/2025 at 7:36 a.m., with Laundry Aid (LA) 2, LA 2 was observed sorting dirty linens outside, entering the clean side of the laundry room where he removed his gloves, and began unloading the washer. LA 2, stated the linens in the washer were clean. LA 2 then proceeded to put the clean linens from the washer into the dryer. LA 2 did not perform hand hygiene nor was his gloves removed after sorting the dirty linens and prior to removing the clean linens from the washer. (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 3/13/2025 at 8:53 a.m., with the Infection Prevention Nurse (IPN), the IPN stated the staff are trained to perform hand hygiene between resident care, prior to walking into a resident room, and prior to exiting a resident room. The IPN stated CNA 2 should have performed hand hygiene when she exited resident room and prior to entering another resident's room. The IPN stated CNA 2 not performing hand hygiene can cause the transmission of infection between residents. The IPN stated not maintaining the dryer temperatures, promotes the spread of infection throughout the facility. The IPN stated the laundry staff should remove his gloves and wash their hands after sorting dirty linens and before handling clean linens and not doing so was a breach in the infection control process. During an interview on 3/14/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON staff should wash their hands before, after, and between resident care to prevent the transmission of infection to other residents. The DON stated the dryer temperatures should be functioning properly and at the correct temperature for infection control purposes. The DON stated if the dryer temperatures were not at the correct temperature, it places the residents at risk for infection, outbreaks, and illnesses. The DON stated, the laundry room staff should be removing their personal protective equipment (PPE equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and washing their hands between handling dirty linens and clean linens to prevent cross contamination. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, undated, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The preferred method of hand hygiene is with an alcohol-based hand rub after contact with objects in the immediate vicinity of the resident. During a review of the facility's P&P titled, Handling the Linen, undated, the P&P indicated, It is the policy of the facility to reduce the risks of infections, illness, and keep patients and employees in the facility safe and comfortable. Ensure the staff are performing proper hand hygiene before and after handling linen. During a review of the facility's P&P titled, Departmental (Environmental Services)- Laundry and Linen, revised 2/2014, the P&P indicated, .To provide a process for the safe and aseptic handling, washing, and storage of linens. Wash hands after handling soiled linen and before handling clean linen. 36943 4. During a review of Resident 134's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 12/11/2024, the MDS indicated Resident 134 was readmitted to the facility on [DATE] with diagnoses including cancer (disease in which some of the body's cells grow uncontrollably and spread to other parts of the body). The MDS indicated Resident 134 had intact cognition (clear ability to think, understand, learn, and remember) and required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for chair/bed-to-chair transfers and walking fifty feet (unit of measure). (continued on next page)

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Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 143's MDS, dated [DATE], the MDS indicated Resident 143 was admitted to the facility on [DATE] with diagnoses including cancer. The MDS indicated Resident 143 had severely impaired for cognition and required substantial/maximal assistance (helper does more than half the effort) for chair/bed-to-chair transfers and walking ten feet. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 was readmitted to the facility on [DATE] with diagnoses including coronary artery disease ([CAD] blood supply to the heart becomes narrowed), heart failure, and diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing). The MDS indicated Resident 16 had intact cognition and required partial/moderate assistance (helper does less than half the effort) for chair/bed-to-chair transfers and walking ten feet. During an observation on 3/11/2025 at 1:08 p.m. in the hallway, Resident 134 had a [NAME]-colored cloth gait belt around the waist with Restorative Nursing Aide 5's (RNA 5's) name written in black lettering. Resident 134 walked with a front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) while RNA 5 held onto the cloth gait belt and pulled a wheelchair behind Resident 134. During an observation on 3/12/2025 at 12:06 p.m. in the hallway, Resident 143 was sitting in a wheelchair with RNA 5's cloth gait belt around the waist. Resident 143 stood up from the wheelchair and walked using the FWW while RNA 5 held onto the gait belt. Resident 143's family member pushed the wheelchair behind Resident 143. During an observation on 3/12/2025 at 12:18 p.m. in Resident 143's room, RNA 5 wiped the FWW using disinfectant wipes, rolled up the cloth gait belt, and placed the rolled gait belt in the side pocket of RNA 5's pants. During an observation on 3/12/2025 at 12:44 p.m. in Resident 134's room, RNA 5 removed the rolled gait belt from the side pocket of RNA's pants and placed it around Resident 134's waist. Resident 134 stood up, walked outside of the room, and walked down the facility's hallways using the FWW while RNA 5 held onto the cloth gait belt. During a concurrent observation and interview on 3/12/2025 at 12:56 p.m. with RNA 5, the gait belt was made of thickly woven cotton fabric. RNA 5 stated the disinfecting wipes were used to wipe down the FWW and the gait belt. During an observation on 3/12/2025 at 2:07 p.m. in the hallway, Resident 16 was sitting in a wheelchair with a [NAME]-colored cloth gait belt around the waist. Restorative Nursing Aide 2 (RNA 2) and RNA 3 were standing on both sides of Resident 16 and physically assisted Resident 16 to transfer from sitting to standing while holding onto the FWW. (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 concurrent interview and record review on 3/14/2025 at 9:41 a.m. with the Infection Prevention Nurse (IPN), the IPN viewed a picture of the gait belts used with Resident 143, 134, and 16 and reviewed the manufacturer's recommendations of the disinfecting wipes. The IPN stated the gait belts were made of cotton, which were porous surfaces. The IPN reviewed the manufacturer recommendations of the disinfecting wipes and stated the disinfecting wipes should be used on hard, nonporous surfaces. The IPN stated the disinfecting wipes were ineffective on the cloth gait belts. The IPN stated there was a potential for transmission of infection without proper disinfection of cloth gait belts between residents' use. During a review of the undated manufacturer's recommendations of the disinfecting wipes, the manufacturer's recommendations indicated it was a violation of Federal law to use the product inconsistent with its labeling. The manufacturer's recommendations indicated the disinfecting wipes were for use on hard, non-porous surfaces of non-critical medical devices.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to implement its protocol for antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinicians) on one of four sampled residents (Resident 91) by failing to monitor and address antibiotic use for Resident 91. This failure had the potential to put Resident 91 at risk for antibiotic resistance (ability of bacteria and other microorganisms to withstand the effects of antibiotics, rendering them ineffective) or inappropriate use of antibiotic. Findings: During a review of Resident 91's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included atrial fibrillation(abnormal, and irregular heartbeat), retention of urine(when the bladder does not empty completely) benign prostatic hyperplasia (BPH- enlarged prostate gland) and obstructive and reflux uropathy (condition where urine flow is blocked in the urinary tract causing damage to the kidney). During a review of Resident 91's Minimum Data Set (MDS- a resident assessment tool) dated 1/28/2025, the MDS indicated the resident had an intact cognition(thought process) and was dependent on staff with toileting hygiene, bathing and dressing. The MDS indicated the resident had an indwelling catheter (thin, flexible tube inserted into the bladder to drain urine continuously). During a review of Resident 91's Change in Condition Evaluation (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) dated 3/9/2025, the COC Evaluation indicated abnormal urine, but the resident had no fever and had no pain. The COC indicated Keflex(antibiotic) 500 milligrams (mgs.- unit of measurement) by mouth four times a day for urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 91's Order Summary Report dated 3/11/2025, the Order Summary Report indicated an order of Macrobid (Nitrofurantoin- antibiotic) 100 mgs. by mouth two times a day for uti for seven days. During a review of Resident 91's Order Summary Report dated 3/9/2025, the Order Summary Report indicated an order of Keflex (a type of cephalosporin antibiotic) 500 mgs. by mouth four times a day for uti until 3/16/2025. During a review of Resident 91's Urine Culture (a laboratory test that detects and identifies bacteria or microorganisms in a urine sample) collected on 3/8/2025 indicated the resident had UTI. The urine culture indicated the bacteria present in the urine is resistant(ineffective to treat the infection) to Macrobid. The urine culture indicated enterococcus is resistant to cephalosporins. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 91's Urine Culture, Physician Order and Progress Notes on 3/13/2025, at 10:06 a.m. with Infection Preventionist Nurse (IPN), IPN confirmed Resident 91's urine culture and sensitivity had greater than 100,000 cfu/ml of proteus mirabilis and enterococcus and was on Keflex and Macrobid for UTI. IPN stated the resident usage of antibiotic did not follow the Mcgeer or Loeb criteria because the resident had an indwelling catheter and not manifesting chills, new onset of delirium(a serious change in abilities), dysuria (painful urination), suprapubic pain or fever. IPN stated she did not talk or verify with the physician why the resident was on two antibiotics for UTI. IPN stated it was the licensed nurses and IPN 's responsibility to ensure appropriateness of antibiotic use on residents and the licensed nurse who had carried out the antibiotic order should have verified and clarified with the physician that the resident was on two antibiotics for uti. IPN stated unnecessary use of antibiotics could lead to the development of multidrug resistant infections (MDRO-are microorganisms that have developed resistance to multiple classes of antibiotics)or clostridium difficile infection (Cdiff- highly contagious bacterial infection that causes diarrhea and inflammation of the colon). During an interview on 3/14/2025, at 6:33 p.m. with Director of Nursing (DON), DON stated using two antibiotics could be an unnecessary medicine which could be harmful to the health condition of the resident because antibiotic resistance, MDRO and C-diff could occur. During a review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship revised 12/2016, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program to ensure antibiotic usage of the residents are monitored. The P&P indicated laboratory results, and the current clinical situation of the resident will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued when a culture and sensitivity (C &S- diagnostic test used to identify bacteria or fungi causing infections and determine which antibiotics are effective) is ordered.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 45269 Based on observation, interview, and record review, the facility failed to ensure laundry washers were maintained in operational condition for 160 of 160 residents by failing to ensure the washer temperature gauges were functioning properly. This failure had the potential to affect the resident's health and place the residents at risk for the spread of infection. Findings: During a concurrent observation and interview on 3/13/2025 on 7:36 a.m., in the laundry room with the Maintenance Supervisor (MS), it was observed three of three washer temperature gauges were not functioning properly. The MS stated the temperature gauges so not always work and he uses a thermometer to check the sink water temperature to monitor the washer temperatures. The MS demonstrated how he checked the temperatures by taking the thermometer, turned on the sink across from the washers, sticking the thermometer under the water, and recorded the reading on the boiler temperature log. The MS stated the washer temperature gauges are not accurate and that is why he uses the sink water temperatures stating they use the same water pipeline. The MS stated he reported this issue to the previous Administrator but not to the current one. During a concurrent observation and interview on 3/13/2025 on 8:16 a.m., with the Laundry Aide (LA) 1, LA 1 stated the washer temperature gauges have not been functional for several weeks, but he has not reported it to anyone. LA 1 demonstrated how he checks the washer temperature by using a thermometer and checking the sink water. LA 1 stated the washer water temperature should be at 160 degrees Fahrenheit (F- scale for measuring temperature) to kill bacteria and prevent the spread of infection which can lead to an outbreak from the contamination of the linens. During a concurrent observation and interview on 3/13/2025 at 8:33 a.m., with LA 2, LA 2 stated he is unsure how long the temperature gauges have not been functional, but he did not report it to anyone. During an interview on 3/14/2025 at 11:14 a.m. with the Director of Nursing (DON), the DON stated checking the washer temperatures via the sink is incorrect and the individual washer temperature gauges should be functioning properly. The DON stated its crucial that the washer water temperatures are accurate to prevent infections, outbreaks, and potential illnesses for the residents. During a review of the facility's policy and procedure (P&P) titled, Departmental (Environmental Services)-Laundry and Linen, revised 2/2014, the P&P indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linens. For high-temperature processing, wash linen in water that is at least 160 degrees Fahrenheit, for a minimum of 25 minutes. During a review of the Maintenance Supervisor (MS) Job Description, the MS Job Description indicated the MS primary functions and responsibilities of this position are as follows: identify, report to administration, and schedule repair of any equipment malfunction. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49145

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to maintain a functional call light (device or button that the residents can press to signal staff for assistance) for one of four sampled residents (Resident 139) by failing to follow facility's policy and procedure regarding call light system. This failure had the potential to result in a delay in meeting Resident 139's needs for assistance which could lead to falls and accidents if assistance is not provided in a timely manner. Findings: During a review of Resident 139's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included repeated falls, muscle weakness, unspecified dementia (a progressive stated of decline in mental abilities),and legal blindness(having very poor eyesight even with glasses or contacts or a severely limited field of vision). During a review of Resident 130's Minimum Data Set (MDS- a resident assessment tool) dated 12/20/2024, the MDS indicated the resident had severely impaired cognitive skills(significant decline in cognitive abilities that interferes with daily functioning and independence) and required substantial/maximal assistance (helper does more than half the effort) with dressing, personal hygiene, bed mobility and toilet transfer. The MDS indicated the resident was incontinent(having no or insufficient voluntary control over urination or defecation) of urine and stool. During a review of Resident 139's Care Plan initiated 9/17/2024, the Care Plan indicated the resident was high risk for injury/accidents and falls related to history of fall, poor safety awareness, dementia, legal blindness secondary to glaucoma(an eye condition that damages the optic nerve which could lead to blindness). The Care plan's interventions included to answer resident's call quickly, anticipate needs and call light should be within reach. During a concurrent observation and interview on 3/1//2025, at 10:54 a.m. with Resident 139, Resident 139 was screaming and stating he had a bowel movement, felt wet and needed his diaper to be changed. Observed Resident 139 pressed his call light but no audible sound or visible light on resident's doorway. Resident 139 stated he had pressed his call light, but no one came to help him. During a concurrent observation and interview on 3/11/2025, at 11:05 a.m. with Licensed Vocational Nurse (LVN 3), LVN 3 check the connection then pressed Resident 139's call light and stated resident's call light was not working. LVN 3 stated Resident 139 would need a working call light to ensure the staff would be able to attend to his needs. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2025, at 11:24 a.m. with Certified Nursing assistant (CNA 6), CNA 6 stated Resident 139 required assistance in all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). CNA 6 stated everyone is responsible in ensuring the call lights are in working condition. CNA 6 stated CNAs should check the call light and report to the charge nurse if the call lights are not working. CNA 6 stated Resident 139 could feel neglected and scared if his call light was not working and needed help. During an interview on 3/142025, at 11:17 a.m. with Maintenance Supervisor (MS), MS stated the staff would need to let him know if a call light is not working and he did not check each resident's call light routinely. MS stated it would be dangerous to the residents if their call light is not working because the staff would not be able to know if the residents need help. During an interview on 3/14/2025, at 4:47 p.m. with Registered Nurse Supervisor (RNS4), RNS 4 stated call light was the only way the resident could communicate their needs that's why call lights should be operational and working. During an interview on 3/14/2025, at 6:13 p.m. with Director of Nursing (DON), DON stated the residents would not be able to get the care they needed and could lead to a negative outcome like fall if their call lights are not working. During a review of facility's policy and procedure (P&P) titled Call System, Resident dated 9/2022, the P&P indicated the resident call system is routinely maintained and tested by the maintenance department. The P&P indicated the resident call system always remains functional, and each resident is provided with a means to call staff for assistance through a communication system that directly calls a staff member. During a review of facility's Job Description and Performance Standards of a Maintenance Supervisor, the Job Description and Performance Standards of Maintenance Supervisor indicated the Maintenance Supervisor will develop and implement a monitoring system for the maintenance department and make recommendations to assure compliance with federal, state and local requirements.