STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056446	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 18) was free from physical restraint by not placing bilateral (both) 1/2 siderails on the bed without a physician's order or assessment. This failure had the potential to place Resident 18 at risk for unnecessary use of restraints that can lead to skin injuries , decline in mobility, and bed entrapment (an event in which a patient is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or bed frame). Findings: During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior)and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During a review of Resident 18's Physician Order dated 4/18/2024, the Physician Order indicated an active order of bilateral 1/4 assist device in bed to aid resident for proper positioning in bed-related side rail use. During an observation on 9/30/2024, at 10:54 a.m. in resident's room, Resident 18 was lying in bed crying , with left 1/2 siderail up and one 1/4 side rail up on the right side of the bed. Observed Resident 18 lying on his back, both legs are bent with left knee touching the left 1/2 siderail . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18 's Physician Order on 10/1/2024 at 4:09 p.m. with RN Supervisor (RNS 1) , RNS 1 confirmed the physician order for siderail is 1/4 (assist device). During an observation on 10/2/2024 at 3:45 p.m. , observed Resident 18 was lying in his back with both 1/2 siderails up in place. During a concurrent observation and interview on 10/2/2024 at 4:12 p.m. with RNS 1 in Resident 18's room, Resident 18 was lying on his back , with pillow on the left side of his legs and bilateral 1/2 siderails up were in place on Resident 18's bed. RNS 1 stated the bilateral 1/2 side rails are considered a restraint because there is no physician order, and no monitoring or assessment were being done for the use of bilateral 1/2 side rails. RNS 1 stated Resident 18's legs could get trapped, and he might feel he was being restrained by the staff. During an interview on 10/2/2024, at 4:19 p.m. with Certified Nursing Assistant (CNA3), CNA 3 stated Resident 18 does not use siderails and using both 1/2 siderails up could lead to fall and restriction of his movement. During an interview on 10/2/2024, at 4:25 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated 1/2 side rails are used if the resident is on a low air loss mattress (mattress designed to prevent and treat pressure injury) but it required a physician's order and consent because it is a form of restraint. During an interview on 10/3/2024, at 1:33 p.m.with LVN 1, LVN 1 stated bilateral 1/2 siderails could restrict residents' movement and are considered a form of restraints. LVN 1 stated the resident could develop skin tear , fracture (broken bone), or danger of entrapment. During an interview on 10/4/2024, at 3:32 p.m. with Director of Nursing (DON), DON stated bilateral 1/2 side rails are considered a restraint because the resident is not able to remove or take the rails down, restricts his ability to move around which could put him at risk for bed entrapment that could result to death. During a review of facility's policy and procedure (P/P) titled Restraint Free Environment reviewed and revised 12/19/2022, the P/P indicated each resident will attain and maintain his/her practicable well-being in an environment that prohibits the use of restraints for discipline or convenience. The P/P indicated behavioral interventions should be used and exhausted prior to the application of a physical restraint(refers to any manual method physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and restricts freedom of movement). 49145 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 18) was free from physical restraint by not placing bilateral (both) 1/2 siderails on the bed without a physician's order or assessment. This failure had the potential to place Resident 18 at risk for unnecessary use of restraints that can lead to skin injuries , decline in mobility, and bed entrapment (an event in which a patient is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or bed frame). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior)and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During a review of Resident 18's Physician Order dated 4/18/2024, the Physician Order indicated an active order of bilateral 1/4 assist device in bed to aid resident for proper positioning in bed-related side rail use. During an observation on 9/30/2024, at 10:54 a.m. in resident's room, Resident 18 was lying in bed crying , with left 1/2 siderail up and one 1/4 side rail up on the right side of the bed. Observed Resident 18 lying on his back, both legs are bent with left knee touching the left 1/2 siderail . During a review of Resident 18 's Physician Order on 10/1/2024 at 4:09 p.m. with RN Supervisor (RNS 1) , RNS 1 confirmed the physician order for siderail is 1/4 (assist device). During an observation on 10/2/2024 at 3:45 p.m. , observed Resident 18 was lying in his back with both 1/2 siderails up in place. During a concurrent observation and interview on 10/2/2024 at 4:12 p.m. with RNS 1 in Resident 18's room, Resident 18 was lying on his back , with pillow on the left side of his legs and bilateral 1/2 siderails up were in place on Resident 18's bed. RNS 1 stated the bilateral 1/2 side rails are considered a restraint because there is no physician order, and no monitoring or assessment were being done for the use of bilateral 1/2 side rails. RNS 1 stated Resident 18's legs could get trapped, and he might feel he was being restrained by the staff. During an interview on 10/2/2024, at 4:19 p.m. with Certified Nursing Assistant (CNA3), CNA 3 stated Resident 18 does not use siderails and using both 1/2 siderails up could lead to fall and restriction of his movement. During an interview on 10/2/2024, at 4:25 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated 1/2 side rails are used if the resident is on a low air loss mattress (mattress designed to prevent and treat pressure injury) but it required a physician's order and consent because it is a form of restraint. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024, at 1:33 p.m.with LVN 1, LVN 1 stated bilateral 1/2 siderails could restrict residents' movement and are considered a form of restraints. LVN 1 stated the resident could develop skin tear , fracture (broken bone), or danger of entrapment. During an interview on 10/4/2024, at 3:32 p.m. with Director of Nursing (DON), DON stated bilateral 1/2 side rails are considered a restraint because the resident is not able to remove or take the rails down, restricts his ability to move around which could put him at risk for bed entrapment that could result to death. During a review of facility's policy and procedure (P/P) titled Restraint Free Environment reviewed and revised 12/19/2022, the P/P indicated each resident will attain and maintain his/her practicable well-being in an environment that prohibits the use of restraints for discipline or convenience. The P/P indicated behavioral interventions should be used and exhausted prior to the application of a physical restraint(refers to any manual method physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and restricts freedom of movement).

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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 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** 45269 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person focused care plan for two of 14 sampled residents (Resident 11 and Resident 18) by failing to: 1.Follow and implement interventions for Resident 11's management of pain. 2.Develop a comprehensive care plan that will address Resident 18's pain. These failures place Resident 11 and Resident 18 at risk for delay of care and treatment. Findings: 1.During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and headaches. During a review of Resident 11's care plan initiated on 10/2/2024, the care plan focus was Resident 11 complains of constant pain with goals that included Resident 11 will minimize complaints of pain. Interventions for Resident 11 included monitor pain every four hours. During a review of Resident 11's Medication Administration Record (MAR), the MAR indicated monitoring for pain every four hours was not initiated until 10/3/2024 at 4:00 p.m. During an interview on 10/1/2024, at 10:09 a.m., with Resident 11, Resident 11 stated he had a headache since 9:00 a.m. and had not yet received his morning medications. During an interview on 10/3/2024, at 3:15 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 11's pain should be assessed every four hours because it is part of his care plan which should be followed for providing good care to Resident 11. During a concurrent interview and record review on 10/4/2024, at 11:30 a.m., with Registered Nurse Supervisor (RNS) 1, RNS stated care plans identify problems and monitors if the interventions are effective for the identified problems. RNS 1 stated Resident 11 has a care plan for pain, initiated on 10/2/2024, and one of the interventions is to monitor Resident 11's pain every four hours. RNS 1 stated documentation for Resident 11's pain began on 10/3/2024 at 4:00 p.m. but should have been started at the time the care plan was initiated on 10/2/2024. During a concurrent interview and record review on 10/4/2024, at 3:05 p.m., with the Director of Nursing (DON), the DON stated Resident 11 has a care plan for pain with intervention to monitor for pain every four hours but there is no documentation that Resident 11's pain was being monitored every four hours. The DON stated the staff should be following Resident 11's care plan because the care plan identifies the needs of the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included Stage 4 pressure ulcer of sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the tail bone), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), autistic disorder(developmental disability that affects how people communicate, interact, learn, and behave), and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During an observation on 9/30/2024, at 10:12 a.m. in Resident 18's room, Resident 18 was lying in his back and was moaning with facial grimacing. During a concurrent observation and interview on 10/3/2024, at 9:36 a.m. with Treatment Nurse (TN 1)in Resident 18's room, Resident was moaning and grimacing during change of wound dressing over the sacral area.TN 1 stated the resident had a stage 4 pressure injury on the sacral area. Observed Resident 18 stated No when asked by TN1 and CNA7 if in pain but Resident 18 was moaning louder, grimacing when TN 1 removed and replaced the dressing on the sacral area. Observed Certified Nursing Assistant (CNA7) turned resident to the right side and resident resisted to be turned to the right side and continuing to moan as the TN 1 continued with the dressing change. During a concurrent interview and record review on 10/3/2024, at 10:28 a.m. with Licensed Vocational Nurse (LVN1), LVN1 confirmed the resident had no care plan addressing his pain. LVN 1 stated the resident had a stage 4 pressure injury and could cause severe pain. LVN 1 stated Care Plan addressing pain is important to ensure monitoring and assessing of pain and checking if interventions provided to the resident was effective or not. During a concurrent interview and record review with RN Supervisor (RNS1) on 10/4/2024, at 11:06 a.m., RNS 1 stated Care Plan was initiated on 10/3/2024 after the surveyor started investigating Resident 18's pain. RNS 1 stated Care Plan for pain is important to determine a plan of care on how to assess pain and treat a specific need of the resident. During an interview on 10/4/2024, at 3:11 p.m. with Director of Nursing (DON), DON stated Care is important to ensure the staff would be aware and know how to implement the plan of care, identify problems, and concerns based on the resident's needs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P/P) titled Comprehensive Care Plans revised 1/25/2024, the P/P indicated the care planning process will include an assessment of the resident's strength and need. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. The P/P indicated the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. During a review of the facility's policy and procedure (P&P) titled, Pain Management, revised 1/25/2024, the P&P indicated, In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 49145 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person focused care plan for two of 14 sampled residents (Resident 11 and Resident 18) by failing to: 1.Follow and implement interventions for Resident 11's management of pain. 2.Develop a comprehensive care plan that will address Resident 18's pain. These failures place Resident 11 and Resident 18 at risk for delay of care and treatment. Findings: 1.During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and headaches. During a review of Resident 11's care plan initiated on 10/2/2024, the care plan focus was Resident 11 complains of constant pain with goals that included Resident 11 will minimize complaints of pain. Interventions for Resident 11 included monitor pain every four hours. During a review of Resident 11's Medication Administration Record (MAR), the MAR indicated monitoring for pain every four hours was not initiated until 10/3/2024 at 4:00 p.m. During an interview on 10/1/2024, at 10:09 a.m., with Resident 11, Resident 11 stated he had a headache since 9:00 a.m. and had not yet received his morning medications. During an interview on 10/3/2024, at 3:15 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 11's pain should be assessed every four hours because it is part of his care plan which should be followed for providing good care to Resident 11. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/4/2024, at 11:30 a.m., with Registered Nurse Supervisor (RNS) 1, RNS stated care plans identify problems and monitors if the interventions are effective for the identified problems. RNS 1 stated Resident 11 has a care plan for pain, initiated on 10/2/2024, and one of the interventions is to monitor Resident 11's pain every four hours. RNS 1 stated documentation for Resident 11's pain began on 10/3/2024 at 4:00 p.m. but should have been started at the time the care plan was initiated on 10/2/2024. During a concurrent interview and record review on 10/4/2024, at 3:05 p.m., with the Director of Nursing (DON), the DON stated Resident 11 has a care plan for pain with intervention to monitor for pain every four hours but there is no documentation that Resident 11's pain was being monitored every four hours. The DON stated the staff should be following Resident 11's care plan because the care plan identifies the needs of the resident. 2. During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included Stage 4 pressure ulcer of sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the tail bone), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), autistic disorder(developmental disability that affects how people communicate, interact, learn, and behave), and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During an observation on 9/30/2024, at 10:12 a.m. in Resident 18's room, Resident 18 was lying in his back and was moaning with facial grimacing. During a concurrent observation and interview on 10/3/2024, at 9:36 a.m. with Treatment Nurse (TN 1)in Resident 18's room, Resident was moaning and grimacing during change of wound dressing over the sacral area.TN 1 stated the resident had a stage 4 pressure injury on the sacral area. Observed Resident 18 stated No when asked by TN1 and CNA7 if in pain but Resident 18 was moaning louder, grimacing when TN 1 removed and replaced the dressing on the sacral area. Observed Certified Nursing Assistant (CNA7) turned resident to the right side and resident resisted to be turned to the right side and continuing to moan as the TN 1 continued with the dressing change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024, at 10:28 a.m. with Licensed Vocational Nurse (LVN1), LVN1 confirmed the resident had no care plan addressing his pain. LVN 1 stated the resident had a stage 4 pressure injury and could cause severe pain. LVN 1 stated Care Plan addressing pain is important to ensure monitoring and assessing of pain and checking if interventions provided to the resident was effective or not. During a concurrent interview and record review with RN Supervisor (RNS1) on 10/4/2024, at 11:06 a.m., RNS 1 stated Care Plan was initiated on 10/3/2024 after the surveyor started investigating Resident 18's pain. RNS 1 stated Care Plan for pain is important to determine a plan of care on how to assess pain and treat a specific need of the resident. During an interview on 10/4/2024, at 3:11 p.m. with Director of Nursing (DON), DON stated Care is important to ensure the staff would be aware and know how to implement the plan of care, identify problems, and concerns based on the resident's needs. During a review of facility's policy and procedure (P/P) titled Comprehensive Care Plans revised 1/25/2024, the P/P indicated the care planning process will include an assessment of the resident's strength and need. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. The P/P indicated the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. During a review of the facility's policy and procedure (P&P) titled, Pain Management, revised 1/25/2024, the P&P indicated, In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45269 49145 Based on observation, interview, and record review, the facility failed to ensure two of three residents had clean and trimmed nails (Resident 17 and 45). This failure had the potential to negatively impact the resident's quality of care and self-esteem. Findings: 1.During a review of Resident 17's Admission Record, the Admission Record indicated Resident 10 was admitted on [DATE] with diagnoses that included Psoriatic Arthritis Mutilans (rare and painful condition that severely damages the hands, feet, and sometimes the spine) and atrial fibrillation (irregular and fast heartbeat). During a review of Resident 17's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/26/2024, the MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) with personal hygiene. During a review of Resident 17's care plan initiated 9/6/2024, the care plan focus was, Resident 17 was at risk for skin integrity with goals that included Resident 17 was to maintain and develop clean and intact skin and was to minimize skin injuries such as skin tears. Interventions for Resident 17 included to avoid scratching and keep hands and body parts from excess moisture; keep fingernails short and to identify/document potential causative factors and eliminate/resolve where possible. During a review of Resident 17's care plan initiated 9/6/2024, the care plan focus was, Resident 17 had potential for bleeding, bruising, and/or skin tears secondary to aspirin therapy (a drug that reduces pain, fever, inflammation, and blood clots) with goals that included Resident 17 will have no bleeding episodes. Interventions for Resident 17 included to check skin per protocol and monitor for bruising or bleeding. During an observation on 10/1/2024, at 2:05 p.m., in Resident 17's room, Resident 17 was observed unclean and long fingernails. Resident 17 stated he is unable to cut his own nails because of his arthritis (swelling and tenderness of one of more joints). During a concurrent observation and interview on 10/1/2024, at 2:10 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 verbally confirmed Resident 17's nails were unclean and long. LVN 3 stated besides the certified nurse assistants (CNA), she is also responsible for cutting the resident's fingernails. LVN 3 stated it is important to keep the residents' nails cut and clean to prevent bacteria from building up under their nails and to prevent residents from scratching or hurting themselves. During an interview on 10/2/2024, at 10:05 a.m., with Certified Nurse Assistant (CNA) 5, CNA 5 stated the CNAs are responsible to cut and clean the residents' fingernails and it is her practice to assess their fingernails when she bathes/showers them. CNA 5 stated it is important to cut the resident's nails and keep them clean for infection control and, so they do not scratch themselves. (continued on next page)

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Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/4/2024, at 11:30 a.m., with the Registered Nurse Supervisor (RNS) 1, RNS 1 was reviewing the Shower Day Skin Inspection form, dated 10/1/2024. RNS 1 stated the form is filled out by the CNA's. RNS 1 verbally confirmed CNA 4 documented Resident 17's fingernails were clean but there was no documentation under need clipping. RNS 1 stated CNA 4 should have documented that Resident 17's nails need trimming because he could potentially scratch himself and for infection control because there could be bacteria under his nails. During a concurrent interview and record review on 10/4/2024, at 3:05 p.m., with the Director of Nursing, the DON states fingernail care for the resident's is the responsibility of the CNA's and is part of their daily tasks. The DON stated long, and dirty fingernails can lead to skin breakdown from scratching which could then lead to infection. The DON reviewed Resident 17's Shower Day Skin Infection form, dated 10/1/2024, and stated CNA 4 documented Resident 17's nails were clean but did not document under need clipping. 2. During a review of Resident 45's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] to the facility with diagnoses that included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified dementia(a progressive state of decline in mental abilities) and osteoporosis(a weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 45's History and Physical (H &P) dated 11/25/2023, the H & P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 45's MDS dated [DATE], the MDS indicated the resident required partial/ moderate assistance with personal hygiene. During a review of Resident 45's Care Plan revised 1/19/2024, the Care Plan indicated the resident had an activity of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) deficit related to disease process, fatigue, and impaired balance. The care plan's goal indicated the resident will improve current level of function in ADL through review date. The care plan's interventions included to check nail length, trim and clean on bath day as necessary and report any changes to the nurse. During a subsequent observation on 9/30/2024, at 10:12 a.m. and 1:10 p.m., observed Resident 45's fingernails were long and dirty. Observed resident eating lunch using his hands and putting a piece of porkchop in his mouth. Resident 45's fingernails remained long and dirty. During a telephone interview on 10/2/2024, at 12:15 p.m. with Certified Nursing Assistant (CNA1), CNA1 stated Resident 45's fingernails were somewhat long and dirty, but the resident refused his fingernails to be trimmed. During an interview on 10/2/2024, 1:26 p.m. with LVN 1, LVN 1 stated nobody told him Resident 45's fingernails were long and dirty. LVN 2 stated it's important to trim residents' fingernails because long and dirty fingernails had bacteria and dirt underneath the fingernails which resident could ingest and cause infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024, at 2:12 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated she could not remember any CNAs reporting Resident 45's long and dirty fingernails. LVN 2 confirmed the resident had no care plan indicating noncompliance to care or refusal of care related to fingernails trimming. During a review of the facility's policy and procedure (P&P) titled, Nail Care, revised 1/25/2025, the P&P indicated, Routine cleaning and inspection of nails will be provided during Activities of Daily Living (ADL) care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Principles of nail care: nails should be kept smooth to avoid skin injury. During a review of the facility's P&P titled, Activities of Daily Living (ADLS), revised 1/25/2024, the P&P indicated, The resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to ensure two of four sampled residents (Resident 39 and Resident 18) received the necessary treatment and services that will prevent development and promote healing of pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) by: a.Failing to monitor and assess Resident 39's skin areas where the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was applied. b. Failing to ensure Resident 18 who had Stage 4 pressure injury on the Sacro coccyx area (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the tail bone) was repositioned to offload (method of reducing or removing pressure on the area to help prevent and heal pressure injury) was implemented. These failures resulted in the development of a Stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) on Resident 39's nose and had the potential to put Resident 18 at risk for delayed healing of Stage 4 pressure injury located in the sacral (triangle shaped bone between the hip bones) and coccyx area (tailbone). Findings: a.During a review of Resident 39's Admission record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included aphasia (a disorder that makes it difficult to speak), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), unspecified dementia (progressive state of decline in mental abilities) and respiratory (relating to lungs) disorder. During a review of Resident 39's History and Physical (H & P) dated 8/10/2024, the H & P indicated the resident had a fluctuating capacity to understand and make decisions due to seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 39's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/9/2024, the MDS indicated the resident was unable express ideas and wants or unable to understand others. The MDS indicated the resident was dependent on the staff with bathing, toileting hygiene, dressing, personal hygiene, oral hygiene, and transfer to and from the bed to a chair. The MDS indicated the resident had no pressure injury. During a review of Resident 39's Quarterly Braden Scale (standardized, assessment tool used to assess and document resident's risk for developing pressure injuries. The score of 15-18 resident is at risk, 13-14 means moderate risk, 10-12 means high risk and score of 9 and below means very high risk)) dated 4/9/2024, Braden Scale indicated the resident's score is 11. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/30/2024, at 3:35 p.m. in Resident 39's room, Resident 39 was lying in bed, removed the nasal cannula and kept pinching his nostril. Observed a reddened area on the nostril of Resident 39 and an unnamed staff applied the nasal cannula that was laying on the bed of Resident 39. During a concurrent observation and interview with Treatment Nurse (TN1) on 9/30/2024, at 4:00 p.m., TN1 stated Resident 39 had redness on the nasal septum (wall of bone, cartilage, and tissue that separates the left and right sides of the nose). TN 1 stated it was a Stage 1 pressure injury on the nasal area because the skin was intact. TN 1 stated the pressure injury was caused by the nasal cannula and the resident had no prior history of pressure injury on the nose. TN 1 stated the Certified Nurse Assistant's (CNA's) supposed to report to her if there was any change in a resident's skin like redness or scratches. TN 1 stated she was not aware of Resident 39's redness on the nasal septum. During a telephone interview on 10/2/2024, at 12:15 p.m. with Certified Nursing Assistant (CNA1), CNA1 stated he was assigned to the Resident 39 last 9/30/2024 and noticed a redness on the center of the nostril and he applied an ointment because the affected skin looked irritated. CNA1 stated he filled out a skin check form and submitted it to Licensed Vocational Nurse (LVN 2). CNA 1 stated any skin changes should be reported to the licensed nurse because the skin problem could get worse. During an interview on 10/2/2024, at 1:44 p.m. with LVN 2, LVN 2 stated she could not remember if Resident 39's skin check form was submitted to her and did not receive any notification from CNA1 that Resident 39 developed redness on the nose. LVN 2 stated everyone is responsible in checking the skin of each resident and if there was any presence of skin issue, the CNA's report them to the licensed nurse and treatment nurse is notified. LVN 2 stated she did not check the skin of Resident 39's skin behind the ears and nose last 9/30/2024. LVN 2 stated she was supposed to check residents' skin every shift. During an interview on 10/2/2024, at 2:55 p.m. with TN 1, TN 1 stated the CNA's supposed to check the skin of all residents while they are doing their care and notify licensed nurses for any skin changes.TN 1 stated the staff should perform skin check every day and should have assessed residents' skin who had medical device like nasal cannula for any skin breakdown while in use because pressure injury could develop within a couple of hours on the nose. During an interview on 10/2/2024, at 3:56 p.m. with RN Supervisor (RNS1), RNS 1 stated all licensed nurses should assess the skin of residents. RNS 1 stated the licensed nurses should have checked the skin of residents with nasal cannula frequently and pressure injury related to the use of nasal cannula is preventable. RNS 1 stated if the resident's skin is not monitored and assessed for skin breakdown related to the use of nasal cannula, redness could develop to deep tissue injury (purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue due to pressure or shear) or the wound could get worse. b.During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included Stage 4 pressure ulcer of sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the tail bone), and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of MDS dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills for daily decision making (decisions are poor and supervision or cues is required), and required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. The MDS indicated the resident had one unhealed Stage 4 pressure injury. During a review of Resident 18's Braden Scale dated 9/13/2024, the Braden scale indicated a score of 15. During a review of Resident 18's Physician Order date 8/20/2024, the Physician Order indicated for Sacro coccyx: cleanse with normal saline, pat dry, apply collagen (medicine used for wound healing), pack with saline moistened hydrofera blue (sterile, absorbent, and moist foam dressing) dressing that provide and cover with foam dressing as needed for pressure ulcer if soiled or dislodged. During a review of Resident 18's Wound Progress Report dated 9/9/2024, the progress Report indicated the resident had a chronic, non-healing pressure ulceration in the Sacro coccyx area and had been present for approximately 7 months. During a review of Resident 18's Care Plan about resident's actual/ potential impairment to skin integrity related to sacrococyx (related to sacral and coccyx area) pressure ulcer/injury revised on 6/25/2024. The Care Plan 's goal indicated the resident will not develop further skin breakdown and complications. The Care Plan interventions included avoiding friction or shearing to prevent further skin impairment, offloading affected area as much as possible and reminding, reeducating resident to reduce constant sliding self-up and down to avoid friction and shear. During an observation on 9/30/2024, at 10:54 a.m., Resident 18 was lying on his back both legs are bent towards the left side of the bed. During a subsequent observation on 10/2/2024, at 8:10 a.m. and on 10/2/2024, at 4:12 p.m. in Resident 18's room, Resident 18 was lying on his back with pillows. During an interview on 10/4/2024, at 10:41 a.m. with Certified Nursing Assistant (CNA7), CNA 7 stated Resident 18 had a pressure injury in his lower back and redness on the scrotal area. CNA7 sated the resident is difficult to turn and reposition because his legs turned to the left side and threw the pillows on his back. CNA7 stated the pillows would only remain on his right side for or left side for ten minutes. CNA7 stated the pillows are placed on the left side of his legs because he liked the position. During an interview on 10/4/2024, at 11:43 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated they were using pillows since April 2024 to reposition and offload the pressure injury on the sacral and coccyx area. LVN 2 stated the resident liked to be positioned to the left and when pillows are used to position him on the right, the resident removed the pillow and always moved a lot. LVN 2 stated if the resident's pressure injury site is not offloaded properly it could get worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/2024, at 1:19 p.m. with Treatment Nurse (TN 1),TN 1 stated the condition of resident's pressure injury on his Sacro coccyx area is up and down because the resident tends to slide down on the bed, TN1 stated they tried to reposition him to reduce the pressure on the wounds by using pillows but the resident removed the pillows and unable to stay in one position because of the contractures on both of his legs. TN 1 stated she could not encourage him to follow instructions in repositioning because the resident would not understand due to poor cognitive skills (a person had trouble with thinking, learning, remembering, and making decisions).TN 1 stated when the resident repositioned himself when he is agitated causing him to slide up and down in the bed. TN 1 stated she should have contacted the physician for effective interventions that could help heal the resident's pressure injury other than what was in place to help offload the sacral area. During an interview on 10/4/2024, at 11:06 a.m. with RN Supervisor (RNS1), RNS 1 stated because of Resident 18's behavior manifested by frequent movements they could not keep him on one position or reposition him on one side. RNS 1 stated the facility is planning to use a wedge pillow to help the resident with repositioning. RNS 1 stated resident's pressure injury was not improving. During a subsequent interview on 10/4/2024, at 3:11 p.m. and at 3:05 p.m. with Director of Nursing (DON), DON stated residents with pressure injury who are not properly repositioned, and interventions implemented for offloading pressure injury were not working, the pressure injury could deteriorate and worsen. DON stated CNAs should identify any skin breakdown during care or shower and report it to the charge nurse. DON stated the CNA's can verbally report the skin concern to the charge nurse and the licensed nurse will do a skin assessment, change of condition, notify the physician, and obtain treatment order. DON stated not monitoring and assessing any skin breakdown could result to a higher degree of pressure injury. During a review of facility's policy and procedure(P/P) titled Pressure Injury Prevention and Management revised 1/25/2024, the P/P indicated the facility is committed to the prevention of avoidable pressure injury, prevent infection and the development of additional pressure injuries. The P/P indicated nursing assistants will inspect skin during bath and will report any concerns to the nurse immediately, licensed nurses will conduct a full body skin assessment at least weekly, and assessment of pressure injuries will be performed by a licensed nurse. The P/P indicated interventions will be modified for any changes in resident's degree of risk for developing a pressure injury, residents' noncompliance, and lack of progression in wound healing.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	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 three of seven sampled residents (Resident 43, 5, and 18) 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. Obtain baseline (initial measurement taken at an early point and used for comparison over time to monitor changes) ROM measurements of Resident 43's both arms and legs upon admission on 8/12/2023 using the Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in both arms and both legs) in accordance with the facility's policy titled, Joint Mobility and Screening and Assessment revised on 1/25/2024. 2. Obtain a baseline ROM measurement of Resident 43's left arm during the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation on 8/14/2023. 3. Assess Resident 43's left wrist hand orthosis ([WHO] material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures [condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness]) for fit and wear tolerance (amount of time a person can wear an orthosis before experience discomfort or any other side effects) of up to eight (8) hours upon discharge from OT services on 9/10/2023 in accordance with professional standards (guidelines that outline the practices, skills, and qualifications that professionals in a given field should follow), including assessment of the orthosis (external medical device used for supporting, immobilizing and treating joints) for fit and wear tolerance. 4. Provide Resident 43 with Restorative Nursing Assistant ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) services from 9/11/2023 to 9/20/2023 (10 days) and from 10/20/2023 to 11/30/2023 (over one month) for passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises to the left arm and the application of Resident 43's left WHO in accordance with the OT Discharge Summary recommendations on 9/10/2023. 5. Monitor ROM changes in both of Resident 43's arms and legs from 9/11/2023 to 4/1/2024 (over 6 months). 6. Apply Resident 43's left WHO on 9/30/2024. 7. Perform ROM exercises to Resident 43's left elbow on 10/1/2024. 8. Obtain baseline ROM measurements of Resident 5's arms and legs upon admission on 7/19/2023 in accordance with the facility's policy and procedure titled Joint Mobility Screening and Assessment, revised on 1/25/2024. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	9. Obtain baseline ROM measurements of Resident 5's legs during the Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation on 10/26/2023. 10. Obtain baseline ROM measurements of Resident 5's arms during the OT Evaluation on 10/27/2023. 11. Monitor ROM changes in both of Resident 5's arms and legs from 10/26/2023 to 8/19/2024 (10 months). 12. Position Resident 18's hips at midline (line through the body that divides it into halves that are mirror images of each other) while lying in bed. These failures resulted in: 1. Resident 43 developing ROM limitations in the left shoulder, elbow, and hand, including the development of a left-hand contracture. 2. Placing Resident 5 and 18 at risk to develop further ROM limitations which would affect the residents' ability to participate in activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility). Findings: a. During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD] irreversible kidney failure), dependence on renal (kidney) dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side (less often used during completion of daily living tasks). During a review of Resident 43's PT Evaluation and Plan of Treatment, dated 8/13/2023, the PT Evaluation indicated Resident 43 fell from the bed and had a right-side brain hemorrhage (bleeding), which caused weakness on the left side of Resident 43's body. The PT Evaluation indicated the ROM in both of Resident 43's legs were within functional limits ([WFL] sufficient movement without significant limitation). During a review of Resident 43's OT Evaluation and Plan of Treatment, dated 8/14/2023, the OT Evaluation indicated Resident 43's ROM in the right arm, left wrist, and left hand were WFL. The OT Evaluation indicated Resident 43's ROM in the left shoulder and elbow was impaired (unspecified). During a review of Resident 43's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/16/2023, the MDS indicated Resident 43 had functional ROM impairments in one arm and one leg. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 43's PT Discharge Summary, dated 9/10/2023, the PT Discharge Summary indicated Resident 43 was dependent (required more than 75 percent [%] physical assistance to perform the task) with bed mobility and transfers, requiring a mechanical lift (a device that helps residents who have difficulty moving on their own to be transferred or moved from one place to another) for transfers. The PT Discharge Summary recommendations indicated for Resident 43 to receive an RNA program for PROM exercises to both legs. During a review of Resident 43's OT Discharge Summary, dated 9/10/2023, the OT Discharge Summary indicated Resident 43 required moderate assistance (required between 26 to 50% physical assistance to perform the task) for hygiene, grooming, and self-feeding. The OT Discharge Summary recommendations indicated for Resident 43 to receive an RNA program for PROM exercises to the left arm and application of a left WHO. The OT Discharge Summary did not include an OT goal related to monitoring Resident 43's wear tolerance of the left WHO. During a review of Resident 43's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated 9/2023, the Documentation Survey Report indicated Resident 43 started receiving PROM on both arms and legs and application of the left WHO for up to 8 hours, five times per week, on 9/21/2023 (10 days after OT Discharge Resident 43). During a review of Resident 43's Nurses Progress Notes, dated 10/19/2023, the Nurses Progress Notes indicated Resident 43 was transferred to a general acute care hospital (GACH) to replace Resident 43's permanent catheter ([PermaCath]- flexible tube interested into a blood vessel in the neck or upper chest and threaded to the right side of the heart) for dialysis. During a review of Resident 43's Documentation Survey Report for RNA, dated 10/2023, the Documentation Survey Report indicated Resident 43 stopped receiving PROM on both arms and legs and application of the left WHO for up to 8 hours, five times per week, on 10/20/2023. During a review of Resident 43's Physician Orders, dated 10/20/2023, the Physician Orders indicated to readmit Resident 43 to the facility and resume all medications. The Physician's Orders did not include an RNA task for Resident 43 upon their admission to the facility on [DATE]. During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had functional ROM impairments in one arm and one leg (unspecified side). During a review of Resident 43's Documentation Survey Report, dated 12/2023, the Documentation Survey Report indicated Resident 43 started receiving RNA program for PROM on both arms and legs and application of the left WHO for up to 8 hours, five times per week, on 12/1/2023 (over one month from the last treatment and application of WHO). During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had functional ROM impairments in one arm and one leg (unspecified side). During a review of Resident 43's OT Evaluation and Plan of Treatment, dated 4/1/2024, the OT Evaluation indicated Resident 43 had WFL ROM in the left arm but impaired (unspecified) ROM in the left shoulder, elbow/forearm, wrist, and hand. The OT Evaluation indicated Resident 43 had a contracture in the left hand, limiting Resident 43's ability to grasp and release. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 43's OT Discharge Summary, dated 4/5/2024 and signed on 4/16/2024, the OT Discharge Summary indicated Resident 43 went to GACH. During a review of Resident 43's Change in Condition ([CIC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation, dated 4/8/2024, the CIC Evaluation indicated Resident 43 refused dialysis in the morning, vomited multiple times, and refused meals. The CIC Evaluation indicated the physician ordered Resident 43's transfer to GACH. During a review of Resident 43's Nurses Progress Notes, dated 4/11/2024, the Nurses Progress Notes indicated Resident 43 was readmitted to the facility on [DATE]. During a review of Resident 43's Joint Mobility Assessment (JMA), dated 4/12/2024, the JMA indicated Resident 43's ROM was within normal limits ([WNL] normal ROM for that joint) at all joints of the right arm and both legs. The JMA indicated Resident 43's ROM was minimally impaired (51 to 75% available range for that joint) for left wrist flexion (bending the wrist downward) and left wrist extension (bending the wrist upward), moderately impaired (26 to 50% available range for that joint) for the left elbow flexion (bending the elbow) and extension (straightening the elbow), and severely impaired (less than 25% available range for that joint) for left shoulder flexion (lifting the arm upward), left shoulder abduction (lifting the arm up and away from the body), left hand/fingers flexion (bending the fingers toward the palm), and left hand/fingers extension (straightening out the fingers). During a review of Resident 43's OT Evaluation and Plan of Treatment, dated 4/12/2024, the OT Evaluation indicated Resident 46 had WFL ROM in the right arm but impaired (unspecified) ROM in the left shoulder, elbow/forearm, wrist, and hand. The OT Evaluation indicated Resident 43 had a contracture in the left hand, limiting Resident 43's ability to grasp and release. During a review of Resident 43's PT Evaluation and Plan of Treatment, dated 4/14/2024, the PT Evaluation indicated Resident 43 had WFL ROM in both legs. During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had functional ROM impairments in one arm and one leg (unspecified side). During a review of Resident 43's OT Discharge Summary, dated 7/25/2024, the OT Discharge Summary indicated Resident 43 required maximum assistance (required 41 to 75% physical assistance to perform the task) for hygiene, grooming, and self-feeding. The OT Discharge Summary indicated Resident 43 achieved an OT goal of safely wearing a left WHO for 8 hours without any redness, swelling, discomfort and pain. The OT Discharge Summary recommendations included RNA program to provide Resident 43 with PROM to both arms and legs and to apply the left WHO. During a review of Resident 43's PT Discharge Summary, dated 7/25/2024, the PT Discharge Summary indicated Resident 43 required maximum assistance for bed mobility and dependent for transfers. The PT Discharge Summary recommendations included RNA to provide Resident 43 with PROM to both legs. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 43's Documentation Survey Report, dated 8/2024, the Documentation Survey Report indicated Resident 43 received RNA for PROM to the left arm and both legs and application of the left WHO on 8/7/2024 (14 days after PT and OT recommendations). During a review of Resident 43's care plan titled, Restorative Nursing Program, initiated 9/19/2023 and revised on 8/7/2024, the care plan interventions included for RNA to provide PROM to the left arm, PROM of both legs, and application of the left WHO for up to six hours, five times per week. During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had clear speech, understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 43 required substantial/maximal assistance (helper does more than half the effort) for eating and rolling to either side while lying in bed and dependent for hygiene, dressing, bathing, and chair/bed-to-chair transfers. The MDS indicated Resident 43 had functional ROM impairments in one arm and one leg (unspecified side). During a concurrent observation and interview on 9/30/2024 at 11:04 a.m. in Resident 43's bedroom, Resident 43 was observed lying awake in bed and unable to move the left arm. Resident 43 stated she required physical assistance from someone to move her left arm. During an interview on 9/30/2024 at 11:23 a.m. with the Director of Rehabilitation (DOR), the DOR stated the therapists (PT and OT) complete a JMA on each resident upon admission and annually. The DOR stated the purpose of the RNA program was to maintain the residents' function to prevent decline in mobility. The DOR stated the RNA program included providing mobility, including walking and transfers, ROM exercises, and application of orthoses (also known as splints; material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion). The DOR stated the purpose of ROM exercises (in general) included to maintain a resident's joint flexibility to prevent stiffness. The DOR stated the purpose of orthoses (in general) included to maintain ROM and prevent the development of contractures, which can cause pain and lead to skin breakdown (tissue damage caused by friction [surfaces rubbing against each other], shear [strain produced by pressure], moisture, or pressure). During a concurrent observation and interview on 9/30/2024 at 12:05 p.m. in Resident 43's bedroom, Resident 43 was observed lying awake in bed and stated she fell from the bed at home, which caused bleeding in the brain. Resident 43 was observed moving the right arm normally at each joint but was unable to move the left arm. Resident 43 stated the nurse (unknown) did exercises (unspecified) on 9/30/2024 morning. Resident 43's left elbow was bent at 90 degrees with the left hand resting on Resident 43's abdomen. Resident 43's left hand was positioned in a closed fist and did not have an orthosis (WHO) applied. Resident 43 stated she received exercises once per week. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 10/1/2024 at 10:27 a.m. in Resident 43's bedroom, Resident 43 was observed sleepy but agreeable to receive RNA services. RNA 1 was observed standing on the right side of Resident 43's bed while RNA 2 was standing on the left side of Resident 43's bed. RNA 1 performed exercises on Resident 43's right leg, including hip flexion (bending the leg at the hip joint toward the body) with the knee extended (straight), hip flexion with knee flexion (bending), hip abduction (moving the leg away from the body), hip rotation (circular motion) in clockwise (in the direction in which the hands of a clock turn) and counterclockwise (opposite direction in which the hands of a clock turn) directions, ankle rotation in clockwise and counterclockwise directions, and rotation of each toe of the right foot. RNA 1 left the room to assist another staff member. RNA 2 performed exercises on Resident 43's left leg, including hip flexion with the knee extended, hip flexion with knee flexion, hip rotation in clockwise and counterclockwise directions, ankle rotation in clockwise and counterclockwise directions, and ankle dorsiflexion (bending the ankle toward the body). Resident 43's left elbow was observed being bent to 90 degrees and the left hand was observed positioned in a closed fist. RNA 2 was observed performing PROM to Resident 43's left arm, including shoulder abduction (lifting the arm up and away from the body), shoulder rotation in clockwise and counterclockwise directions, wrist rotation in clockwise and counterclockwise directions, thumb rotation, and attempted to extend Resident 43's left-hand fingers. RNA 2 was observed being unable to fully extend Resident 43's fingers, which remained in a bent position. RNA 2 did not perform any PROM to Resident 43's left elbow. RNA 2 attempted to apply Resident 43's left WHO. The portion of the left WHO for Resident 43's fingers was bent completely downward to accommodate Resident 43's fingers. RNA 2 had difficulty extending Resident 43's fingers to apply the left WHO and stated he needed another person's assistance. The Physical Therapy Assistant (PTA 1) came into the room and assisted with extending Resident 43's left-hand fingers while RNA 2 applied the left WHO. Resident 43 complained of pain while RNA 2 and PTA 1 applied the left WHO. Resident 43 stated the WHO has not been applied to her left hand in two months. During an interview on 10/1/2024 at 10:59 a.m., RNA 1 and RNA 2, RNA 1 stated Resident 43 received PROM exercises to the left arm and both legs. RNA 2 stated he could not extend Resident 43's left-hand fingers and required two people to apply the left WHO. RNA 2 stated he forgot to perform the left elbow PROM exercises on 10/1/2024 at 10:27 a.m. During an observation on 10/1/2024 at 11:09 a.m. in Resident 43's bedroom, RNA 2 performed PROM exercises to Resident 43's left elbow into flexion and extension. RNA 2 was unable to fully extend Resident 43's left elbow, which continued to have a bent position. During a concurrent interview and record review on 10/2/2024 at 1:50 p.m. with the DOR, Resident 43's OT Discharge Summary, dated 9/10/2023, was reviewed. The DOR stated the professional standard for therapists prior to providing a resident with an orthosis (in general) included the therapist determining the orthosis' fit, monitoring the skin, and determining the wear time. The DOR stated a resident (in general) could develop skin breakdown if a therapist (PT or OT) did not monitor and determine the orthosis wear time. The DOR stated Resident 43 was provided a left WHO without establishing an OT goal to determine Resident 43's wear tolerance. During an interview on 10/2/2024 at 4:03 p.m. the Regional Director of Rehabilitation (RDR) stated the therapists (PT and OT) should perform JMA on each resident upon admission, change of condition, and annually. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 10/2/2024 at 4:40 p.m. with the DOR, Resident 43's clinical record (medical records -collection of documents that contain a resident's medical history and care) was reviewed for the JMA. The DOR was unable to locate Resident 43's JMA upon admission to the facility on [DATE]. During a concurrent interview and record review on 10/3/2024 at 12:19 p.m., with the Director of Medical Records (DMR), the DMR reviewed Resident 43's RNA tasks, dated 8/2024. The DMR stated Resident 43 did not receive RNA for PROM on the left arm and both legs and application of the left WHO until 8/7/2024 when the care plan, titled Restorative Nursing Program, was revised on 8/7/2024. During a concurrent observation and interview on 10/3/2024 at 2:00 p.m. with RNA 2 and Resident 43, in Resident 43's room, Resident 43 was observed lying in bed while RNA 2 removed the left WHO. RNA 2 stated the WHO was applied to Resident 43's left hand at 9:20 a.m. and tolerated wearing the left WHO for more than four hours. Resident 43 stated the facility did not provide exercises and apply the left WHO that often (unspecified amount of time) prior to this week. During a concurrent interview and record review on 10/3/2024 at 4:20 p.m. with the DOR and the MDS Coordinator (MDSC), Resident 43's clinical record was reviewed, including Resident 43 MDS, PT Evaluation dated 8/13/2023, and OT Evaluation dated 8/14/2023. The DOR and MDSC were unable to locate Resident 43's JMA upon admission to the facility on [DATE] in the electronic and physical clinical records. The DOR and MDSC reviewed Resident 43's PT Evaluation, dated 8/13/2023, which indicated Resident 43 had WFL ROM in both legs. The DOR and MDSC reviewed Resident 43's OT Evaluation, dated 8/14/2023, which indicated Resident 43 had WFL ROM in the right arm, left wrist, and left hand and impaired ROM in the left shoulder and elbow. The MDSC stated the OT Evaluation did not indicate any measurement of Resident 43's ROM impairments in the left shoulder and elbow. The MDSC reviewed Resident 43's MDS, dated [DATE], which indicated Resident 43 had ROM impairments in one arm and one leg. The MDSC stated the MDS did not indicate which arm and leg were impaired, did not indicate which joints in the arm and leg were impaired, and did not indicate ROM measurements of the impairments. The DOR stated the facility did not have a baseline ROM assessment for Resident 43's left arm impairments. During the same concurrent interview and record review on 10/3/2024 at 4:20 p.m. with the DOR and the MDSC, Resident 43's OT Treatment Notes from 8/14/2023 to 9/10/2023, OT Discharge Summary, dated 9/10/2023, PT Discharge Summary, dated 9/10/2023, and RNA tasks for 9/2023 were reviewed. The DOR and MDSC reviewed Resident 43's OT Discharge Summary, dated 9/10/2023, which indicated recommendations for the RNA to perform PROM exercises to both arms and to apply the left WHO. The DOR stated Resident 43's PT Discharge recommendation included for the RNA to perform PROM exercises to both legs. The MDSC reviewed Resident 43's RNA tasks and stated the DOR inputted the RNA tasks to provide PROM to both arms and legs and to apply the left WHO for up to 8 hours in Resident 43's clinical record on 9/20/2023 (10 days after discharge). The DOR reviewed all OT treatment notes and stated the OT documentation did not include any assessment of Resident 43's left WHO for fit and 8-hour wear tolerance prior to discharge on 9/10/2023. The MDSC stated Resident 43 did not receive RNA program from 9/11/2023 to 9/20/2023. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview on 10/3/2024 at 4:20 p.m. with the DOR and the MDSC, Resident 43's RNA tasks note from 10/2023 to 12/2023 were reviewed. The MDSC stated Resident 43's RNA tasks were cancelled on 10/19/2023 due to Resident 43's hospitalization on [DATE] for a PermaCath replacement. The MDSC stated Resident 43 returned to the facility on [DATE]. The MDSC stated Resident 43's RNA tasks for PROM exercises to both arms and legs and application of the left WHO were not inputted into Resident 43's electronic clinical records until 11/30/2023 (more than one month after readmission to the facility). The MDSC stated Resident 43 did not receive RNA for PROM to both arms and legs and the application of the left WHO from 10/20/2023 to 11/30/2023. During a concurrent interview and record review on 10/3/2024 at 4:20 p.m. with the DOR and the MDSC, Resident 43's Nurses Progress Notes and JMA, dated 4/12/2024, were reviewed. The MDSC reviewed the Nurses Progress Notes, dated 4/8/2024, which indicated Resident 43 was transferred to the hospital for vomiting related to missing dialysis. The MDSC stated the facility readmitted Resident 43 on 4/12/2024. The MDSC and DOR reviewed the JMA, dated 4/12/2024, which indicated Resident 43's had minimal ROM limitations in the left wrist, moderate ROM limitations in the left elbow, and severe ROM limitations in the left shoulder and hand. The DOR stated Resident 43's hand experienced a three step (WFL, minimal, moderate, severe) ROM decline from WFL on 8/14/2023 to severe ROM impairment on 4/12/2024. During the same concurrent interview with the DOR and the MDSC on 10/3/2024 at 4:20 p.m., Resident 43's quarterly MDS assessments since 8/16/2023 (admission) and RNA meetings notes were reviewed. The DOR stated the facility relied on RNA report and the MDS to monitor Resident 43's ROM since it was the facility's policy to perform the JMA upon admission and annually. The MDSC and DOR were unable to locate any RNA meetings notes for any resident with RNA services, including Resident 43, from 9/2023 to 4/2024. The MDSC stated Resident 43's MDS assessments were performed quarterly but the MDS did not indicate which arm and leg had ROM impairments, the joint location of the ROM impairment, and the severity of the ROM impairment. The MDSC stated Resident 43's quarterly MDS assessments did not reflect any changes in ROM. During an interview on 10/3/2024 at 6:08 p.m. with the Director of Nursing (DON), DOR, and MDSC, the DON stated the facility's process for monitoring each resident's ROM included RNA meetings and the MDS assessments. The DON stated there was a potential for a resident (in general) to experience a decline in ROM without the application of an orthosis and provision of ROM exercises. The DON stated the measuring and monitoring ROM was not in the RNA's scope of practice. The DON stated quarterly assessments completed for each resident included smoking, risk for developing skin breakdown, and falls. The DON stated the facility did not perform any quarterly assessments to monitor residents (in general) for ROM. The DOR stated Resident 43's medical condition caused Resident 43 to develop hypertonicity (increased muscle stiffness or tightness) in the left arm. The DOR stated Resident 43's hypertonicity in the left arm should be monitored since the hypertonicity increased Resident 43's risk for ROM decline. The DOR was unable to provide any documentation Resident 43's left arm ROM was monitored due to hypertonicity from 9/2023 to 4/2024. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 10/4/2024 at 7:54 a.m. with the DOR, the DOR reviewed Resident 43's OT Evaluation, dated 8/13/2023, Treatment Notes from 8/13/2023 to 9/10/2023, and OT Discharge Summary, dated 9/10/2023. The DOR stated Resident 43's baseline ROM of the left hand was WFL. The DOR stated the typical position of the WHO included the fingers positioned in extension. The DOR reviewed Resident 43's OT Treatment Notes and Discharge Summary and stated the OT documentation did not indicate Resident 43's left WHO was adjusted from the typical position upon discharge on 9/10/2023. During a review of a textbook titled, Occupational Therapy for Physical Dysfunction, (Fifth edition, 2002, page 316), the textbook indicated the OT's Role is to evaluate the need for a splint clinically and functionally; to select the most appropriate splint; to provide or fabricate (make) the splint; to assess the fit of the splint; to teach the patient and caregivers the purpose, care, and use of the splint. The Occupational Therapy for Physical Dysfunction textbook, page 316, indicated the OT must consider, carefully monitor, and teach the patient and caregiver to report any of these problems related to orthotic use, including impaired skin integrity (skin health), pain, and swelling. b. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 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) and 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 right side and facial weakness following a cerebral infarction. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 expressed ideas and wants, clearly understood verbal content, and had intact cognition. The MDS indicated Resident 5 had functional ROM limitations in one arm and one leg. During a review of Resident 5's care plan titled, Restorative Nursing Program, initiated on 10/5/2023, the care plan interventions included for the RNA to perform PROM to both resident's arms and legs and apply a right-hand palm guard (material used as a barrier between fingers and palmar skin to prevent injury to the palm from severe finger flexion contracture). During a review of Resident 5's PT Evaluation, dated 10/26/2023, the PT Evaluation indicated Resident 5's ROM in both hips and knees were within functional limits ([WFL] sufficient movement without significant limitation). The PT Evaluation indicated Resident 5's ROM in both ankles were impaired (unspecified). During a review of Resident 5's PT Discharge Summary, dated 10/26/2023, the PT Discharge Summary recommendations indicated for the RNA to provide PROM to both legs. During a review of Resident 5's OT Evaluation, dated 10/27/2023, the OT Evaluation indicated Resident 5's ROM in the left arm and right elbow were WFL. The OT Evaluation indicated Resident 5's ROM in the right shoulder, right wrist, and right hand were impaired (unspecified). The OT Evaluation indicated Resident 5 had a contracture in the right hand, limiting Resident 5's ability to grasp and release. During a review of Resident 5's OT Discharge Summary, dated 10/27/2023, the OT Discharge Summary indicated recommendations for the RNA to provide PROM to both arms and apply a right-hand palm guard. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 5's MDS, dated [DATE], 1/24/2024, 4/19/2024, and 7/23/2024, the MDS indicated Resident 5 expressed ideas and wants, clearly understood verbal content, and had intact cognition. Each MDS indicated Resident 5 had ROM limitations in one arm and one leg (unspecified side). During a review of Resident 5's JMA, dated 7/23/2024, the JMA indicated Resident 5's ROM was WNL in the left shoulder, both elbows, left wrist, left hand, both hips, and both knees. The JMA indicated Resident 5's ROM was severely impaired (less than 25 percent [%] available range for that joint) in the right shoulder, right wrist, right hand, and both ankles. During an interview on 9/30/2024 at 11:23 a.m. with the Director of Rehabilitation (DOR), the DOR stated the therapists (PT and OT) complete a JMA on each resident upon admission and annually. During an observation on 9/30/2024 at 12:43 p.m. in the dining room, Resident 5 was observed sitting in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) eating lunch while watching a movie. Resident 5 moved the left arm actively at all joints to scoop food from the plate and hold a cup to drink liquids. Resident 5's moved the right arm at the elbow and shoulder joints, but Resident 5's right hand was observed positioned in a closed fist without a palm guard. During a concurrent observation and interview on 9/30/2024 at 2:00 p.m. with Resident 5, in the facility lobby, Resident 5 was observed awake, alert, and sitting upright in a Geri chair. Resident 5 used gestures and the left hand to write responses to questions. Resident 5 wrote and gestured that the RNAs does not apply the palm guard to the right hand every day. During an observation on 10/1/2024 at 9:15 a.m., in Resident 5's bedroom, Resident 5 was observed awake and lying flat in bed. Resident 5 was already wearing a right-hand palm guard, which was lined with sheepskin, and both ankles were positioned in plantar flexion (ankle bent with toes pointing away from the body). RNA 1 was observed standing on the right side of Resident 5's bed and RNA 2 was standing on the left side. RNA 1 was observed performing PROM on Resident 5's right leg into hip flexion (bending the leg at the hip joint toward the body) and hip abduction (moving the leg away from the body). RNA 1 attempted to perform right knee flexion (bending the knee) but Re [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 18) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility (ability to move) had two staff members present while using a mechanical lift (a device that helps people who have difficulty moving on their own to be transferred or moved from one place to another) during a transfer from the bed to the shower bed. This failure placed Resident 18 at increased risk for accidents, including a fall from the mechanical lift which could have resulted in physical injury. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including parkinsonism (group of conditions with symptoms including slow movements, stiffness, tremors, and balance issues), autistic disorder (neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), and contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) of both knees. During a review of Resident 18's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 9/12/2024, the MDS indicated Resident 18 had limited ability to make requests, responded to simple and direct communication only, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 18 required substantial/maximal assistance (helper does more than half the effort) for eating and upper body dressing and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for lower body dressing, bathing, and chair/bed-to-chair transfers. During a review of Resident 18's care plan titled Self-care performance deficit, initiated 8/7/2021, the care plan interventions indicated Resident 18 was totally dependent on two staff for transfers and required a mechanical lift with two staff for transfers. During an observation on 9/30/2024 at 10:23 a.m. in Resident 18's bedroom, observed Resident 18 lying awake in bed with the head-of-bed (HOB) fully elevated into an upright position. Resident 18's left hip was positioned in external rotation (hip rotated away from the body), the right hip was positioned in internal rotation (hip rotated toward the body), and both of Resident 18's knees were bent and pointed to the left side of the room. During a concurrent observation and interview on 10/2/2024 at 8:38 a.m. in the bedroom, with Certified Nursing Assistant 10 (CNA 10), observed CNA 10 alone and standing on the left side of Resident 18's bed while operating the mechanical lift. Resident 18 was suspended over the bed in a sling (fabric that wraps around a person's body to help a caregiver transfer them to another location using mechanical lift). CNA 10 stated she was transferring Resident 18 by herself from the bed to the shower bed. (continued on next page)

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	056446	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/2/2024 at 8:38 a.m., with the Director of Nursing (DON), the DON stated residents transferred in mechanical lifts should always have two-person assistance for resident's safety due to a risk of fall and injury. Observed the DON went into Resident 18's room and instructed CNA 10 to stop the transfer and wait for assistance. During an interview on 10/2/2024 at 2:43 p.m., with CNA 10, CNA 10 stated she used the mechanical lift to transfer Resident 18 from the bed to the shower bed alone because the other staff members (unknown) were busy and because it was easy to transfer Resident 18 using the mechanical lift. CNA 10 stated when using the mechanical lift, it should be a two person assist for resident's safety and to reduce injury. During a review of the facility's policy and procedure (P&P) titled, Safe Resident Handling/Transfers, revised 1/25/2024, the P&P indicated the facility ensured resident were handled and transferred safety to prevent or minimize risk for injury and to provide a safe environment for residents while keeping employees safe. The P&P indicated two staff members must be utilized when transferring residents with a mechanical lift.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, Licensed Vocational Nurse (LVN) 4 failed to keep one of one sampled resident (Resident 38) head of the bed elevated at a minimum 30 degrees at all times during the administration of feedings or medications to prevent aspiration (accidental inhalation of food, liquid, or other material into the lungs) and pneumonia (lung infection) per facility's policy and procedure (P&P). This failure had the potential to place Resident 38 at risk for aspiration and pneumonia. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including gastrostomy ([g-tube] tube inserted in the stomach to assist with feeding), hypertensive heart disease ((heart problems that occur because of high blood pressure), depression (a low mood or loss of pleasure or interest in activities for long periods of time), diabetes mellitus type 2 (the body has trouble controlling blood sugar), and dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 38's Minimum Data Set ([MDS] federally mandated resident assessment tool) dated [DATE] indicated Resident 28 had impaired cognitive (ability to think, understand, learn, and remember) skills. During a review of Resident 38's History and Physical (H&P) dated [DATE] indicated Resident 28 alert and orientated to self and unable to make decisions for self. During an observation on [DATE] at 12:15 p.m. in Resident 38's room, observed LVN 4 checking Resident 38's g-tube for placement and residual (the amount of fluid or contents remaining in the stomach after enteral [tube feeding] nutrition feeding) while Resident 38 lying on her right side at a 20-degree angle then began to administer Resident 38's medications. LVN 4 stopped the medication administration and proceeded to reposition Resident 38 at a 75-degree angle with Resident 38 lying on her back. LVN 4 did not re-check g-tube for placement or residual prior to administering medications. During a review of Resident 38's Resident 38's Physician Order Summary dated [DATE], the Physician Order Summary indicated the following orders: enteral feeding every shift, check residual volume. Hold if residual exceeds 100 milliliters (ml unit of measurement). Re check residual in one hour. Notify the physician if residual volume is more than 100 ml on the second check. Enteral feed orders every shift check for tube feeding placement. During an interview on [DATE] at 3:00 p.m. with LVN, LVN 4 stated, when giving medications through the g-tube residents need to be lying on their back at a 45-degree angle to prevent aspiration pneumonia. LVN 4 stated Resident 38 was lying on her right side at a 20-degree angle and that he was trying to save time. LVN 4 stated, Resident 38 could have aspirated and died . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:50 a.m. with Director of Staff Development (DSD), DSD stated residents being administered medications through a g-tube need to be at a 45-degree angle lying on their back to prevent aspiration pneumonia. During an interview on [DATE] at 10:09 a.m. with the Director of Nursing (DON), the DON stated residents should not be lying on their right side at a 20-degree angle when administering medication via g-tube. The DON stated residents should be at a 45-degree angle in supine (on their back) position when administering medications through a g-tube. The DON stated resident could possibly aspirate, be hospitalized , or possibly die if not positioned properly. During a review of the facility's policy and procedure (P&P) titled, Verifying Placement of Feeding Tube dated [DATE], the P&P indicated, Resident's head of bed (HOB) should be kept elevated at a minimum 30 degrees at all times during the administration of feedings or medications to prevent aspiration and pneumonia. unless otherwise specified in medical orders or contraindication for other reasons. During a review of the facility's P&P titled Medication Administration Via Enteral Tube dated [DATE], indicated, to elevate the bed to a comfortable working height and place the patient in fowler's (a semi-sitting position where a patient's head and upper body are raised at an angle of ,d+[DATE] degree) position. 49889 Based on observation, interview, and record review, Licensed Vocational Nurse (LVN) 4 failed to keep one of one sampled resident (Resident 38) head of the bed elevated at a minimum 30 degrees at all times during the administration of feedings or medications to prevent aspiration (accidental inhalation of food, liquid, or other material into the lungs) and pneumonia (lung infection) per facility's policy and procedure (P&P). This failure had the potential to place Resident 38 at risk for aspiration and pneumonia. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including gastrostomy ([g-tube] tube inserted in the stomach to assist with feeding), hypertensive heart disease ((heart problems that occur because of high blood pressure), depression (a low mood or loss of pleasure or interest in activities for long periods of time), diabetes mellitus type 2 (the body has trouble controlling blood sugar), and dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 38's Minimum Data Set ([MDS] federally mandated resident assessment tool) dated [DATE] indicated Resident 28 had impaired cognitive (ability to think, understand, learn, and remember) skills. During a review of Resident 38's History and Physical (H&P) dated [DATE] indicated Resident 28 alert and orientated to self and unable to make decisions for self. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 12:15 p.m. in Resident 38's room, observed LVN 4 checking Resident 38's g-tube for placement and residual (the amount of fluid or contents remaining in the stomach after enteral [tube feeding] nutrition feeding) while Resident 38 lying on her right side at a 20-degree angle then began to administer Resident 38's medications. LVN 4 stopped the medication administration and proceeded to reposition Resident 38 at a 75-degree angle with Resident 38 lying on her back. LVN 4 did not re-check g-tube for placement or residual prior to administering medications. During a review of Resident 38's Resident 38's Physician Order Summary dated [DATE], the Physician Order Summary indicated the following orders: enteral feeding every shift, check residual volume. Hold if residual exceeds 100 milliliters (ml unit of measurement). Re check residual in one hour. Notify the physician if residual volume is more than 100 ml on the second check. Enteral feed orders every shift check for tube feeding placement. During an interview on [DATE] at 3:00 p.m. with LVN, LVN 4 stated, when giving medications through the g-tube residents need to be lying on their back at a 45-degree angle to prevent aspiration pneumonia. LVN 4 stated Resident 38 was lying on her right side at a 20-degree angle and that he was trying to save time. LVN 4 stated, Resident 38 could have aspirated and died . During an interview on [DATE] at 8:50 a.m. with Director of Staff Development (DSD), DSD stated residents being administered medications through a g-tube need to be at a 45-degree angle lying on their back to prevent aspiration pneumonia. During an interview on [DATE] at 10:09 a.m. with the Director of Nursing (DON), the DON stated residents should not be lying on their right side at a 20-degree angle when administering medication via g-tube. The DON stated residents should be at a 45-degree angle in supine (on their back) position when administering medications through a g-tube. The DON stated resident could possibly aspirate, be hospitalized , or possibly die if not positioned properly. During a review of the facility's policy and procedure (P&P) titled, Verifying Placement of Feeding Tube dated [DATE], the P&P indicated, Resident's head of bed (HOB) should be kept elevated at a minimum 30 degrees at all times during the administration of feedings or medications to prevent aspiration and pneumonia. unless otherwise specified in medical orders or contraindication for other reasons. During a review of the facility's P&P titled Medication Administration Via Enteral Tube dated [DATE], indicated, to elevate the bed to a comfortable working height and place the patient in fowler's (a semi-sitting position where a patient's head and upper body are raised at an angle of ,d+[DATE] degree) position.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 49145 Based on observation, interview and record review, the facility failed to ensure two of 14 sampled residents received effective pain management by: 1.Failing to assess and treat one of three resident's experiencing pain (Resident 11). 2.Failing to ensure Resident 18's pain level assessment is based on the cognitive level (mental process involved in knowing, learning, and understanding things) of the resident. These failures had the potential to put Resident 11 and Resident 18 at risk for pain to go unrecognized and untreated leading to delay of care and treatment. Findings: 1.During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and headaches. During a review of Resident 11's care plan initiated on 2/16/2024, the care plan focus was, Resident 11 had hypertension with goals that included Resident 11 was to remain free from signs and symptoms (s/s) of hypertension. Interventions for Resident 11 included monitoring, documenting, and reporting any s/s of hypertension: headache, visual problems, and confusion. During a review of Resident 11's care plan initiated on 10/2/2024, the care plan focus was Resident 11 complains of constant pain with goals that included Resident 11 will minimize complaints of pain. Interventions for Resident 11 included monitor pain every four hours. During a review of Resident 11's Medication Administration Record (MAR), the MAR indicated monitoring for pain every four hours was not initiated until 10/3/2024 at 4:00 p.m. During an interview on 10/1/2024, at 10:09 a.m., with Resident 11, Resident 11 stated he had a headache since 9:00 a.m. and had not yet received his morning medications and his nurse had not yet been in to see him. During a review of Resident 11's MAR, Resident 11 had Fioricet (medication for tension headaches) scheduled for 8:00 a.m. but was not documented that it was given. During an interview on 10/1/2024 at 11:30 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated he did not pass medications for Resident 11 because Resident 11 can be difficult sometimes and he usually asks the nurse in station 1 to pass Resident 11's medications but was not thinking and forgot to ask the other nurse. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024 at 3:37 p.m., with Registered Nurse Supervisor (RNS) 1, RNS stated it is important to assess for pain, so the resident does not suffer. RNS 1 stated for Resident 11, it's important to assess and treat his headache because he has a history of hypertension, and it could possibly lead to a stroke. During an interview on 10/4/2024 at 3:05 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses are responsible for rounding on the residents every two hours and assessing them for pain. The DON stated Resident 11 should have been assessed and treated for pain because he has hypertension and was complaining of a headache which could possibly lead to complications such as a stroke. 2. During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included Stage 4 pressure ulcer of sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone on the tail bone), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), autistic disorder(developmental disability that affects how people communicate, interact, learn, and behave), and contracture of right and left knee (stiffening /shortening at ant joint that reduces the joint's range of motion of right and left knees). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During a review of Resident 18's Physician Order dated 9/18/2024, the Physician Order indicated Acetaminophen (Tylenol, medicine used to relieve pain) 325 milligrams (mgs, unit of measurement) 2 tablets by mouth every 4 hours as needed for pain not to exceed three grams (GM, unit of measurement) in 24 hours. During a review of Resident 18's Medication Administration Record (MAR) for October 2024, the MAR indicated on 10/3/2024, at 7:15 a.m. Resident 18 received acetaminophen 325 mgs. 2 tablets for a pain level of 5. (numerical pain rating scale, pain screening tool used to assess pain severity using a 0-10 scale with zero meaning no pain, 1 to 3 is mild pain,4 to 6 is moderate and 7-10 is severe pain). During a review of Resident 18's Quarterly Pain Interview dated 9/12/2024, the Quarterly Pain Interview indicated the resident was unable to answer when asked if the resident had pain or hurting at any time in the last five days. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/3/2024, at 9:36 a.m. with Treatment Nurse (TN 1) in Resident 18's room, Resident was moaning and grimacing during change of wound dressing over the sacral area.TN 1 stated the resident had a stage 4 pressure injury on the sacral area. Observed Resident 18 stated No when asked by TN1 and CNA7 if in pain but Resident 18 was moaning louder, grimacing when TN 1 removed and replaced the dressing on the sacral area. Observed Certified Nursing Assistant (CNA7) turned resident to the right side and resident resisted to be turned to the right side and continued to moan as the TN 1 resumed with the dressing change. TN 1 stated Resident 18 received Acetaminophen 325 mgs. at 7:15 a. m. today for pain. During a subsequent observation and interview on 10/3/2024, at 10:28 a.m. at 1:39 p.m. with, LVN 1 stated the Resident 18 pain level was 5/10 when he administered the at 7:15 a.m., was verbally responsive and could give him the intensity of pain level. LVN 1 asked Resident 18 if he was in pain by using numerical pain rating scale and explained to the resident how to use the numerical pain rating scale. LVN 1 stated to the resident if his pain level was 4, Resident 18 responded Yeah and when LVN 1 asked the resident if his pain level was 5 out of 10 and explained again how to use the numerical pain rating scale to the resident, the resident responded Yeah. LVN 1 stated the resident could only answer yes or no but could not carry a conversation. LVN 1 agreed using numerical pain rating scale was not an accurate way of assessing pain level of the resident due to impaired cognitive skills (a person had difficulty with thinking, learning, remembering, and using judgement).LVN 1 stated he should have monitored nonverbal signs of pain like facial grimacing or moaning when assessing pain level of Resident 18 to determine if he was really in pain or not. During an interview on 10/4/2024, at 11:06 a.m. with RN Supervisor (RNS 1), RNS 1 stated Resident 18 pain level should be assessed using nonverbal signs because he could not talk. RNS 1 stated nonverbal signs of pain are moaning, body movement become tense, stiff, and gripping on the caregiver. RNS 1 stated using numerical pain rating is not a reliable indicator of pain and they would not be able to manage Resident 18's pain adequately because pain was not assessed properly. During an interview on 10/4/29024, at 3:11 p.m. with Director of Nursing (DON), DON stated the staff should use nonverbal signs of pain because Resident 18 had a cognitive impairment and could only answer to questions yes or no. DON stated the facility would not be able to provide effective pain management if the pain assessment was inaccurate. During a review of facility's policy and procedure (P/P) titled Pain management revised 1/25/2024, the P/P indicated the facility staff will observe for nonverbal indicators which may indicate the presence of pain and will use a pain assessment tool which is appropriate for the resident's cognitive status to assist the staff in consistent assessment of resident's pain. In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 49145 Based on observation, interview, and record review, the facility failed to: a.Ensure five of five Restorative Nursing Assistants ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) had an annual competency evaluation (systematic process that evaluated an individual's skill and knowledge) for providing range of motion ([ROM] full movement potential of a joint [where two bones meet]) exercises, application of orthotics (also known as splints, material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), and ambulation (the act of walking) to 13 residents receiving RNA services, including one of seven sampled residents (Resident 43) with limited ROM and mobility (ability to move). This failure had the potential for 13 residents receiving RNA services, including Resident 43, to experience a decline in ROM and mobility. b. Ensure Registered Nurse Supervisor (RNS) 1 and Licensed Vocational Nurse (LVN) 4 were competent when taking Resident 27's blood pressure prior to administering Nitroglycerin (medication used to treat chest pain). This failure had the potential for Resident 27 to have a false blood pressure reading and can lead to adverse reaction with Nitroglycerin medications including hypotension (low blood pressure) unresponsiveness (not reacting or moving at all), or cardiac arrest (when the heart stops beating suddenly). Findings: a.During an interview on 9/30/2024 at 11:23 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of the RNA program was to maintain the residents' function to prevent decline in mobility. The DOR stated the RNA program included providing mobility, including walking and transfers, ROM exercises, and application of orthoses. The DOR stated the purpose of ROM exercises (in general) included to maintain a resident's joint flexibility to prevent stiffness. The DOR stated the purpose orthoses (in general) included to maintain ROM and prevent the development of contractures [condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), which can cause pain and lead to skin breakdown (tissue damage caused by friction [surfaces rubbing against each other], shear [strain produced by pressure], moisture, or pressure). During a review of the facility's Care Plan Item/Task Listing Report (list of residents with a care plan and tasks for a specific intervention) for the RNA Program, dated 9/30/2024, 13 residents, including Resident 43, were receiving RNA program. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD] irreversible kidney failure), dependence on renal (kidney) dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side (less often used during completion of daily living tasks). During a review of Resident 43's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated 10/2024, the Documentation Survey Report indicated Resident 43 received RNA program for passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) on the left arm and both legs, five times per week, and for application of a left wrist hand orthosis ([WHO] material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures [condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness]), five times per week. During a concurrent observation and interview on 10/1/2024 at 10:27 a.m. in Resident 43's bedroom, Resident 43 was observed sleepy but agreeable to receive RNA services. RNA 1 was observed standing on the right side of Resident 43's bed while RNA 2 was standing on the left side of Resident 43's bed. RNA 1 performed exercises on Resident 43's right leg, including hip flexion (bending the leg at the hip joint toward the body) with the knee extended (straight), hip flexion with knee flexion (bending), hip abduction (moving the leg away from the body), hip rotation (circular motion) in clockwise (in the direction in which the hands of a clock turn) and counterclockwise (opposite direction in which the hands of a clock turn) directions, ankle rotation in clockwise and counterclockwise directions, and rotation of each toe of the right foot. RNA 1 left the room to assist another staff member. RNA 2 performed exercises on Resident 43's left leg, including hip flexion with the knee extended, hip flexion with knee flexion, hip rotation in clockwise and counterclockwise directions, ankle rotation in clockwise and counterclockwise directions, and ankle dorsiflexion (bending the ankle toward the body). Resident 43's left elbow was observed being bent to 90 degrees and the left hand was observed positioned in a closed fist. RNA 2 was observed performing PROM to Resident 43's left arm, including shoulder abduction (lifting the arm up and away from the body), shoulder rotation in clockwise and counterclockwise directions, wrist rotation in clockwise and counterclockwise directions, thumb rotation, and attempted to extend Resident 43's left-hand fingers. RNA 2 was observed being unable to fully extend Resident 43's fingers, which remained in a bent position. RNA 2 did not perform any PROM to Resident 43's left elbow. RNA 2 attempted to apply Resident 43's left WHO. The portion of the left WHO for Resident 43's fingers was bent completely downward to accommodate Resident 43's fingers. RNA 2 had difficulty extending Resident 43's fingers to apply the left WHO and stated he needed another person's assistance. The Physical Therapy Assistant (PTA 1) came into the room and assisted with extending Resident 43's left-hand fingers while RNA 2 applied the left WHO. During an interview on 10/1/2024 at 10:59 a.m., RNA 1 and RNA 2, RNA 1 stated Resident 43 received PROM exercises to the left arm and both legs. RNA 2 stated he could not extend Resident 43's left-hand fingers and required two people to apply the left WHO. RNA 2 stated he forgot to perform the left elbow PROM exercises on 10/1/2024 at 10:27 a.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/2/2024 at 4:03 p.m. with the Regional Director of Rehabilitation (RDR), reviewed RNA 1, RNA 2, RNA 3, RNA 4, and RNA 5's competency evaluations. The RNA competency evaluations included ambulation with assistance, application of the splint, ROM exercise (upper extremity [arm], and ROM exercise lower extremity {leg}). RNA 1's competency evaluation was completed on 5/9/2023. RNA 2's competency evaluation was completed on 5/8/2023. RNA 3's competency evaluation was completed on 5/8/2023. RNA 4's competency evaluation was completed on 5/11/2023. RNA 5's competency evaluation was completed on 5/8/2023. The RDR stated the RNA competency evaluations were completed annually and should have been completed in 5/2024. During an interview on 10/3/2024 at 11:12 a.m. with the Director of Staff Development (DSD), the DSD stated the rehabilitation staff performed the annual competency evaluations for the RNAs. The DSD stated annual competency evaluations ensured the staff were performing safe and correct techniques for their jobs. During an interview on 10/4/2024 at 4:12 p.m. with the Director of Nursing (DON), the DON stated competency evaluations were completed upon hire, annually, and as needed to ensure staff (in general) had the ability to perform their job duties. The DON stated there was a potential for staff members to perform tasks incorrectly without having a competency evaluation. During a review of the facility's policy and procedure (P&P) titled, Nursing Services and Sufficient Staff, revised 1/25/2024, the P&P indicated the facility provided sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated the facility must ensure nurse aides demonstrated competency in skills and techniques necessary to care for residents' needs identified in the resident's care plan. Cross reference F688 b.During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including morbid obesity (more than 80-100 pounds above their ideal body weight), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 27's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 27 was dependent (a person that relies on another for support) on staff for bathing, dressing, and toileting. During a review of Resident 27's care plan, titled Resident 27 was on diuretic (medicines that help reduce fluid buildup in the body) therapy for edema (swelling caused by fluid buildup in body tissues) and hypertension (high blood pressure) revised 4/26/2024, the care plan goals included to Resident 27 be free from adverse side effects if diuretic therapy. The care plan interventions for Resident 27 included monitoring, documenting, and reporting adverse reactions to diuretic therapy: dizziness (feeling faint, woozy, weak, or unsteady), hypotension, and fatigue (lack of energy and motivation). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/2024, at 12:15 p.m., Resident 27 complained of chest pain. The Registered Nurse Supervisor (RNS) 1 applied blood pressure cuff on Resident 27's left forearm to check blood pressure. Licensed Vocational Nurse (LVN) 4 was in the room and informed RNS 1 he usually checked Resident 27's blood pressure on her forearm. LVN 4 provided RNS 1 with Resident 27's blood pressure reading he checked earlier that morning of 10/1/2024. During an interview on 10/1/2024, at 3:15 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated the correct place to check a blood pressure was applying the blood pressure cuff on the upper arm to ensure accuracy of the reading. LVN 4 stated it was important to have accurate blood pressure because Resident 27 was given Nitroglycerin and there are parameters to follow. LVN 4 stated there were extra-large blood pressure cuffs available but failed to use it and used the smaller blood pressure cuff. During an interview on 10/2/2024, at 3:37 p.m., with RNS 1, RNS 1 stated she should have used extra-large blood pressure cuff on Resident 27's upper arm rather than the smaller blood pressure cuff on her forearm because the reading was more accurate when taken on the upper arm. RNS 1 stated because Resident 27 was given Nitroglycerin, it was important for an accurate blood pressure reading because an inaccurate blood pressure reading could lead to hypotension, unresponsiveness (not reacting or moving at all), or cardiac arrest (when the heart stops beating suddenly). During an interview on 10/4/2024, at 3:05 p.m., with the Director of Nursing (DON), the DON stated checking the blood pressure on the forearm was not best practice and the upper arm was the most accurate. The DON stated the staff should have used a larger blood pressure cuff on Resident 27's upper arm when she was given Nitroglycerin for chest pain because an inaccurate reading could lead to complications such as hypotension. During a review of the facility's policy and procedure (P&P) titled, Nursing Services and Sufficient Staff, revised 1/25/2024, the P&P indicated, It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Deficiency Text Not Available

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 18) was free from unnecessary medication by: 1.Ensuring non-pharmacological interventions (intervention that does not primarily use medicine) was ordered for Resident 18 who was prescribed with psychotropic medicine (any drug or substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, and behavior). This failure had the potential to result in the use of unnecessary psychotropic medication to Resident 18. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and autistic disorder(developmental disability that affects how people communicate, interact, learn, and behave). During a review of Resident 18's History and Physical (H & P) dated 4/15/2024, the H and P indicated the resident did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making(decisions are poor and supervision or cues is required), The MDS indicated the resident required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. During a review of Resident 18's Order Summary Report dated 9/8/2024, indicated a physician order of Alprazolam oral .5 milligram (mg., unit of measurement) give 1 tablet by mouth every 6 hours as needed for anxiety for 30 days manifested by inability to relax). During a concurrent interview and record review of Resident 18's Medication Administration Record and Physician's Order on 10/4/2024, at 11:43 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated there was no documentation about non-pharmacological interventions before Alprazolam was administered to Resident 18.LVN 2 stated Alprazolam is administered to the resident for inability to relax LVN 2 stated psychotropic medicine like Alprazolam could cause side effects like sleepiness and respiratory depress (also known as hypoventilation, is a breathing disorder that occurs when a person breathes too slowly or shallowly, preventing the lungs from exchanging oxygen and carbon dioxide properly) and should be given if the non-pharmacological interventions are not effective. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 18's electronic chart on 10/3/2024, at 4:24 p.m. with RN Supervisor (RNS1), RNS 1 stated Resident 18 received Alprazolam .5 mg. every 6 hours as needed for anxiety manifested by inability to relax. RNS 1 stated his usual behavior was removing colostomy bag and the targeted behavior for the alprazolam was inability to relax. RNS 1 agreed inability to relax was general and not specific on what behavior the resident is manifesting to receive alprazolam. RNS 1 confirmed thru record review Resident 18 was not receiving any non-pharmacological interventions for the use of Alprazolam and offering some food, repositioning , providing calm and quiet environment , listening to music, and assessing for pain could help or solve the behavior. RNS 1 stated using non-pharmacological approach is important because psychotropic medications could cause side effect and giving the alprazolam first without using nonpharmacological interventions could be giving unnecessary psychotropic medicine. During an interview on 10/4/2024, at 4:04 p.m. with Director of Nursing (DON), DON stated they used non-pharmacological interventions for prn (as needed) psychotropic medicines. DON stated it is important to use non- pharmacological interventions first before administering alprazolam because it could result into unnecessary psychotropic medicine. DON stated alprazolam is used for inability to relax as needed . DON stated this behavior might not be an appropriate behavior for the use of alprazolam because it should be a specific behavior for anxiety. DON stated alprazolam might not be warranted for that specific behavior (inability to relax) and can be considered unnecessary psychotropic medicine. During a review of facility's policy and procedure (P/P) titled Use of Psychotropic Medication revised 1/25/2024, the P/P indicated indications for use of any psychotropic drug will be documented in the medical record and residents should receive non-pharmacological interventions to facilitate reduction or discontinuation of the drug. The P/P indicated prn orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition and specific rationale are documented in the medical record.

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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** 49889 Based on observations, interview, and record review the facility failed to ensure it was free from a medication error rate of five percent or greater as evidenced by the identification of eleven medications errors out of thirty-three opportunities for error, to yield a total error rate of 33.33 percent for the two of four sampled residents (Residents 28 and 37). This failure had the potential for medications to not maintain a therapeutic dose level (maintain a certain level in your blood to work well) when not administer according to physician orders. Findings: During an observation on 10/1/2024 at 10:30 a.m., in Resident 37's room, observed Licensed Vocational Nurse (LVN) 4 administer Resident 37's 9:00 a.m. medications at 10 :30 a.m. During an observation on 10/1/2024 at 11:24 a.m. in Resident 28's room, observed LVN 4 administer Resident 28's 9:00 a.m. medications at 11:24 a.m. a.During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with the diagnoses including acute and chronic respiratory failure (a long-term condition that makes it difficult for the body to exchange oxygen and carbon dioxide [gas]), pulmonary hypertension (the heart work harder than normal to pump blood into the lungs) , hypertensive heart disease (heart problems that occur because of high blood pressure), epilepsy (disorder in which nerve cell activity in the brain is disturbed causing, seizures), diabetes mellitus type 2, (the body has trouble controlling blood sugar), diabetic neuropathy (nerve damage caused from diabetes), dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 28's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/17/2024, the MDS indicated Resident 28's cognitive (ability to think, understand, learn, and remember) skills are moderately impaired with fluctuating (comes and goes) capacity. During a review of Resident 28's History and Physical (H&P) dated 5/14/2024 indicated Resident 28 has fluctuating capacity to understand and make decisions. During a concurrent observation and review of the Resident 28's Physician Order dated 10/3/24, the active order summary report indicated, Resident 28 had orders for: 1.Amiodarone 200 mg give 1tablet by mouth two times a day for atrial fibrillation (irregular heart rate (A-fib). Administration time 9:00 a.m., observed administered 11:24 a.m. 2. Apixaban 5mg give one tablet by mouth two times a day for A-fib. Administration time 9:00 a.m., observed administered 11:24 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Budesonide inhalation suspension 0.25 mg/2ml give 4ml two times a day for acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has two much carbon dioxide). Rinse mouth out with water after use. Administration time 9:00 a.m., observed administered 2:16 p.m. 4. Levetiracetam oral solution 100 mg/ml give 5ml every 12 hours for seizure (a sudden uncontrolled burst of electrical activity in the brain), disorder. Administration time 9:00 a.m., observed administered 11:24 a.m. 5. Pregabalin 50 mg give 1 capsule by mouth three times a day for nerve pain. Administration time 9:00 a.m., observed administered 11:24 a.m. 6. Sildenafil 20 mg give one tablet by mouth three times a day pulmonary hypertension (high blood pressure that effects arteries in the lungs and in the heart) Administration time 9:00 a.m., observed administered 11:24 a.m. b. During a review of Resident 37' s Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hypertensive heart disease without heart failure, cerebral infarction (disrupted blood flow to the brain), and depression (a low mood or loss of pleasure or interest in activities for long periods of time). During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 had intact cognitive in daily decision making. During a concurrent observation and review of Resident 37's Resident 37's Physician Order dated 10/3/24, the Physician Order indicated, Resident 37 had orders for: 1 Finasteride 5 mg give one tablet by mouth once a day for benign prostatic hyperplasia (enlarged prostate (BPH). Administration time 9:00 a.m., observed administered 10:30 a.m. 2. Gabapentin 100 mg give one capsule two times a day for polyneuropathy (multiple nerves in the body malfunction). Administration time 9:00 a.m. observed administered 10:30 a.m. 3. Hydralazine 25 mg give one tablet by mouth two times a day for hypertension (pressure in your blood is high), Hold if SBP < 110. Administration time 9:00 a.m., observed administered 10:30 a.m. During an interview on 10/1/24 at 3:15 p.m. with LVN 4, LVN 4 stated, Resident's 28 and 37 medications were scheduled for 9:00 a.m., Resident 28's medication was given at 11:24 a.m. and Resident 37's medication was given at 10:30 a.m. LVN 4 stated 9:00 a.m. medications can be given between 8:00 - 10:00 a.m., per facility protocol. LVN 4 stated Resident 28 and 37's physician should have been informed of the delay in the administration of the medication. LVN 4 stated delayed in administration of medication had the potential for reduced effectiveness of the medication, that can lead to inadequate symptom control or treatment outcomes. During an interview on 10/2/25 at 10:09 a.m. with the Director of Nursing (DON), the DON stated medications scheduled for 9:00 a.m. should be given between 8 a.m.-10 a.m. The DON stated LVN 4 should have called Resident 28 and 37's physician of the delay in medication administration to make sure it was still okay to administer the medications. The DON stated residents are at risk for rehospitalization when not maintaining therapeutic drug levels. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General guidelines, dated 10/2017, indicated, medications are administered within 60 minutes of scheduled time (one hour before and one hour after), except before or after meals, which is administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. The policy also indicated; medications are administered in accordance with written orders of the attending physician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to provide one of two sampled Residents (Resident 43) with meals that accommodated resident's food preferences. This failure had the potential to result in decreased meal intake and can lead to weight loss. Findings: During a review of Resident 43's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses that included end stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus(DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dependence on renal dialysis (procedure to remove waste products and excess fluids from the blood when the kidneys stop properly). During a review of Resident 43's History and Physical(H&P) dated 6/1/2024, the H &P indicated the resident had a fluctuating capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/12/2024, the MDS indicated the resident was dependent on the staff with bathing, oral hygiene, toileting hygiene, dressing, bed mobility, and personal hygiene. During a review of Resident 43's Care Plan titled Potential for Malnutrition as evidenced by Nutritional Screening Tool undated , the Care Plan's goal indicated resident's intake of nutrients will meet metabolic needs. The Care Plan interventions included for the dietary to follow up with resident's food preferences. During a review of Resident 43's Care Plan tiled Resident 43 had chronic renal failure related to ESRD and the resident was on hemodialysis(treatment that filters waste and excess fluid from the blood when the kidneys are no longer healthy to do so).The Care plan interventions included dietary consult to regulate protein and potassium intake. During a review of Resident 43's Order Summary Report, the Order Summary Report indicated an order of Liberal House Renal Diet soft and bite sized texture, thin consistency and may have bread. During a review of Resident 43's meal tray card for lunch (menu based on resident's diet order, standing orders and food preferences), the meal tray card indicated no food preferences and dislikes for food. During an interview on 9/30/2024, at 11:04 a.m. and a subsequent interview on 10/3/2024 , at 8:10 a.m.with Resident 43, Resident 43 stated she was on hemodialysis and the kitchen would give her potatoes, yams, and cheese most of the time. Resident 43 stated no one from the kitchen had asked her what she would prefer to eat. She stated potatoes, yams and cheese are not allowed in her diet because of her kidney problem. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/2024, at 9:50 a.m. with Certified Nursing Assistant (CNA5), CNA 5 stated Resident 43 did not like cheese on her scrambled eggs or on top of the egg. CNA5 stated she told Dietary Manager, [NAME] 1 and [NAME] 2 about resident's preferences about cheese. CNA5 stated not following Resident 43's food preferences could result into weight loss and sickness. During an interview on 10/2/2024, at 10:44 a.m. with [NAME] (CK1), Ck 1 stated sometimes Resident 43 do not like the eggs and asked for a peanut butter sandwich. [NAME] 1 stated an unnamed CNA always said the resident disliked the scrambled eggs served to her but we never asked the resident why she disliked it. CK 1 stated she told the DM about Resident 43's disliking the scrambled eggs two weeks ago.CK 1 stated DM is responsible in checking what the resident dislikes and likes in food. CK1 stated Resident 43 might not eat well and this could lead to weight loss if her food preferences are not followed. During a concurrent interview and record review of Resident 43's electronic chart on 10/2/204, at 9:12 a.m. with DM, DM confirmed her charting regarding resident's condition was 6/18/2024. DM stated nutritional assessment is conducted upon admission and as needed to address food dislikes , food allergy and food preferences. DM stated she was not aware Resident 43 did not like cheese. DM stated she did make room rounds yesterday and asked Resident 43 about the food served for lunch. DM stated it was a quick round and the resident stated Yes after she was asked about the food served during lunch. DM stated everyone in the facility can report residents' food preferences to them. DM stated it's important to follow residents' food preferences so they can eat better and be satisfied with the food being served to them. During a review of facility's policy and procedure (P/P) titled Initial Resident Visitation/ Nutritional Screening dated 2016, the P/P indicated the frequency of subsequent visitations should depend on the nutritional status of the resident and each resident should be visited quarterly in preparation for each care reference. The P/P indicated the DM, registered dietician or other clinically qualified nutrition professional should explain what diet the physician had prescribed, obtain food preferences, allergies, or intolerances, and note in the Dietary/ Interview/ Prescreen or other designated form and tray card.

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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. 45269 Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen by failing to: a.Date and label open bag of peanut butter dough, bag of frozen fries and open bottles of salsa in the freezer and refrigerator. b.Practice hand washing during cooking, checking of temperatures of cooked food items and distribution of food during tray line. c.Use a beard net (worn to contain facial hair)during food preparation and food distribution during lunch tray line. These failures had the potential to cause cross contamination (unintentional transfer of harmful bacteria from one object to another)and food borne illnesses (any illness resulting from eating contaminated/ spoiled foods)among the residents. Findings: a.During an initial tour observation on 9/30/2024, at 8:10 a.m. with Dietary Aide (DA1) , an open bag of frozen fries and an open bag of peanut butter dough were open but was not labeled when they were opened by kitchen personnel in the freezer. During an observation and interview on 9/30/2024 with [NAME] (CK1), observed two open bottles of salsa were not dated when it was open and labeled by use date in the refrigerator. CK 1 stated the kitchen personnel should have dates and labeled when they opened the bottles of salsa and labeled them with by use date. During an interview on 10/2/2024, at 8:27 a.m. with CK 1, CK 1 stated it's important to date and label open food items to know when the food items were open which will prevent residents from getting sick. During an interview on 10/2/2024, at 8:47 a.m. with Dietary Manager (DM), DM stated food items are labeled and dated when they are open to make sure the food that was served is not old and to prevent food borne illness among the residents. b. During an observation on 10/1/2024, at 11:30 a.m. with CK 2. CK 2 cooked a burger patty and buns in a pan , then checked the temperature of cooked food in the steam table several times , removed cooked fish fillets from the oven into the steam table and started placing food items into the residents' plates with same gloves. Observed CK 2 did not perform handwashing and change of gloves during cooking, checking temperatures, preparation of food and tray line (system of food preparation). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024, at11:02 a.m. with CKk 2, CK 2 confirmed he did not wash his hands because he was busy and forgot. CK 2 stated handwashing should be practiced every time he would change a task in the kitchen and should have washed his hands and change his gloves every time he changed a task for infection control. During an interview on 10/2/2024, at 8:27 a.m. with CK 1, CK 1 stated handwashing should be performed every time gloves are removed, before preparing food and before food is served during tray line. CK 1 stated CK k2 should have washed his hands in between tasks to ensure hands are clean and free of bacteria. CK 1 stated handwashing will prevent residents from getting sick of food borne illnesses. During an interview on 10/2/2024, atv8:47 a.m. with DM, DM stated handwashing should be performed when gloves is changed and in between tasks to prevent food contamination. During a review of facility's policy and procedure (P/P) titled Labeling and Dating Foods undated , the P/P indicated newly opened food would need to be closed and labeled with an open date and used by date. During a review of facility's P/P titled Personal Hygiene/ Safety/Food Handling/ Infection Control' revised 5/18/2023, the P/P indicated hands must always be washed after handling any unsanitary items. The P/P indicated the guidelines are used for personal hygiene to promote a safe and sanitary condition in the department. During a review of facility's P/P titled Handwashing and Glove Use revised 4/15/2020, the P/P indicated gloves must be changed as often as hands need to be washed and gloves may be used for one task only. The P/P indicated hands must be washed when working with different food substances like raw chicken to fresh fruit, and following contact with any unsanitary surfaces. c.During an observation on 10/1/2024, at 11:30 a.m. , CK 2 had facial sideburns, and beard. CK 2 was wearing a hair net but no beard net while cooking, preparing food , checking temperatures of cooked food in the steam table and meal plating during lunch tray line. During an interview on 10/2/2024, at 11:02 a.m. , CK 2 confirmed he was not wearing a beard net when he was cooking and serving food yesterday because he was busy and forgot. CK 2 stated beard net should be worn for exposed facial hair because the hair could get into the residents' food which can cause cross contamination leading to food borne illness. During an interview on 10/2/2024, at 8:27 a.m. with CK 1, CK 1 stated wearing a beard net is important to prevent hair from falling into the food which will be eaten by residents. CK1 stated CK 2 should have worn a beard net before he started cooking and working with food in the kitchen because residents could get sick from cross contamination. During an interview on 10/2/2024, at 8:47 a.m. with DM, DM stated CK 2 should have worn the beard net to cover exposed facial hair for food safety by preventing cross contamination leading to food borne illness. (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 facility's P&P titled Personal Hygiene/Safety/Food Handling/Infection Control revised 5/18/2023, the P&P indicated beards, mustaches or any body hair that may be exposed must be covered.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide therapy services, including Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function), Speech Therapy ([SLP] profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders), and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) to one of seven sampled residents (Resident 5) with range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns in accordance with Resident 5's physician signed care plans for OT, PT, and SLP. This failure resulted in Resident 5 not receiving any interventions to improve communication, mobility, and activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) to reach Resident 5's maximum physical and psychosocial (way a person's mental and emotional health interacts with their social life and relationships) well-being. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 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) and 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 right side and facial weakness following a cerebral infarction. During a review of Resident 5's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/24/2023, the MDS indicated Resident 5 expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 5 had functional ROM limitations in one arm and one leg. The MDS also indicated Resident 5 required limited assistance (resident highly involved in activity) with one-person assistance for eating, extensive assistance (resident involved in activity while staff provide weight-bearing support) with two-person assistance for bed mobility and dressing, and total dependence (full staff performance every time) with two-person assistance for bathing and transfers between surfaces. During a review of Resident 5's PT Evaluation and Plan of Treatment, dated 10/26/2023, the PT Evaluation indicated Resident 5's ROM in both hips and knees were within functional limits ([WFL] sufficient movement without significant limitation). The PT Evaluation indicated Resident 5's ROM in both ankles were impaired (unspecified). Resident 5's 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 used to improve the ability to perform activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility)], wheelchair management training (training on proper positioning and ability to propel the wheelchair), and orthotic (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) management, three times per week for four weeks. The PT Evaluation and Plan of Treatment indicated Resident 5's physician signed and certified (verified) the need for PT services on 10/28/2023. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's PT Discharge Summary, dated 10/26/2023 (same day as the PT Evaluation) and signed 12/14/2023 (over one month later), the PT Discharge recommendations indicated for the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) to perform PROM to both legs. During a review of Resident 5's SLP Evaluation and Plan of Treatment, dated 10/26/2023, the SLP evaluation indicated Resident 5 had mild to moderate oral dysphagia (difficulty swallowing that occurs when there are issues with the mouth, lips, or tongue). Resident 5's SLP Plan of Treatment included treatment of swallowing dysfunction and oral function for feeding, two times per week for four weeks. The SLP Evaluation and Plan of Treatment indicated Resident 5's physician signed and certified the need for SLP services on 10/28/2023. During a review of Resident 5's SLP Discharge Summary, dated 10/26/2023 (same day as the SLP Evaluation) and signed 12/27/2023 (two months later), the SLP Discharge Summary indicated for Resident 5 to eat puree consistency food and thin liquids with close supervision. During a review of Resident 5's OT Evaluation and Plan of Treatment, dated 10/27/2023, the OT Evaluation indicated Resident 5's ROM in the left arm and right elbow were WFL. The OT Evaluation indicated Resident 5's ROM in the right shoulder, right wrist, and right hand were impaired (unspecified). The OT Evaluation indicated Resident 5 had a contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) in the right hand, limiting Resident 5's ability to grasp and release. Resident 5's Plan of Treatment included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training, three times per week for one week. The OT Evaluation and Plan of Treatment indicated Resident 5's physician signed and certified the need for OT services on 10/28/2023. During a review of Resident 5's OT Discharge Summary, dated 10/27/2023 (same day as the OT Evaluation) and signed 12/14/2023 (over one month later), the OT Discharge recommendations indicated for the RNA to provide PROM to both arms and apply a right-hand palm guard (material used as a barrier between fingers and palmar skin to prevent injury to the palm from severe finger flexion contracture). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 expressed ideas and wants, clearly understood verbal content, and had intact cognition. During an interview on 9/30/2024 at 11:23 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of PT (in general) included to maintain or improve mobility, including wheelchair mobility. The DOR stated the purpose of OT (in general) included to maintain or improve self-care and ADLs for a resident's quality of life. The DOR stated the purpose of SLP (in general) included to improve communication and ensure the resident had the least restrictive diet (diet that maximizes safety for eating). During an observation on 9/30/2024 at 12:43 p.m. in the dining room, Resident 5 was sitting in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) eating lunch while watching a movie. Resident 5 moved the left arm actively at all joints to scoop puree food from the plate and hold a cup to drink liquids. Resident 5's moved the right arm at the elbow and shoulder joints, but Resident 5's right hand was positioned in a closed fist. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/30/2024 at 2:00 p.m., Resident 5 used the left hand to write responses to questions. During a concurrent observation and interview on 10/1/2024 at 4:34 p.m. in Resident 5's bedroom, observed Resident 5 had active movement in both arms except the right hand, which was positioned in a fist. Resident 5 put on eyeglasses using the left hand and the thumb of the right hand. Resident 5 wrote she had a stroke (when the blood supply to part of the brain is blocked or reduced) and used to walk. Resident 5 proceeded to lift and lower both legs. Resident 5 stated she never received therapy while residing at the facility. During a telephone interview on 10/3/2024 at 9:48 a.m. with Resident 5's Family Member (FM 1), FM 1 stated Resident 5 was left-handed and had a stroke more than [AGE] years ago. FM 1 stated Resident 5 walked and performed most ADLs after the stroke since it affected Resident 5's nondominant (used less often during completion of daily living tasks), right side. FM 1 stated Resident 5 had additional smaller strokes which eventually affected Resident 5's speech and worsening the function in the right arm. FM 1 stated Resident 5 walked using a walker (an assistive device used for stability when walking) but progressed to being wheelchair bound due to neglect at another facility. FM 1 stated there were discussions with facility regarding obtaining therapy to attempt to improve Resident 5's mobility since Resident 5 was motivated to try. FM 1 stated there were difficulties with Resident 5's health insurance to obtain therapy. During a concurrent interview and record review on 10/3/2024 at 3:30 p.m. with the DOR, Resident 5's PT Evaluation and Plan of Treatment, dated 10/26/2023, SLP Evaluation and Plan of Treatment, dated 10/26/2023, and OT Evaluation and Plan of Treatment, dated 10/27/2023, were reviewed. The DOR stated Resident 5's Plan of Treatment for PT services three times per week for four weeks, SLP services two times per week for four weeks, and OT services three times per week for one week were certified by Resident 5's physician. The DOR stated Resident 5's Plan of Treatment for PT, SLP, and OT were not implemented since Resident 5 was totally dependent for mobility and ADLs. The DOR stated there was a verbal agreement among PT, OT, and SLP that Resident 5 would benefit from RNA instead of therapy services. During a concurrent interview and record review on 10/4/2024 at 4:02 p.m. with the Director of Nursing (DON), Resident 5's PT Evaluation and Plan of Treatment, dated 10/26/2023, SLP Evaluation and Plan of Treatment, dated 10/26/2023, and OT Evaluation and Plan of Treatment, dated 10/27/2023, were reviewed. The DON stated the therapists could provide treatment after Resident 5's physician signed the Plan of Treatment. The DON stated residents (in general) could decline in function without therapy intervention. During a review of the facility's policy and procedure (P&P) titled, Purpose and Objectives of Inpatient Rehabilitation Services, revised 1/25/2024, the P&P indicated the objective of the rehabilitation department included to restore residents to their highest level of function.

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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 failed to: a. Ensure accurate documentation for two of six sampled residents (Resident 43 and 32) with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns. This failure resulted in inaccuracies in the provision of care recorded in the clinical records of Resident 43 and 32. b. Ensure one out of three sampled residents (Resident 38) medication administration record (MAR) accurately reflect licensed nurse administered Resident 38's medication on 10/3/2024 at 9 a.m. This failure had the risk for medication errors or omission in medication administration. Findings: a. During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD] irreversible kidney failure), dependence on renal (kidney) dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side (less often used during completion of daily living tasks). During a review of Resident 43's OT Discharge Summary, dated 9/10/2023, the OT Discharge Summary indicated Resident 43 required moderate assistance (required between 26 to 50 percent [%] physical assistance to perform the task) for hygiene, grooming, and self-feeding. The OT Discharge Summary recommendations indicated for Resident 43 to receive a Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) program for passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises to the left arm and application of a left wrist hand orthoses ([WHO] material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures [condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness]). During a review of Resident 43's PT Discharge Summary, dated 9/10/2023, the PT Discharge Summary indicated Resident 43 was dependent (required more than 75 percent [%] physical assistance to perform the task) with bed mobility and transfers, requiring a mechanical lift (a device that helps people who have difficulty moving on their own to be transferred or moved from one place to another) for transfers. The PT Discharge Summary recommendations indicated for Resident 43 to receive an RNA program for PROM exercises to both legs. (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 43's care plan titled, Restorative Nursing Program, initiated 9/19/2023 and revised on 8/7/2024, the care plan interventions included for RNA to provide PROM to the left arm, PROM of both legs, and application of the left WHO for up to six hours, five times per week. During a review of Resident 43's Minimum Data Set ([MDS] federally mandated resident assessment tool), dated 8/12/2024, the MDS indicated Resident 43 had clear speech, understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 43 required substantial/maximal assistance (helper does more than half the effort) for eating and rolling to either side while lying in bed and dependent for hygiene, dressing, bathing, and chair/bed-to-chair transfers. The MDS indicated Resident 43 had functional ROM impairments in one arm and one leg (unspecified side). During a review of Resident 43's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated 9/2024, the Documentation Survey Report indicated Restorative Nursing Assistant 1 (RNA 1) provided Resident 43 with PROM on both legs, PROM on the left arm, and application of the left WHO for up to six hours on 9/30/2024. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 9/30/2024 for the 7:00 a.m. to 3:00 p.m. shift, RNA 1 was not on the nursing staff assignment and did not sign in for work. During a review of the RNA time sheets, RNA 1's time sheet indicated RNA 1 was on vacation on 9/30/2024. During a concurrent observation and interview on 9/30/2024 at 11:04 a.m. in Resident 43's bedroom, Resident 43 was lying awake in bed and unable to move the left arm. Resident 43 stated she required physical assistance from someone to move her left arm. During a concurrent observation and interview on 9/30/2024 at 12:05 p.m. in Resident 43's bedroom, Resident 43 was observed lying awake in bed and stated she fell from the bed at home, which caused bleeding in the brain. Resident 43 was observed moving the right arm normally at each joint but was unable to move the left arm. Resident 43 stated the nurse (unknown) did exercises (unspecified) on 9/30/2024 morning. Resident 43's left elbow was bent at 90 degrees with the left hand resting on Resident 43's abdomen. Resident 43's left hand was positioned in a closed fist and did not have an orthosis (WHO) applied. Resident 43 stated she received exercises once per week. During an interview on 9/30/2024 at 12:47 p.m. with Restorative Nursing Assistant 3 (RNA 3), RNA 3 stated RNA 2 and RNA 3 were assigned as the RNAs on 9/30/2024. RNA 3 stated she was providing all RNA treatment since RNA 2 went to an appointment with a resident (unknown). (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 observation and interview on 10/1/2024 at 10:27 a.m. in Resident 43's bedroom, Resident 43 was sleepy but agreeable to receive RNA from RNA 1 and RNA 2. RNA 1 was observed standing on the right side of Resident 43's bed while RNA 2 was standing on the left side of Resident 43's bed. RNA 1 performed PROM on Resident 43's right leg and then left the room to assist another staff member. RNA 2 performed PROM on Resident 43's left leg and left arm. RNA 2 attempted to apply Resident 43's left WHO. The portion of the left WHO for Resident 43's fingers was bent completely downward to accommodate Resident 43's fingers. RNA 2 had difficulty extending Resident 43's fingers to apply the left WHO and stated he needed another person's assistance. The Physical Therapy Assistant (PTA 1) came into the room and assisted with extending Resident 43's left-hand fingers while RNA 2 applied the left WHO. Resident 43 complained of pain while RNA 2 and PTA 1 applied the left WHO. Resident 43 stated the WHO has not been applied to her left hand in two months. During an interview on 10/4/2024 at 8:49 a.m. with the Director of Staff Development (DSD), the DSD stated the RNA providing the services (in general) should document the services in the resident's clinical record. The DSD stated the RNA providing RNA services should indicate in the resident's clinical record if there were any changes observed during the RNA session. During a concurrent interview and record review on 10/4/2024 at 12:20 p.m. with the DSD, Resident 43's Documentation Survey Report for 9/30/2024 and the facility's Nursing Staffing Assignment for 9/30/2024 were reviewed. The DSD stated Resident 43's Documentation Survey Report for 9/30/2024 indicated RNA 1 provided Resident 43 with PROM to the left arm, PROM to both legs, and the application of the left WHO. The DSD stated RNA 1 was not in the facility on 9/30/2024 and was on vacation. During a concurrent interview and record review on 10/4/2024 at 12:22 p.m. with Registered Nurse 1 (RN 1), Resident 43's Documentation Survey Report for 9/30/2024 and RNA tasks were reviewed. RN 1 stated RNA 1 documented on 10/1/2024 at 8:01 a.m. that Resident 43 received RNA services on 9/30/2024. During an interview on 10/4/2024 at 1:48 p.m. with RNA 1, RNA 1 stated he did not provide services to Resident 43 on 9/30/2024 since he was on vacation. RNA 1 stated Resident 43's RNA clinical record was missing documentation for 9/30/2024 and inputted the documentation. RNA 1 stated he did not know if Resident 43 received RNA for the PROM exercises and application of the left-hand WHO on 9/30/2024. During a concurrent interview and record review on 10/4/2024 at 4:14 p.m. with the Director of Nursing (DON), Resident 43's Documentation Survey Report for RNA on 9/30/2024 was reviewed. The DON stated the RNA providing the treatment directly to the resident should document in the clinical record after the RNA treatment was completed. The DON stated the documentation for the provision of RNA services should be accurate to ensure the resident received the services. The DON reviewed Resident 43's Documentation Survey Report which indicated RNA 1 provided treatment on 9/30/2024 but was not present at the facility. The DON stated RNA 1 should not document in Resident 43's clinical record if RNA 1 was not present in the facility on 9/30/2024. The DON stated Resident 43's Documentation Survey Report for 9/30/2024 was false and inaccurate. The DON stated there was a possibility that Resident 43 was not seen for RNA services on 9/30/2024. (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 facility's policy and procedure (P&P) titled, Documentation in Medical Record, revised 1/25/2024, the P&P indicated the resident's clinical record documentation shall be factual and accurate about the resident's care. The P&P indicated false information shall not be documented. Cross reference F688. b. During a review of Resident 32's Admission Record, The Admission Record indicated Resident 32 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) and 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 right dominant side. During a review of Resident 32's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/1/2024, the MDS indicated Resident 32 had clear speech, expressed ideas, and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). During a review of Resident 32's care plan for RNA, initiated 9/5/2024, the interventions included for the RNA to perform active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) to both legs, including the hip, knee, and ankle joints, five times per week. During an interview on 10/1/2024 at 1:24 p.m., Resident 32 stated the RNAs provided exercises twice per week instead of five times per week. Resident 32 stated Restorative Nursing Assistant 3 (RNA 3) provided ROM exercises on 9/30/2024. Resident 32 stated RNA 1 and RNA 2 never provided ROM exercises to Resident 32 due to conflict in the past. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet, dated 10/1/2024 for the 7:00 a.m. to 3:00 p.m. shift, the Nursing Staffing Assignment indicated RNA 1 and RNA 2 provided RNA services. The Nursing Staffing Assignment indicated RNA 3 did not work on 10/1/2024. During a concurrent interview and record review on 10/1/2024 at 3:09 p.m., with RNA 2, Resident 32's RNA documentation dated 10/1/2024 was reviewed on a mounted computer screen. RNA 2 stated Resident 32 did not like receiving RNA exercises from RNA 2. RNA 2 stated he did not provide any RNA services to Resident 32 on 10/1/2024. RNA 2 stated RNA 1 was not supposed to provide any RNA services to Resident 32 due to past conflict. RNA 2 reviewed Resident 32's RNA documentation for 10/1/2024 which indicated RNA 1 provided AROM to both of Resident 32's legs. During an interview on 10/2/2024 at 8:47 a.m. with RNA 1, RNA 1 stated he did not provide any RNA services to Resident 32 due to conflict in the past. RNA 1 stated he documented in Resident 32's RNA documentation for 10/1/2024. During an interview on 10/2/2024 at 8:52 am. with RNA 1 and RNA 2, RNA 2 stated he provided the AROM exercises to Resident 32's legs on 10/1/2024 after discovering the RNA documentation error. RNA 1 stated the documentation for 10/1/2024 was inputted into Resident 32's clinical record prior to providing RNA services. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/2024 at 11:12 a.m. with the Director of Staff Development (DSD), the DSD stated RNA 1 never provided Resident 32 with RNA services due to past conflict. The DSD stated the RNA providing the service to the resident (in general) should document the RNA services provided in the resident's clinical record. During a review of Resident 32's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated 9/2024, the Documentation Survey Report indicated RNA 1 provided Resident 32 with AROM to both legs on 9/6/2024, 9/9/2024, 9/12/2024, and 9/13/2024. During a concurrent interview and record review on 10/3/2024 at 2:38 p.m. with RNA 1, Resident 32's Documentation Survey Report for RNA, dated 9/2024, was reviewed. RNA 1 stated RNA 3, RNA 4, and RNA 5 usually provided RNA services to Resident 32. RNA 1 stated he documented in Resident 32's clinical record for 9/6/2024, 9/9/2024, 9/12/2024, and 9/13/2024 because the other RNAs were busy. RNA 1 stated he documented in Resident 32 clinical record on behalf of the other RNAs because he did not want to have any missing documentation. RNA 1 stated Resident 32's Documentation Survey Report for 9/2024 was inaccurate since the RNA performing the exercises did not document in Resident 32's clinical record. During a concurrent interview and record review on 10/4/2024 at 8:49 a.m. with the DSD, the DSD reviewed Resident 32's Documentation Survey Report for 9/2024 and 10/2024. The DSD stated it was not appropriate for RNA 1 to document in Resident 32's clinical record since RNA 1 did not provide RNA services to Resident 32 on 9/6/2024, 9/9/2024, 9/12/2024, and 9/13/2024. The DSD stated it was not appropriate for RNA 1 to document Resident 32 received RNA services on 10/1/2024 without providing RNA services. The DSD stated Resident 32's clinical records for RNA was not accurate. During an interview on 10/4/2024 at 4:14 p.m. with the Director of Nursing (DON), the DON stated the RNA providing the treatment directly to the resident should document in the clinical record after the RNA treatment was completed. The DON stated the documentation for the provision of RNA should be accurate to ensure the resident received the services. During a review of the facility's policy and procedure (P&P) titled, Documentation in Medical Record, revised 1/25/2024, the P&P indicated the resident's clinical record documentation shall be factual and accurate about the resident's care. The P&P indicated false information shall not be documented. c. During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including gastrostomy (tube inserted in the stomach to assist with feeding), hypertensive heart disease ((heart problems that occur because of high blood pressure), depression (a low mood or loss of pleasure or interest in activities for long periods of time), diabetes mellitus type 2 (the body has trouble controlling blood sugar), and dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 38's Minimum Data Set ([MDS] federally mandated resident assessment tool) dated 8/27/2024 indicated Resident 28 had impaired cognitive (ability to think, understand, learn, and remember) skills. During a review of Resident 38's History and Physical (H&P) dated 8/15/2024 indicated Resident 28 alert and orientated to self and unable to make decisions for self. (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 38's Resident 38's Physician Order Summary dated 10/3/24, the Physician Order Summary indicated the following orders: a. Creon oral capsule delayed release particles 6000-19000 give one capsule via gastrostomy tube (peg tube) two times a day for indigestion. b. Fluoxetine oral capsule 20 milligram (mg-unit of measurement) give one capsule via peg tube one time a day for depression, c. Folic acid oral tablet give one tablet via peg-tube one time a day for anemia (low blood count) d. Galantamine hydrobromide oral tablet eight (8) mg give one tablet via peg-tube two times a day for dementia. e. Vitamin C oral liquid 500 mg/milliliter (ml-unit of measurement) give 5 ml via peg tube two times for supplement. f. Vitamin D oral tablet 25 microgram (mcg) give two tablets via peg-tube one time a day for supplement. During a review of Resident 38's Medication Administration History Report dated 10/3/2024, the Medication Administration history report indicated Licensed Vocational Nurse (LVN) 2 documented on Resident 38 MAR for Resident 38's medication administered by LVN 4 at 9:00 a.m. During an interview on 10/03/24 at 3:00 p.m. with LVN 4, LVN 4 stated, he must have opened the wrong screen on the computer and documented under LVN 2's name for Resident 38 medication administration. LVN 4 stated LVN 2 must have left Point Click Care ([PCC] electronic health record) open. LVN 4 stated licensed nurses should never document care given to a resident under another licensed nurse name. LVN 4 stated another nurse could be held liable for care they did not provide. During an interview on 10/3/24 at 2:35 p.m., with LVN 2, LVN 2 stated she did not provide care to Resident 38 on 10/2/2024. LVN 2 stated she must have left her PCC open and LVN 4 documented under her name. LVN 2 stated, medication administration record was a legal document, and she could be held liable for care that she did not provide. During an interview on 10/2/25 at 10:09 a.m., with the Director of Nursing (DON), the DON stated, licensed nurses should never document under another nurse's name. The DON stated residents medical record would inaccurately reflect the care provided. The DON stated it could indicate a possible falsification of records. During a review of the facility's policy and procedure titled, Medication Administration-General guidelines, dated 10/2017, indicated, the individual who administers the medication dose records the administration on the resident's medication administration record (MAR) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to ensure Resident 3 was aware of what she was signing when she signed the arbitration agreement (AA- a contract in which you give up your right to being certain claims to court). This failure had the potential to result in Resident 3 not having her right to limit opportunity to initiate judicial proceedings that challenge unfavorable decisions. Findings: During a review of Resident 3's admission record, the admission record indicated Resident 3 was admitted [DATE] with diagnoses including Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and legal blindness (severely impaired vision). During a review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/29/2024, the MDS indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a tool used to assess a patient's cognitive function) score of 15 which indicates that a person's cognition is intact. During a review of Resident 3's AA, dated 10/10/2021, the AA indicated Resident 3 signed the arbitration agreement on 10/10/2021. During an interview on 10/3/2024, at 10:02 a.m., with Resident 3, Resident 3 stated her vision is blurry and she can see very little, but she is able to sign forms if someone reads to her what she is signing and guide her where to sign. Showed Resident 3 the arbitration agreement that she signed 10/10/2021, stated she was unable to see it. Resident 3 defined what an arbitration agreement was and stated she would not sign something like that. Resident 3 stated she does not recall signing the arbitration agreement or anyone explaining the form to her. During an interview on 10/3/2024, at 10:30 a.m., with the Admissions Coordinator (AC), the AC stated she is responsible for completing the arbitration agreement with the residents upon admission but was not working at the facility at the time Resident 3 signed the arbitration agreement. AC stated Resident 3 is alert and understands what is going on but is blind. AC stated she would not have asked Resident 3 to sign the arbitration agreement form without a witness present being she is blind. During an interview on 10/4/2024, at 3:05 p.m., with the Director of Nursing (DON), the DON stated Resident 3 should not have been asked to sign the arbitration agreement unless there was a family member or representative being she is blind. The DON stated having Resident 3 sign the arbitration agreement is unacceptable because it takes away her rights to go to court. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreement, revised 1/25/2024, the P&P indicated, Ensure the resident or his or her representative acknowledges that he or she understands the agreement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the Quality Assessment Assurance (QAA) Committee failed to implement corrective action from the previous re-certification survey regarding the provision of Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) services for range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move). This failure resulted in repeated deficient practices for Quality of Care related to the RNA program during the current re-certification survey. Findings: During a review of the Federal Statement of Deficiencies from the facility's last re-certification survey, dated 10/6/2023, Federal Statement of Deficiencies indicated the facility failed to ensure the Restorative Nursing Assistant (RNA) service provided passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises and applied a splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to one randomly sampled resident. 1.During a review of Resident 32's Admission Record, the facility admitted Resident 32 on 4/29/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and 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 right dominant side (more often used during completion of daily living tasks). During a review of Resident 32's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/1/2024, the MDS indicated Resident 32 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). During a review of Resident 32's care plan for RNA, initiated 9/5/2024, the care plan interventions included for the RNA to perform active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) to both legs, including the hip, knee, and ankle joints, five times per week. During an interview on 10/1/2024 at 1:24 p.m., Resident 34 stated he usually received RNA exercises twice per week instead of five times per week. 2. During a review of Resident 5's Admission Record, the facility admitted Resident 5 on 7/19/2023 with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side and facial weakness following a cerebral infarction. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 had unclear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). During a review of Resident 5's care plan for RNA, initiated on 10/5/2023, the care plan interventions included for the RNA to perform PROM to both arms and legs and apply a hand palm guard (material used as a barrier between fingers and palmar skin to prevent injury to the palm from severe finger flexion contracture [condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness]). During an interview on 9/30/2024 at 2:00 p.m., Resident 5 stated the RNAs did not apply the palm guard to the right hand every day. During a follow-up interview on 10/1/2024 at 4:34 p.m., Resident 5 stated the RNAs did not attempt to provide Resident 5 with exercises every day. 3. During a review of Resident 43's Admission Record, the facility initially admitted Resident 43 on 8/12/2023. The Admission Record indicated Resident 43's diagnoses included End Stage Renal Disease ([ESRD] irreversible kidney failure), dependence on renal dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and hemiplegia affecting the left nondominant side (less often used during completion of daily living tasks). During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had clear speech, understood verbal content, and was severely impaired cognition (ability to think, understand, learn, and remember). During a review of Resident 43's care plan for the RNA, dated 9/19/2023, the care plan interventions, initiated 8/7/2024, included for the RNA to provide PROM of the left arm, PROM of both legs, and apply the left wrist hand orthoses ([WHO] material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures), five times per week. During a concurrent observation and interview on 9/30/2024 at 12:05 p.m. in the bedroom, Resident 43 was lying awake in bed and stated the nurse (unknown) did exercises (unspecified) this morning. Resident 43's left elbow was bent at 90 degrees with the left hand resting on Resident 43's abdomen. Resident 43's left hand was positioned in a closed fist and did not have an orthosis applied. Resident 43 stated she received exercises once per week. During an interview on 10/4/2024 at 3:05 p.m. with the Director of Nursing (DON), the DON stated she was unable to locate evidence that the findings from their last recertification survey regarding ROM and splint application were addressed during their QAA meetings. During an interview on 10/4/2024 at 5:27 p.m. with the DON, the DON stated the facility did not have evidence the QAA addressed the provision of ROM and RNA services from the last recertification survey. Cross reference F688 and F842.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observe infection control measures. The facility failed to : a.Ensure Resident 1 and 48's tube feeding (medical device used to provide nutrition to resident who cannot obtain nutrition by mouth) and water bags were changed every 24 hours. These failures had the potential to result in cross contamination and place the residents at risk for the spread of infection. b. To practice handwashing during wound care treatment on Resident 18 who had a Stage 4 pressure injury (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the sacro coccyx (tail bone) area. c. To ensure dirty linens were handled and disposed in a sanitary way after providing personal care for Resident 33 who was treated with antibiotic because of Extended spectrum beta lactamase ([ESBL]-an enzyme that makes bacteria resistant to many antibiotics {medication to treat infection} which makes the infection difficult to treat). d. To ensure Resident 33's intravenous heplock (IV catheter placed in a vein to administer medication or fluids into the bloodstream) site was assessed and dressing was changed. e. Ensure the door separating the soiled linen and clean linen was closed while placing soiled linen in the washing machine f. Ensure soiled disposable gowns (worn to provide a barrier of protection) were not hung on a hook near the clean linen area. g. Ensure three of four sampled residents (Residents 28,37,38,) shared care equipment was disinfected before and after each use. Resident 28's, blood pressure cuff, stethoscope (instrument that listens to the heart) and pulse oximeter (measures oxygen in the blood and heart rate), Resident 37's blood pressure cuff, stethoscope, and Resident 38's stethoscope. These failures had the potential to result in cross contamination and place the residents at risk for the spread of infection. h. Ensure facility have Legionella (bacteria found in natural occurring water) water management program. This failure had the potential for Legionella to grow and multiply and cause disease for resident who inhale the contaminated aerosol water. Findings: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (loss of blood flow to a part of the brain) and dysphagia (swallowing difficulties). During a review of Resident 48's care plan titled Impaired immunity initiated on 8/22/2024, the care plan goal indicated for Resident 48 to remain free of infection. The care plan interventions included monitoring, documenting, and reporting any signs and symptoms of infection and keeping the environment clean because Resident 48 was at risk for contracting infections due to impaired immune system (helps the body fight infections and other diseases). During a concurrent observation and interview on 9/30/2024, at 9:40 a.m., in Resident 48's room, Licensed Vocational Nurse (LVN) 4 verbally confirmed Resident 48's tube feeding water bag was dated 9/28/2024 and should have been changed. LVN 4 stated the tube feeding water bags were supposed to be changed every 24 hours. During an interview on 10/2/2024, at 3:37 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated tube feeding water bags were supposed to be changed every 24 hours to prevent infection. During an interview on 10/3/2024, at 11:30 a.m., with Infection Prevention Nurse (IPN), the IPN stated tube feeding water bags were changed every 24 hours and should not go more than 24 hours because it can place the residents at high risk for infection. During an interview on 10/4/2024, at 3:05 p.m., with the Director of Nursing (DON), the DON stated it was the responsibility of the licensed nurses to change the tube feeding water bags every 24 hours to prevent infection and to ensure the resident does not receive spoiled tube feeding nutrition. b. To practice handwashing during wound care treatment on Resident 18 who had a Stage 4 pressure injury (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the sacro coccyx (tail bone) area. c. To ensure dirty linens were handled and disposed in a sanitary way after providing personal care for Resident 33 who was treated with antibiotic because of Extended spectrum beta lactamase ([ESBL]-an enzyme that makes bacteria resistant to many antibiotics {medication to treat infection} which makes the infection difficult to treat). d. To ensure Resident 33's intravenous heplock (IV catheter placed in a vein to administer medication or fluids into the bloodstream) site was assessed and dressing was changed. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Stage 4 pressure ulcer of sacral region, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and autistic disorder(developmental disability that affects how people communicate, interact, learn, and behave). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Convalescent Hosp.	8558 East Rosecrans Avenue Paramount, CA 90723

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 18's History and Physical (H&P) dated 4/15/2024, the H&P indicated Resident 18 did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS- federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated the Resident 18 had moderately impaired cognitive skills for daily decision making, and required substantial assistance with eating, oral hygiene, dressing, toileting, personal hygiene, and bed mobility. The MDS indicated the resident had one unhealed Stage 4 pressure injury. During a review of Resident 18's Physician Order Summary Report dated 8/20/2024, the Physician Order Summary Report indicated an physician order for sacro coccyx : cleanse with normal saline (cleaning solution) , pat dry, apply collagen (medicine used for wound healing), pack with saline moistened hydrofera blue (sterile, absorbent, and moist foam dressing) dressing that provide and cover with foam dressing as needed for pressure ulcer if soiled or dislodged. During a review of Resident 18's Physician Order Summary Report dated 9/24/2024, the Physician Order Summary Report indicated ammonium lactate (skin cream used to dry skin and other skin conditions) cream to apply on both arms topically (used on the outside of the body) every day for xerosis (rough, dry skin that may have scales or small cracks) for four weeks. During a wound care dressing observation on 10/3/2024, at 9:36 a.m., in Resident 18's room with Treatment Nurse (TN 1) and Certified Nursing Assistant (CNA 7), TN 1 removed the soiled (dirty) dressings on the sacro coccyx area and changed gloves without performing hand hygiene. TN 1 applied medication and special dressing on the sacrococcyx wound and used the same gloves when TN 1 applied ammonium lactate cream on both arms of the resident. During an interview on 10/3/2024 at 10:24 a.m., with TN 1, TN 1 stated she should have done hand hygiene and not used the same gloves before applying the cream on Resident 18's arms. TN 1 stated hand hygiene should be practiced before entering the resident's room, in between the dressing change, each wound to prevent spread of infection. During an interview on 10/4/2024, at 11:18 a.m., with Infection Preventionist Nurse (IPN), IPN stated TN 1 should performed handwashing after removal of soiled dressing of the Stage 4 pressure injury and before applying the new wound dressing and not just changed gloves because this practice could cause cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread of infection. During an interview on 10/4/2024, at 3:11 p.m., with the Director of Nursing (DON), the DON stated hand hygiene should be practiced every time gloves were changed, after removal of old and soiled dressings to prevent spread of infection. During a review of facility's policies and procedures (P&P) titled Hand Hygiene revised 1/25/2024, the P&P indicated hand hygiene was indicated after handling contaminated objects, before and after handling clean or soiled dressings, when during resident care, moving from a contaminated body site to a clean site. The P& P indicated the use of gloves does not replace hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (long term condition where the kidneys gradually lose their ability to filter blood properly), ESBL, and bipolar disorder. During a review of Resident 33's H &P dated 5/10/2024, the H&P indicated Resident 33 had a capacity to understand and make decisions. During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 required substantial assistance (helper does more than half the effort) with bathing, toileting hygiene, dressing, and personal hygiene. During an observation on 10/3/2024, at 9:47 a.m., in Resident 33's room, observed CNA 2 carrying dirty linens on her arms and gloved hands after providing personal care to Resident 33. Observed the soiled linens were not placed on a plastic bag. CNA 2 called an unnamed staff to bring the hamper near Resident 33's room. During an interview on 10/3/2024, at 10:56 a.m., with CNA 2, CNA 2 stated dirty linens should be placed in a plastic bag before bringing them in the hamper. CNA 2 stated she wanted her job to be easy and quick because of other residents she needs to attend. CNA 2 stated she did not use a plastic bag to put the dirty linens from Resident 33's room. During an interview on 10/3/2024, at 11:06 a.m., with IPN, IPN stated dirty linens should be placed in a plastic bag and placed them in a hamper outside the door of the resident's room. IPN stated placing the soiled linens in a plastic bag will prevent cross contamination and spread of infection among the residents. During a review of facility's P&P titled Laundry reviewed and revised 1/25/2024, the P&P indicated linens should be bagged separately from resident's clothing at the point of use. The P&P indicated soiled linens shall be handled as little as possible with minimum agitation to avoid contamination of air, surfaces, and persons. d. During a review of Resident 33's Physician Order dated 9/17/2024, the Physician Order indicated an order of ertapenem sodium (antibiotic) injection one gram (gm- unit of measurement) intravenously one time a day for ESBL of urine for seven days. During a review of Resident 33's Physician Order dated 9/17/2024, the Physician Order indicated to change/restart IV as needed, change dressing with site change and as needed. The Physician Order indicated to check IV site for signs and symptoms of complications or adverse reactions from IV therapies every shift for 7 days. During an observation on 9/30/2024, at 10:12 a.m., in Resident 33's room, Resident 33 had an IV heplock on his right arm, site looked dirty, with transparent dressing dated 9/13/2024. Resident 33 stated he had told the staff to remove the heplock due to pain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and record review of Resident 33's picture of heplock on 10/2/2024, at 2:12 p.m., with LVN 2, LVN 2 stated the heplock dressing was dirty and had to be changed. LVN 2 stated she should have told Registered NS 1 Resident 33's heplock required assessment and change of dressing because the resident could have an infection on the IV heplock site. LVN 2 stated she forgot to report to RN Supervisor (RNS1). During an interview on 10/4/2024, at 11:25 a.m., with RNS 1, RNS 1 stated registered nurses (RN) were responsible in assessing IV heplock site. RNS 1 stated Resident 33 was on IV antibiotic when he came back from the hospital. RNS 1 stated she forgot to remove the heplock. RNS 1 stated not assessing and changing the dressing could lead to infection. During an interview on 10/4/ 2024, at 3:32 p.m. with the DON, the DON stated the IV heplock dressing should be changed and assessed. The DON stated RNs were responsible in monitoring and assessing IV sites and the practice in the facility was as soon as the resident was finished with the IV therapy, the heplock is discontinued to prevent infection in the iv site. During a review of facility P&P titled Peripheral Needleless Access Device Change dated 3/2023, the P&P indicated peripheral catheter are changed at the time of site rotation or at least every seven days and anytime the integrity of the needless device is questioned. During a review of facility's P&P titled Peripheral Catheter Dressing Change dated 3/2023, the P&P indicated to assess site for complications included redness, drainage, leakage, tenderness in the site. The P&P indicated transparent dressings are changed at least every seven days or if the integrity of the dressing is compromised (wet, soiled, and loose). e. During a concurrent observation and interview on 9/30/2024 at 8:29 a.m., in the clean linen room, Laundry Staff 1 (Laundry 1) was observed wearing a disposable gown and gloves to place soiled linen in the washing machine. A disposable gown was hanging on a hook, which was in the soiled linen area and directly next to the clean linen area. Laundry 1 closed the door dividing the clean linen room and soiled linen room. Laundry 1 stated the disposable gown hanging in the soiled linen area should be thrown away since it was dirty and was located close to the clean linen area. f.During a concurrent observation and interview on 10/2/2024 at 9:04 a.m., with the Infection Prevention Nurse (IPN) and Laundry Staff 2 (Laundry 2), the door between the clean linen and soiled linen room was locked. IPN stated the door between the soiled linen and clean linen rooms should be closed while placing soiled linen in the washing machine to prevent contamination of the clean linen. The IPN stated the disposable gowns used to handle soiled linen should not be hung in the soiled linen area because the gown was contaminated and can potentially contaminate the clean linens. During a review of the facility's policy and procedure (P&P) titled, Handling Soiled Linen, revised 1/25/2024, the P&P indicated transmission of pathogens (bacteria, viruses, and any microorganism causing disease) can occur through direct contact with linens or aerosols (tiny particles or droplets suspended in the air) generated from sorting and handling contaminated linen. The P&P indicated soiled linen shall be kept separate from clean linen. g.During an observation on 10/1/24 at 10:10 a.m., in Resident 37's room, Licensed Vocational Nurse (LVN 4), observed LVN 4 took Resident 37's blood pressure and did not disinfect the blood pressure cuff or stethoscope before or after using the shared care equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/1/24 at 11:10 a.m., in Resident 28's room, observed LVN 4 took Resident 28's blood pressure and did not disinfect the blood pressure cuff, or stethoscope before or after using the shared care equipment. LVN 4 also checked Resident 28's heart rate with a pulse oximeter and did not disinfect equipment before or after using it on Resident 28. During an observation on 10/1/24 at 12:15 p.m., in Resident 38's room observed LVN 4 checked for placement of Resident 38 gastrostomy tube ([g-tube] tube inserted through the abdomen into the stomach) and did not disinfect the stethoscope before or after using the shared care equipment on Resident 38. During a review of Resident 37' s Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hypertensive heart disease without heart failure, cerebral infarction (disrupted blood flow to the brain), and depression (a low mood or loss of pleasure or interest in activities for long periods of time). During a review of Resident 37's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 9/25/2024, the MDS indicated Resident 37 had intact cognitive (ability to think, understand, learn, and remember) skills in daily decision making. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with the diagnoses including acute and chronic respiratory failure (a long-term condition that makes it difficult for the body to exchange oxygen and carbon dioxide [gas]), pulmonary hypertension (the heart work harder than normal to pump blood into the lungs) , hypertensive heart disease (heart problems that occur because of high blood pressure), epilepsy (disorder in which nerve cell activity in the brain is disturbed causing, seizures), diabetes mellitus type 2, (the body has trouble controlling blood sugar), diabetic neuropathy (nerve damage caused from diabetes), dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 28's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/17/2024, the MDS indicated Resident 28's cognitive (ability to think, understand, learn, and remember) skills are moderately impaired with fluctuating (comes and goes) capacity. During a review of Resident 28's History and Physical (H&P) dated 5/14/2024 indicated Resident 28 has fluctuating capacity to understand and make decisions. During a review of Resident 38's Admission Record dated 10/3/ 2024, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including gastrostomy (tube inserted in the stomach to assist with feeding), hypertensive heart disease (heart problems that occur because of high blood pressure), depression (a low mood or loss of pleasure or interest in activities for long periods of time) type 2 diabetes mellitus (the body has trouble controlling blood sugar), and dementia (loss of cognitive functioning, thinking, and remembering). During a review of Resident 38's MDS dated [DATE] indicated Resident 28 had severe impairment in cognitive skills. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 38's History and Physical (H&P) dated 8/15/2024 indicated Resident 38 was alert and orientated to self and unable to make decisions for self. During an interview on 10/1/24 at 3:15 p.m., with LVN 4, LVN 4 stated, he did not disinfect the blood pressure cuff, stethoscope, or pulse oximetry, before or after using the shared resident's care equipment for Resident's 28, 37, and 38. LVN 4 stated he should have disinfected Resident 28,37, and 38's shared care equipment before and after using it. LVN 4 stated Residents 28,37, and 38 were at risk for infection due to cross contamination. During an interview on 10/2/24 at 2:38 p.m. with Infection Preventionist Nurse (IPN), IPN stated all shared resident care equipment (blood pressure cuff, stethoscope, and pulse oximetry] needs to be disinfected before and after using them on residents. IPN stated without properly disinfecting shared care equipment residents (in general) were at risk for infection due to cross contamination. During an interview 10/2/24 at 10:09 a.m. the Director of Nursing (DON), the DON, stated all shared care equipment blood pressure cuff, stethoscope and pulse oximetry are to be disinfected before and after using them on the residents. The DON stated residents were at risk for infection when shared care equipment was not disinfected properly. During a review of the facility's policy and procedure titled Cleaning and Disinfection of Residents-Care Equipment dated 1/25/2024, indicated Resident -care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations in order to break the chain of infection. Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non- critical equipment. Each user is responsible for routine cleaning and disinfection of multi- use items after each use, particularly before use for another resident. Use only Environment Protection Agency ([EPA]) registered disinfectants with kill claims for the common organisms found in the facility. If the equipment is exposed to residents on transmission-based precautions, verify the disinfectants are registered for use with the relevant organism. h.During a concurrent interview and record review on 10/02/24 at 3:47 p.m., with Maintenance Supervisor (MS), reviewed facility's Legionella Water Management Program dated 1/5/2024, the Legionella Water Management Program indicated, that water samples are collected to be tested by a certified, CDC- approved laboratory. MS stated the facility was not testing the water for legionella. The MS stated we do not have a Legionella water management program in place. The MS stated residents can get sick and die from Legionella. During an interview on 10/3/24 at 11:30 a.m. with Administrator (ADM), ADM stated, the facility has no plan in place to check for legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent phone interview and record review on 10/3/24 at 4:22 p.m. with Facility Consultant (FC), reviewed the facility's Legionella Water Management Program dated 1/5/ 2024, the FC stated the Legionella water management program prepared for the facility was a sample and that no assessment or testing of the facilities water system was completed. FC stated residents who inhale aerosol water infected with Legionella could get Legionnaires disease (type of pneumonia) which was associated with high mortality (death) rates for residents with co- morbidities (two or more diseases or medical conditions). During a review of the facility's policy and procedure (P&P) titled, Legionella Surveillance dated 12/19/2022, indicated the facility is to establish primary and secondary strategies for the prevention and control of Legionella infections. Primary prevention strategies: a. Diagnostic testing 1.Investigation for a facility source of Legionella, which may include culturing of facility water for Legionella: Physical Controls: Cooling towers and potable water systems shall be routinely maintained. 11. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. iii. non-potable water systems shall be routinely cleaned and disinfected. Iv. Nebulization devices shall be filled only with sterile fluid (e.g., sterile water or aerosol medication). Temperature controls: Cold water shall be stored and distributed below 68 F. Hot water shall be stored above 140 F and circulated at a minimum return temperature of 124 F. 36943 45269 49889

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure the wall in one of 19 rooms (Room A) was properly maintained without any holes. This failure had the potential to expose one of 52 residents (Resident 27) to hazards located in the walls, including water, fire, and pests. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including morbid obesity (condition where a person has an extremely high amount of body fat which can lead to serious health problems), hypertensive heart disease (condition where the heart has to work harder than normal because of high blood pressure), congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), and reduced mobility (ability to move). During a review of Resident 27's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/29/2024, the MDS indicated Resident 27 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 27 required supervision for eating, substantial/maximal assistance (helper does more than half the effort) for upper body dressing, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for toileting, lower body dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. During a concurrent observation and interview on 10/1/2024 at 11:48 a.m. in Resident 27's room, observed Resident 27 lying awake in bed and stated the bed was uncomfortable. There was a silver-colored horizontal bar attached to the wall directly behind Resident 27's bed. There was a hole through the drywall on the right side of the horizontal bar. During an observation on 10/2/2024 at 9:50 a.m., in Resident 27's bedroom, the horizontal bar continued to be attached to the wall directly behind Resident 27's bed. The wall continued to have a hole through the drywall. During a review of the Maintenance Log for Nursing Station 1 and Nursing Station 2 from 9/2024 to 10/2024, the Maintenance Log did not include the hole in the drywall behind Resident 27's bed. During a concurrent observation and interview on 10/2/2024 at 4:54 p.m. with the Maintenance Supervisor (MS) in Resident 27's bedroom, the MS observed the wall behind Resident 27's bed. The MS stated the silver-colored horizontal bar attached to the wall prevented Resident 27's bed from hitting the wall. The MS observed the hole in the drywall and stated it was not reported to the maintenance staff. The MS stated water, fire, and pests could potentially penetrate the hole and enter Resident 27's room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 8:36 a.m., the MS stated the maintenance staff performed room rounds daily but no one reported the hole in Resident 27's wall in the facility's Maintenance Log. During a review of the facility's policy and procedure (P&P) titled, Preventative Maintenance Program, the P&P indicated the Maintenance Director was Responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.