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	12/05/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement proper infection control practices for all residents in the facility by failing to:1. To ensure Resident 27 was on Enhanced Barrier Precautions (EBP-infection control measure to prevent the spread of germs), for a chronic pressure injury (PI- injury to skin and underlying tissue resulting from prolonged pressure on the skin).2. To ensure hand hygiene was performed prior to checking the residents' lunch meal trays.These failures had the potential to spread germs through 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) to residents, staff and visitors.Findings:1. During an observation on 12/04/2025 at 9:10 a.m. in Resident 27's room. There was no sign or personal protective equipment (PPE) alerting staff Resident 27 should be on EBP. The treatment nurse (TXN) was observed doing a wound care dressing change and was observed not wearing any personal protective equipment.During a review of Resident 27's admission Record (face sheet) dated 12/4/2025, the admission record indicated Resident 27 was admitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), sick sinus syndrome (abnormal heart rhythms) and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 27's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 27 had fluctuating capacity to understand and make decisions.During a review of Resident 27's Minimum Data Set (MDS)- a standardized assessment and care screening tool), the MDS indicated Resident 27 cognition was intact. The MDS also indicated Resident 27 needed substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 27's Physician Order dated 9/18/2025, the physician order indicated Resident 27 had a sacrococcyx (triangle bone at the bottom of your spine) PI, to clean with normal saline (NS) pat dry apply collagen powder (promotes wound bed healing) and calcium alginate (absorbent wound dressing used for heavy drainage) cover with super absorbent dressing every day, for pressure injury.During an interview on 12/04/2025 at 4:19 p.m. with the TXN, the TXN stated Resident 27 does have a chronic wound on her sacrococcyx and should have been on EBP. The TXN stated there was a risk of transferring bacteria from her clothing to Resident 27's open wound.2. During an observation on 12/02/2025 at 12:09 p.m. in the hallway near the dining room. The IP nurse was observed not washing her hands prior to checking the resident's meal trays.During an interview on 12/04/2025 at 4:24 p.m. with the IP nurse. The IP nurse stated Resident 27 should have been on EBP because Resident 27 had a chronic wound on her sacrococcyx. The IP stated there was a possibility for the staff to spread infection through cross contamination. The IP also stated she should have washed her hands prior to checking the resident's meal trays to ensure there would be no cross contamination from her hands to the resident's meal tray.During an interview on 12/05/2025 at 10:54 a.m. with the Director of Nurses (DON), the DON stated Resident 27 does have a chronic wound on her sacrococcyx and should have been on EBP, to help prevent the spread of infection through cross contamination. The DON stated the (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	IP should have done hand hygiene prior to checking the meal trays to ensure the food the residents are being served is clean.During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 12/19/2022 the P&P indicated, it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves during high contact resident care activities. EBP are indicated for residents with wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and even if the resident is not known to be infected or colonized with a MDRO. The P&P indicated to:a. Make gowns and gloves available prior to performing tasks. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.During a review of the facility's policy and procedure titled, Hand Hygiene dated 12/19/2022 the P&P indicated, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, between resident contacts and before performing.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe discharge and transfer for four of four residents (Resident 3, Resident 27, Resident 29 and Resident 51) by failing to:1. Ensure the Long Term Care (LTC) Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) was notified when Resident 3, Resident's 27 and Resident 29 were transferred to the General Acute Care Hospital (GACH).2. Ensure Resident 3, Resident 27 and Resident 51 were offered a bed hold before being transferred to the GACH.These failures violated Resident 3, Resident 27, Resident 29 and Resident 51's rights and had the potential to affect Resident 3, Resident 27 and Resident 51's emotional wellbeing if they could not return to the facility.Findings: A. During a review of Resident's 3 admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 6/12/2025, and was readmitted on [DATE] with diagnoses including encephalopathy (disorder affecting brain function or structure), chronic kidney disease (long-lasting condition where the kidneys slowly stop working), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic pulmonary edema (long-term condition where extra fluid builds up in the lungs). During a review of Resident 3's History and Physical (H&P) dated 11/13/2025, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a concurrent interview and record review on 12/03/2025 at 1:43 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 reviewed Resident 3's medical record and stated Resident 3 was transferred to a hospital on [DATE] due to a low hemoglobin (a protein inside red blood cells that carries oxygen) low blood test of 5.6 grams (gm, unit of measurement) per deciliter (dL, unit of measurement). LVN 3 stated she was unable to locate a bed hold form in the medical record. LVN 3 stated the responsibility for ensuring a bed hold form was completed was the nurse discharging the resident. LVN 3 stated a bed hold was a resident right and the resident or responsible party (RP) may have uncertainty regarding their ability to return to their room and maintain continuity of care. During a concurrent interview and record review on 12/4/2025 at 8:30 a.m. with Registered Nurse (RN) 3, RN 3 reviewed Resident 3's medical record and stated there was no bed hold form completed for Resident 3. RN 3 stated the discharge nurse was responsible for completing the required bed hold form on 11/25/2025 at the time of Resident 3's transfer. RN 3 stated providing a written bed-hold notice was important to inform Resident 3 and the RP of their rights and expectations regarding Resident 3's ability to return to their bed following hospitalization. During a record review of the facility's policy and procedure (P&P) titled, Bed Hold Prior to Transfer, dated 3/10/2025, indicated .The facility will have policies that address holding the resident's bed during periods of absence, such as during hospitalization. B. During a review of Resident's 3 admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 6/12/2025 and was readmitted on [DATE] with diagnoses including encephalopathy (disorder affecting brain function or structure), chronic kidney disease (long-lasting condition where the kidneys slowly stop working), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic pulmonary edema (long-term condition where extra fluid builds up in the lungs). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's History and Physical (H&P) dated 11/13/2025, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a concurrent interview and record review on 12/03/2025 at 1:43 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 reviewed Resident 3's medical chart and stated Resident 3 was transferred to the hospital on [DATE] due to a low hemoglobin (Hgb- a protein inside red blood cells that carries oxygen). LVN 3 stated there was no documentation the Ombudsman was notified of Resident 3's transfer. LVN 3 stated the Social Services Director (SSD) was responsible for notifying the Ombudsman when residents are transferred to hospitals or other facilities. LVN 3 stated notifying the Ombudsman was a required resident-right protection. During a concurrent interview and record review on 12/4/2025 at 8:09 a.m. with the SSD regarding LTC Ombudsman notification, the SSD stated she overlooked notifying the Ombudsman when Resident 3 was discharged from the facility on 11/25/2025. The SSD stated her role included sending discharge notifications to the Ombudsman and stated the Ombudsman's role was to provide advocacy for residents as part of required resident rights. During a concurrent interview and record review on 12/4/2025 at 4:17 p.m. with the Director of Nursing (DON), the DON reviewed Resident 3's discharge on [DATE] in the medical record. The DON stated Resident 3 was transferred due to the hospital due to a low Hgb level. The DON stated the Ombudsman was not notified at the time of Resident 3's transfer and that notifying the Ombudsman was necessary to inform them of the resident's location and to allow the Ombudsman to follow up with the resident, as they serve as advocates for residents. During a record review of the facility's policy and procedure (P&P) titled, Transfer and Discharge (including AMA), dated 12/19/2022, indicated .Exceptions to the 30-day requirement apply when the transfer or discharge is effected because.An immediate transfer or discharge is required by the resident's urgent medical needs;.In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, the LTC ombudsman as soon as practicable before transfer or discharge. C. During a review of Resident 27's admission Record (face sheet) dated 12/4/2025, the admission record indicated Resident 27 was admitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), sick sinus syndrome (abnormal heart rhythms) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 27's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS- a standardized assessment and care screening tool), the MDS indicated Resident 27's cognition was intact. The MDS also indicated Resident 27 needed substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of the facility's Census List dated 12/5/2025, the census list indicated Resident 27 was transferred to GACH on 9/13/2025 and readmitted back to the facility on 9/15/2025. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. During a review of Resident 29's admission Record dated 12/4/2025, the admission record indicated Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including chronic obstruction pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 29's H&P dated 9/9/2025, the H&P indicated Resident 29 had the capacity to understand and make decisions. During a review of Resident 29's MDS, the MDS indicated Resident 29's cognition was intact. The MDS also indicated Resident 29 needed substantial/maximal assistance with ADLs such as toileting, showering and putting on and dressing. During a review of the facility's Census List dated 12/5/2025, the census list indicated Resident 29 was transferred to GACH on, 1. 9/30/2025 and readmitted back to the facility on [DATE] 2. 10/06/2025 and readmitted back to the facility on [DATE]. 3. 10/27/2025 and readmitted back to the facility on [DATE]. E. During a review of Resident 51's admission Record dated 12/4/2025, the admission record indicated Resident 51 was admitted to the facility on [DATE] with diagnosis including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities) and hyperlipidemia (having too many fats in the blood). During a review of Resident 51's H&P dated 12/2024, the H&P indicated Resident 29 does not have the capacity to understand and make decisions. During a review of Resident 51's MDS, the MDS indicated Resident 51's cognition was severely impaired. The MDS also indicated Resident 51 was totally dependent (helper does all the work) with ADLs such as toileting, showering and dressing. During a review of the facility's Census List dated 12/5/2025, the census list indicated Resident 51 was transferred to GACH on 6/23/2025 and readmitted back to the facility on 6/26/2025. During a concurrent interview and record review on 12/4/2025 at 7:11 a.m. with the Social Services Director (SSD), Resident 27 and Resident 29's GACH transfers were reviewed. The SSD stated she was responsible for letting the Ombudsman know when a resident was transferred to the GACH. The SSD stated Resident 27 was transferred to the hospital on 9/13/2025, and Resident 29 was transferred to the GACH on 10/06/2025 and 10/17/2025. The SSD stated the Ombudsman was not notified of Resident 27 or Resident 29's transfers to the GACH. The SSD stated she should have notified the Ombudsman because the Ombudsman is the residents advocate and can ensure the residents transfer to the GACH was appropriate. During a concurrent interview and record review on 12/4/2025 at 11:16 a.m. with Registered Nurse 3 (RN3), RN3 stated bed holds are done when residents are transferred to the GACH. RN 3 stated Resident 29 was transferred to GACH on 10/6/2025 and 10/17/2025, Resident 51 was transferred to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the GACH on 6/23/2025 and no bed hold notice was offered to either Resident 29 or Resident 51. RN 3 stated bed holds are done to inform residents that they have a safe place to return to the facility. RN 3 stated that the residents should not worry about not having a place to come back to and should be focused on getting better. During an interview on 12/05/2025 at 10:54 a.m. with the Director of Nurses (DON), the DON stated she was aware that when Resident 27 and Resident 29 were transferred to GACH, the Ombudsman was not notified. The DON stated the Ombudsman is the advocate for the residents and should have been notified to ensure the transfers were appropriate and safe. The DON stated she was also aware that Resident 29 and Resident 51 were not offered a bed hold notice when transferred to the GACH and that they should have been offered one. The DON stated it could affect the residents' emotional well-being when not knowing if they will have a place to return to. During a review of the facility's Policy and Procedure (P&P) titled, Bed Hold Prior To Transfer dated 03/10/2025, the P&P indicated it is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. During a review of the facility's P&P titled, Transfer and discharge dated 12/19/2022, the P&P indicated, this facility will permit each resident to remain in the facility and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The P&P indicated that in these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge. The P&P indicated the facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to:1.Complete a change of condition ([COC] 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) for three of four sampled residents (Resident 2, Resident 7, and Resident 13). 2.Review Resident 2's general acute care hospital (GACH) notes during the admission Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meeting. These failures resulted in the lack of necessary care and treatment related to antibiotic use for Resident 2, Resident 7, and Resident 13. Findings:1.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease (your kidneys are damaged and slowly lose their ability to clean waste from your blood), urinary tract infections (UTI- an infection of the bladder/urinary tract), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/17/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of metronidazole (antibiotic used to treat a variety of infections caused by bacteria) 500 milligrams (mg- unit of measurement), via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every eight hours for Helicobacter pylori (H. Pylori- stomach infection) prophylaxis (preventative care to stop disease before it starts) with a stop date to follow.During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of tetracycline (antibiotic-medication to treat infection) 250 mg via gastrostomy tube every 12 hours for H. Pylori prophylaxis with a stop date to follow. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental disorder in which people interpret reality abnormally), hypertension (HTN- high blood pressure), and traumatic brain injury (TBI- serious medical issue that affects how your brain works).During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognition was severely impaired and Resident 7's was dependent (helper does all the effort) with ADLs. During a review of Resident 7's Order Details dated 11/15/2025, the Order Details indicated an order for azithromycin (antibiotic-medication to treat infection) 250 mg, two tablets once followed by one tablet for four days for a respiratory infection for four days.During a review of Resident 7's Nursing Progress Note dated 11/18/2025 at 3:04 p.m., the Nursing Progress Note indicated a note to continue monitoring for cough. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and HTN. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13's cognition was intact, and Resident 13 required maximal assistance with ADLs. During a review of Resident 13's Order Details dated 11/20/2025, the Order Details indicated an order for Ertapenem Sodium (antibiotic-medication to treat infection) 1 gram (g- unit of measurement) for seven days.During a concurrent interview and record review on 12/4/2025 at 7:30 a.m., with the Infection Prevention Nurse (IPN), the IPN stated no COC documentation was completed for Resident 2, Resident 7, or Resident 13 in relation to their antibiotic therapy. The IPN stated COC's should be (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiated when an antibiotic was ordered and when a resident was admitted to the facility on antibiotics to ensure staff are monitoring the resident. During an interview on 12/5/2025 at 10:52 a.m. with the Director of Nursing (DON), the DON stated a COC should be documented whenever an antibiotic was initiated for a resident. The DON stated COC documentation was essential to ensure staff were aware of the residents' change in condition and were actively monitoring and addressing their care needs. The DON stated failure to document a COC could result in inadequate follow up and compromised resident care. During a review of the facility's policy and procedure (P&P) titled, Notification of Changes, dated 12/19/2022, the P&P indicated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician when there is a change requiring notification. Need to alter treatment significantly- commence a new treatment to deal with a problem. Circumstances that require a need to alter treatment includes a new treatment.During a review of the facility's Registered Nurse Job Description dated 2023, the Registered Nurse Job Description indicated, Observes for changes in the residents' status and documentsu accordingly. 2.During an interview on 12/4/2025 at 4:37 p.m., with Registered Nurse Supervisor (RNS) 4, RNS 4 stated the IDT was responsible for reviewing all admission documents during the resident's IDT admission meeting. During an interview on 12/5/2025 at 7:20 a.m., with the IPN, the IPN stated there should have been an IDT meeting regarding Resident 2's antibiotics upon admission. The IPN stated Resident 2 was at high risk for side effects and the development of multidrug resistant infections (MDROs- are microorganisms that have developed resistance to multiple classes of antibiotics).During an interview on 12/5/2025 at 10:52 a.m., with the DON, the DON stated upon a resident's admission, the Interdisciplinary Team (IDT) holds a meeting to review the resident's documentation. The DON indicated the IDT should have reviewed Resident 2's hospital discharge records to ensure the accuracy of medication orders and to prevent potential medication errors. The DON stated reviewing hospital discharge documents was essential for providing appropriate care and ensuring resident safety.During a review of the facility's P&P titled, admission of a Resident, dated 3/10/2025, the P&P indicated, The admission process is intended to obtain all possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. The admission process has several phases including review all available transfer information.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 2 and 27) drug regimen was free from unnecessary medications by failing to: 1. Include a stop date for prescribed antibiotics, and by failing to reassess the continued need for the medications for Resident 2. 2. Ensure Resident 27 was not overprescribed antibiotics. This deficient practice resulted in Resident 2 receiving prolonged antibiotic therapy without appropriate monitoring or clinical justification, increasing the risk of adverse drug effects (unwanted, harmful, or unexpected problem as a result of a medicine) and had the potential for Resident 27 to develop multi-drug-resistant organisms (MDROs- bacteria resistant to multiple antibiotics.)Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease (your kidneys are damaged and slowly lose their ability to clean waste from your blood), urinary tract infections (UTI- an infection of the bladder/urinary tract), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/17/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of metronidazole (antibiotic used to treat a variety of infections caused by bacteria) 500 milligrams (mg- unit of measurement), via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every eight hours for Helicobacter pylori (H. Pylori- stomach infection) prophylaxis (preventative care to stop disease before it starts) with a stop date to follow. During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of tetracycline (antibiotic used to treat a variety of infections caused by bacteria) 250 mg via gastrostomy tube every 12 hours for H. Pylori prophylaxis with a stop date to follow. During an interview on 12/4/2025 at 2:00 p.m., with the Infection Prevention Nurse (IPN) and the Director of Nursing (DON), the IPN stated there was no stop date for the metronidazole and tetracycline but could not tell me why there should be a stop date. The IPN unable to answer when asked about the potential harm of Resident 2's prolonged antibiotic usage. The DON stated Resident 2's order for antibiotics should have had a stop date because long term usage could lead to kidney problems, the development of multidrug resistant infections (MDROs- are microorganisms that have developed resistance to multiple classes of antibiotics) or clostridium difficile (C-diff- a highly contagious bacteria that causes severe diarrhea). During a phone interview on 12/4/2025 at 4:08 p.m., with the Pharmacy Consultant (PC), the PC stated all antibiotic orders should have a stop date. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program dated 12/19/2022, the P&P indicated, All prescriptions for antibiotics shall specify the dose, duration, (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and indication for use. 2. During a review of Resident 27's admission Record (face sheet) dated 12/4/2025, the admission record indicated Resident 27 was admitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), sick sinus syndrome (abnormal heart rhythms) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 27's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set(MDS)- a standardized assessment and care screening tool), the MDS indicated Resident 27 cognition was intact. The MDS also indicated Resident 27 needed substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 27's Order Listing Report dated 12/04/2025, the order listing report indicated Resident 27 was prescribed the following antibiotics: 1. Daptomycin (antibiotic) 500 milligrams (mg- unit of measure) with a start date of 9/08/2025 for 14 days for bacteremia (bacteria in the blood). 2. Ertapenem (antibiotic) one gram (gm-unit of measure) with a start date of 9/16/2025 for 14 days for a Urinary tract infection (UTI- an infection in the bladder/urinary tract). 3. Meropenem (antibiotic) one gram every 12 hours with a start date of10/01/2025 for a UTI. 4. Metronidazole (antibiotic) 500 mg, three times a day (TID) for five days, with a start date of 10/26/25 for foul smelling discharge (abnormal body fluid). 5. Ceftriaxone (antibiotic) one gram, one time a day for seven days, with a start of date10/26/2025 for UTI. 6. Cephalexin (antibiotic) 500 mg TID for five days, with a start date of 10/31/2025 for UTI. 7. Bactrim DS (antibiotic) 888-160 mg's two times a day for five days, with a start date for 11/21/2025 for UTI. During a concurrent interview and record review on 12/03/2025 at 11:35 a.m. with the Infection Preventionist Nurse (IPN), Resident 27's antibiotic use from 9/8/2025 – 12/1/2025 was reviewed. The IPN stated Resident 27 had been on seven different antibiotics and that she had not discussed it with anyone in the facility. The IPN stated she should have discussed it because Resident 27 was at risk for overuse of antibiotics. During an interview on 12/05/2025 at 10:54 a.m. with the Director of Nurses (DON), the DON stated she was made aware that Resident 27 had been on seven different antibiotics since admission to the facility this past September 2025. The DON stated Resident 27 should have had an Interdisciplinary Team Meeting ([IDT] team members from different departments working together with a common (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	purpose to set goals and make decisions that ensure residents receive the best care), to discuss Resident 27's multiple use of antibiotics, to ensure Resident 27 was not over prescribed antibiotics. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program dated 12/19/2022 the P&P indicated, it is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The P&P indicated the purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The P&P indicated the Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. The P&P indicated the program includes antibiotic use protocols and a system to monitor antibiotic use. The P&P indicated 1. Nursing staff shall assess residents who are suspected of having an infection and complete an SBAR form prior to notifying the physician. 2. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. 3. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. 4. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. 5. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out). 6. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. 7. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness

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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. Based on observation, interview and record review, the facility failed to ensure infection control practices in the kitchen were followed by failing to ensure the [NAME] and Dietary Aid washed hands and changed gloves when switching tasks during tray line (process where staff assemble meal trays for residents).These deficient practices had the potential to place residents at risk for acquiring food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria or viruses). Findings: During a kitchen observation on 12/4/2025, at 11:32 a.m., the [NAME] was observed engaging in multiple food service tasks without performing appropriate hand hygiene or changing gloves between activities. Specifically, The [NAME] transitioned from checking food temperatures to scooping beef onto plates without washing hands or changing gloves. The [NAME] walked to the dishwashing area to retrieve a dish and returned to the food preparation area without performing hand hygiene or changing gloves. The [NAME] was also observed opening drawers and then immediately scooping food onto plates, again without washing hands or changing gloves.During an observation on 12/4/2025 at 11:45 a.m., the Dietary Aid (DA) was observed switching tasks from transferring plated meals onto food cart to filling up hot water dispensers. The DA was observed removing used gloves and putting on a new pair of gloves without washing hands. The DA was observed switching tasks from placing food trays on cart to assisting the Dietary Supervisor (DS) with dessert. The DA was observed removing used gloves and putting on a new pair of gloves without washing hands. During an interview on 12/4/2025 at 1:13 p.m. with the Cook, the [NAME] stated, per facility policy staff should wash hands and change gloves every time a new task is performed. The [NAME] stated she should have washed her hands and changed gloves when switching tasks and that failure to do so places residents at risk of acquiring food-borne illnesses.During an interview on 12/4/2025 at 1:20 p.m. with the DA, the DA stated, per facility policy staff should wash hands every time gloves are changed. The DA stated staff should wash hands and change gloves every time a new task is performed. The DA stated she should have washed her hands every time she changed gloves and that failure to do so places residents at risk of acquiring food-borne illnesses. During an interview on 12/4/2025 at 1:30 p.m. with the DS, the DS stated, dietary staff should wash their hands every time gloves are changed and before starting a new task. The DS stated failure to wash hands and change gloves during tray line can result in cross contamination and places residents at risk of acquiring infectionDuring a review of facility policy and procedure (P&P) titled Handwashing Guidelines for Dietary Employees dated 12/19/2022, indicated Dietary employees shall clean their hands and exposed portions of their arms.Before donning gloves for working with food, after engaging in any activity that may contaminate the hands.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinicians) including the use of McGeer's Criteria (standardized surveillance definitions to identify and track infections for prevention and control) for three of six residents (Resident 2, Resident 25, and Resident 27).This failure placed the Resident 2, Resident 25 and Resident 27 at risk for unnecessary antimicrobial therapy, adverse drug reactions, and the development of antimicrobial resistance. Findings: A. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease (your kidneys are damaged and slowly lose their ability to clean waste from your blood), urinary tract infections (UTI- an infection of the bladder/urinary tract), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/17/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of metronidazole (antibiotic used to treat a variety of infections caused by bacteria) 500 milligrams (mg- unit of measurement), via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every eight hours for Helicobacter pylori (H. Pylori- stomach infection) prophylaxis (preventative care to stop disease before it starts) with a stop date to follow. During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of tetracycline (antibiotic-medication to treat infection) 250 mg via gastrostomy tube every 12 hours for H. Pylori prophylaxis with a stop date to follow. During a review of Resident 2's general acute care hospital (GACH) Discharge Note dated 10/6/2025, the GACH Discharge Note indicated for the treatment of Helicobacter pylori (H. Pylori- stomach infection) continue metronidazole (antibiotic used to treat a variety of infections caused by bacteria) and tetracycline (antibiotic used to treat a variety of infections caused by bacteria) for a duration of 14 days. Confirmation of eradication should be conducted at least four weeks after completing the antibiotic regimen. During a concurrent interview and record review on 12/4/2025 at 2:00 p.m., with the Infection Prevention Nurse (IPN) and the Director of Nursing (DON), the IPN stated that because the antibiotics were prescribed prophylactically, she did not believe they needed to be included in the facility's antibiotic stewardship program (refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use). The Director of Nursing (DON) stated that the IPN should have assessed the appropriateness of Resident 2's antibiotic regimen upon admission, as prolonged use could lead to kidney complications, the development of multidrug-resistant organisms (MDROs—microorganisms resistant to multiple classes of antibiotics), or Clostridium difficile (C. diff—a highly contagious bacterium that (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	causes severe diarrhea). B. During a review of Resident 25's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/12/2025 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage), hypertension (HTN-high blood pressure), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 25's History and Physical (H&P) dated 11/13/2025, the H&P indicated Resident 25 has fluctuating capacity to understand and make decisions. During a record review on 12/4/2025 at 7:35 a.m. of Resident 25's medication administration records [(MAR) a daily documentation of record used by a licensed nurse to document medication treatments given to a resident], the MAR indicated a physician's order dated on 11/13/2025 at 9:00 a.m., to administer Levofloxacin 500 milligram (mg, unit of measurement), give one tablet by mouth in the morning for UTI for 7 days. During a concurrent interview and record review on 12/4/2025 at 7:55 a.m. with the Infection Preventionist (IP), the IP reviewed the Antibiotic Stewardship Surveillance form and McGeer's criteria for Resident 25. The IP stated she did not review Resident 25's progress notes to assess whether Resident 25 met McGeer's criteria for a UTI prior to completing the surveillance form. The IP stated Resident 25's symptoms from the progress notes were not documented, and corresponding progress notes did not match the required clinical indicators for McGeer's criteria. The IP stated not reviewing Resident's chart and symptoms before completing the Antibiotic Stewardship Surveillance form may place residents at risk of receiving antibiotics without clinical justification. The IP stated accurate symptom documentation was necessary to determine whether a resident meets clinical criteria to reduce unnecessary antibiotic exposure. During a concurrent interview and record review on 12/4/2025 at 4:45 p.m. with the Director of Nursing (DON), the DON reviewed Resident 25's Antibiotic Stewardship Surveillance form and progress notes. The DON stated the IP did not review Resident 25's documented symptoms prior to completing the surveillance form. The DON stated the progress notes did not match the required clinical indicators for McGeer's criteria. The DON stated by not accurately documenting symptoms would be treated with antibiotics not meeting McGeer's criteria and exposing residents to potential medication side effects and antibiotic overuse. During a record review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated 12/19/2022, indicated Infection Preventionist – coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff.The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria) to define infections.Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to: .Data collection forms for antibiotic use, process, and outcomes measures. C. During a review of Resident 27's admission Record (face sheet) dated 12/4/2025, the admission record indicated Resident 27 was admitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), sick sinus syndrome (abnormal heart rhythms) and anemia (a condition where the body does not have enough healthy red blood cells). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS)- a standardized assessment and care screening tool), the MDS indicated Resident 27 cognition was intact. The MDS also indicated Resident 27 needed substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 27's Order Listing Report dated 12/04/2025, the order listing report indicated Resident 27 was prescribed metronidazole (antibiotic) 500 mg three times a day (TID) for five days for foul smelling discharge (abnormal body fluid) on 10/25/2025 and Cephalexin (antibiotic) 500 mg TID for five days for urinary tract infection ((UTI- an infection in the bladder/urinary tract). During a concurrent interview and record review on 12/03/2025 at 11:35 a.m. with the Infection Preventionist (IP) Resident 27's antibiotic use from 9/8/2025 – 12/1/2025 was reviewed. The IP stated the facility used the McGeer's Criteria (assessment tool used to help define a true infection) to ensure that residents are not over prescribed antibiotics. The IP stated Resident 27 was prescribed metronidazole 500 mg three times a day (TID) for five days, on 10/25/2025 and Cephalexin 500 mg TID for five days on10/31/2025 and that no McGeer's criteria assessment was found. The IP stated there should have been an assessment done to ensure that Resident 27 met the criteria to be started on antibiotics. The IP stated that Resident 27 was at risk for multi-drug resident organisms (MDRO – germs that have become resistant to multiple antibiotics) when being over prescribed antibiotics. During an interview on 12/05/2025 at 10:54 a.m. with the Director of Nurses (DON), the DON stated the McGeer's Criteria should have been completed by the IP nurse when Resident 27 was started on the metronidazole and the Cephalexin to ensure Resident 27 meet the criteria of a true infection to be placed on antibiotics. The DON stated Resident 27 was at risk of becoming resistant to antibiotics if over prescribed. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated 12/19/2022, the P&P indicated, It is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The Infection Preventionist coordinates all antibiotic stewardship activities, maintains documentation, and serves as a source for all clinical staff. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a significant weight loss (a weight loss greater than 5% in one month, or 10% change in weight in six months) following readmission from General Acute Care Hospital (GACH) stay for one of four sampled residents (Resident 53).This deficient practice had the potential to delay the Physician's assessment and intervention, placing Resident 53 at risk for continued weight loss and malnutrition. Findings:During a review of Resident 53's admission Record (face sheet), the admission Record indicated the facility admitted Resident 53 on 9/23/2025 and was readmitted on [DATE] with diagnoses including atrial fibrillation (an irregular and often rapid heartbeat caused by abnormal electrical signals in the hearts upper chambers), gastroesophageal reflux disease (GERD- a chronic condition where stomach acid frequently flows back up into the esophagus), and dysphagia (difficulty swallowing). During a review of Resident 53's History and Physical (H&P) dated 11/7/2025, the H&P indicated the resident had the capacity to understand and make decisions.During a review of Resident 53's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 53 had severely impaired cognition (ability to think and understand). The MDS indicated Resident 53 was dependent on staff for toileting, dressing and required substantial assistance from staff for eating. The MDS indicated Resident 53 had a weight loss of 5% or more in the last month and not on physician prescribed weight loss regimen. During a review of Resident 53's weights and vitals summary for October 2025, indicated Resident 53's weight on 10/1/2025 (monthly weight) was 224 pounds and on 10/14/2025 (admission date from the hospital) Resident 53's weight was 184 pounds. Resident 53's weight and vitals summary indicated Resident 53 had a 17.9% weight loss between 10/1/2025 and 10/14/2025. During a concurrent interview and record review on 12/3/2025 at 3:15 p.m. with Registered nurse (RN) 3, Resident 53's admission inquiry dated 10/14/2025 was reviewed. RN 3 stated Resident 53 was admitted to General Acute Care Hospital (GACH) from 10/6/2025 to 10/13/2025. Resident 53's weight and vitals summary for October 2025 was reviewed, RN 3 stated Resident 53 had a weight loss of 40 pounds from GACH on 10/1/2025 to 10/14/2025. RN 3 stated per facility policy, this weight loss of 17.9% would be considered a significant weight loss upon readmission. RN 3 stated Licensed Nurses are expected to notify physician for significant changes in resident condition including significant weight loss upon readmission. RN 3 stated failure to notify physician of significant weight loss can result in continued weight loss and malnutrition.During a concurrent interview and record review on 12/5/2025 at 8:38 a.m. with the Director of Nursing (DON), Resident 53's weight and vitals summary for October 2025 was reviewed. The DON stated Resident 53 had a weight loss of 40 pounds from GACH on 10/1/2025 to 10/14/2025 and is considered a significant weight loss. The DON stated nurses are expected to notify physician for significant weight loss. During a subsequent interview with the DON on 12/5/2025 at 8:38 a.m. and record review of Resident 53's nursing progress note dated 10/13/2025 was reviewed, the DON stated that the nurse did not notify the physician of significant weight loss following discharge from the GACH. The DON stated there was no documentation indicating the physician notification of Resident 53's significant weight loss. The DON stated failure to notify physician of significant weight loss could result in continued weight loss and malnutrition. During a review of facility policy and procedure titled, Notification of Changes dated 12/19/2022, the P&P indicated, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and record review, the facility failed to monitor target behaviors for one of 14 residents (Resident 25) while on a psychotropic medication (substance that affects how the brain works, used to treat mental illnesses).This failure resulted in Resident 25 not receiving individualized behavior monitoring necessary to identify the presence, absence, or change in behaviors targeted by the psychotropic medication. Findings:During a review of Resident 25's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/12/2025 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage), hypertension (HTN-high blood pressure), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), urinary tract infection (UTI- an infection in the bladder/urinary tract).During a review of Resident 25's History and Physical (H&P) dated 11/13/2025, the H&P indicated Resident 25 has fluctuating capacity to understand and make decisions.During a record review on 12/4/2025 at 7:35 a.m. of Resident 25's medication administration records (MAR- a daily documentation of record used by a licensed nurse to document medication treatments given to a resident), the MAR indicated a physician's order dated on 11/13/2025 at 9:00 a.m., aripiprazole 5 milligram (mg, unit of measurement), give one tablet by mouth in the morning psychosis for angry outburst with a stop date of 11/18/2025.During a record review on 12/4/2025 at 7:35 a.m. of Resident 25's monitor behavior form, used to document targeted behavior for monitoring when an antipsychotic medication is ordered, the form indicated Resident 25's behavior was not monitored or documented during every shift on 11/13/2025, and there was no documentation for the morning and afternoon shifts on 11/14/2025.During a concurrent interview and record review on 12/4/2025 at 8:51 a.m. with a Registered Nurse (RN) 4, Resident 25's MAR for aripiprazole 5 mg, ordered for psychosis and angry outburst was reviewed. RN 4 stated the behavior monitoring form and identified monitoring was not performed on 11/13/25 for the morning, afternoon, and evening shifts, and not performed on 11/14/25 for the morning and afternoon shifts. RN 4 stated the lack of monitoring and documentation meant the facility was unable to assess Resident 25's response to aripiprazole, determine medication effectiveness, or identify potential adverse reactions. During a concurrent interview and record review on 12/4/2025 at 4:31 p.m. with the Director of Nursing (DON), Resident 25's MAR for aripiprazole 5 mg, ordered for psychosis and angry outburst and the behavior monitoring form and identified monitoring was not performed on 11/13/25 for the morning, afternoon, and evening shifts, and not performed on 11/14/25 for the morning and afternoon shifts were reviewed. The DON stated behavior monitoring should occur every shift when an antipsychotic medication was prescribed. The DON stated when behavior monitoring was not completed, staff are unable to track changes in Resident 25's target behaviors, which may prevent the facility from determining the effectiveness of aripiprazole. The DON stated staff may fail to recognize or report critical side effects or adverse reactions when Resident 25's behavior was not monitored as required.During a record review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated 12/19/2022, indicated .The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as:.In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan.The resident's response to the medication(s), including progress towards the goal and presence/absence of adverse consequences, shall be documented in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement goals and interventions on the care plan for two of two residents (Resident 2 and Resident 27) by failing to: 1. Ensure the Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care), developed a care plan for Resident 27 who had multiple Urinary tract infections (UTI- an infection in the bladder/urinary tract) and was prescribed multiple antibiotics (medication that kills bacteria). 2. Ensure Resident 27 who should have been on Enhanced Barrier Precautions (EBP-infection control measure to prevent the spread of germs) for a chronic pressure injury pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) had goals and interventions for the care plan.3. Review Resident 2's hospital discharge notes upon admission. These failures resulted in delayed care and necessary treatment for Resident 2, as well as a lack of appropriate care for Resident 27, increasing the potential for the spread of infection to other residents, staff, and visitors. Findings: 1. During a review of Resident 27's admission Record (face sheet) dated 12/4/2025, the admission record indicated Resident 27 was admitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), sick sinus syndrome (abnormal heart rhythms) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 27's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS)- a standardized assessment and care screening tool), the MDS indicated Resident 27 cognition was intact. The MDS also indicated Resident 27 needed substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 27's Order Listing Report dated 12/04/2025, the order listing report indicated Resident 27 was prescribed: 1.Daptomycin (antibiotic) 500 milligrams (mg- unit of measure) give once a day for 14 days, starting date 9/08/2025 for bacteremia (bacteria in the blood). 2. Ertapenem (antibiotic) one gram (unit of measure) give once a day for 14 days, starting date 9/16/2025 for UTI. 3. Meropenem (antibiotic) one gram every 12 hours for seven days, start date10/01/2025 for UTI. 4. Metronidazole (antibiotic) 500 mg give three times a day (TID) for five days, start date 10/26/25 for foul smelling discharge. 5. Ceftriaxone (antibiotic) one gram give one time a day for seven days, start date10/26/2025 for UTI. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Cephalexin (antibiotic) 500 mg give TID for five days, start date 10/31/2025 for UTI. 7. Bactrim DS (antibiotic) 888-160 mg give two times a day (BID) for five days, start date 11/21/2025 for UTI. 2. During a review of Resident 27's Physician Order dated 9/18/2025, the physician order indicated Resident 27 had a sacrococcyx pressure injury to clean with normal saline (NS) pat dry apply collagen powder (promotes wound bed healing) and calcium alginate (absorbent wound dressing used for heavy drainage) cover with super absorbent dressing every day, for pressure injury. During a review of Resident 27's care plan dated 9/24/2025 titled Resident is on Enhanced Barrier Precautions related to (r/t) chronic wound the care plan indicated there were no goals or interventions in place for Resident 27. During a concurrent interview and record review on 12/03/2025 at 11:35 a.m. with the Infection Preventionist (IP), Resident 27's antibiotic use from 9/8/2025 – 12/1/2025 was reviewed. The IP stated Resident 27 had been on six different antibiotics for UTI's and one for bacteremia. The IP stated the facility should have had an IDT meeting for Resident 27, so the team could have discussed possible interventions to help with prevention for Resident 27 and come up with a plan of care. During a concurrent interview and record review on 12/04/2025 at 4:24 p.m. with the IP, Resident 27's EBP care plan was reviewed. The IP stated Resident 27 care plan for EBP did not have any goals or interventions in place and did not know why. The IP stated the care plan was important to ensure the staff would know how to provide the appropriate care for Resident 27. During an interview on 12/05/2025 at 10:54 a.m. with the Director of Nurses (DON), the DON stated all care plans need to have a goal and interventions for the staff to properly coordinate care for the residents. The DON stated the facility should have had an IDT meeting to develop a plan of care for Resident 27's who had multiple UTI's and had been on multiple antibiotics, to ensure Resident 27's received the appropriate care. During a review of the facility's policy and procedure (P&P) titled Comprehensive Care Plan dated 12/19/2022, the P&P indicated, It is the policy of this facility to 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, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be prepared by an interdisciplinary team. 3. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease (your kidneys are damaged and slowly lose their ability to clean waste from your blood), urinary tract infections (UTI- an infection of the bladder/urinary tract), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/17/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). (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 review of Resident 2's general acute care hospital (GACH) Discharge Note dated 10/6/2025, the GACH Discharge Note indicated For Helicobacter pylori (H. Pylori- stomach infection) treatment, continue metronidazole (antibiotic used to treat a variety of infections caused by bacteria) and tetracycline (antibiotic-medication to treat infection) for 14 days, eradication (elimination) may be confirmed four weeks or more after completion of antibiotic therapy. During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of metronidazole 500 milligrams (mg- unit of measurement), via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every eight hours for H. Pylori prophylaxis (preventative care to stop disease before it starts) with a stop date to follow. During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of tetracycline 250 mg via gastrostomy tube every 12 hours for H. Pylori prophylaxis with a stop date to follow. During a concurrent interview and record review on 12/4/2025 at 4:37 p.m., with Registered Nurse Supervisor (RNS) 4, RNS 4 stated the Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) reviews all admission documents during the IDT admission meeting. RNS 4 stated she did not review Resident 2's hospital discharge notes and stated she should have. During an interview on 12/5/2025 at 7:20 a.m., with the Infection Prevention Nurse (IPN), IPN stated that an IDT meeting should have occurred regarding Resident 2's antibiotics upon admission due to the resident's high risk for side effects and development of multidrug-resistant organisms (MDROs- are microorganisms that have developed resistance to multiple classes of antibiotics). During an interview on 12/5/2025 at 10:52 a.m., with the Director of Nursing (DON), the DON stated that the IDT was responsible for reviewing admission documents to ensure proper medication orders and prevent potential medication errors. The DON stated the hospital discharge documents should have been reviewed upon admission for Resident 2's safety and care. During a review of the facility's policy and procedure (P&P) titled, admission of a Resident, dated 3/10/2025, the P&P indicated, The admission process is intended to obtain all possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. The admission process has several phases including review all available transfer information. During a review of the facility's P&P titled, Antibiotic Stewardship, dated 12/19/2022, the P&P indicated, Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform consistent monitor Resident 53's nutritional status by failing to:a. Initiate a weight variance (monitoring process triggered when a resident experiences significant weight fluctuations) andb. Discuss nutritional recommendations during the Interdisciplinary Care Conference {(ICC), a collaborative meeting involving various healthcare professionals to review and update the resident's care plan} after Resident 53 had a significant weight loss (a weight loss greater than 5% in one month, or 10% change in weight in 6 months) of 40 pounds (unit for measuring weight) following admission from the General Acute Care Hospital (GACH) for one of four sampled residents (Resident 53).This deficient practice had the potential to place resident at risk for continued weight loss. Findings:During a review of Resident 53's admission Record, the admission Record indicated the facility admitted Resident 53 on 9/23/2025 and was readmitted on [DATE] with diagnoses including atrial fibrillation (an irregular and often rapid heartbeat caused by abnormal electrical signals in the hearts upper chambers), gastroesophageal reflux disease (GERD- a chronic condition where stomach acid frequently flows back up into the esophagus), and dysphagia (difficulty swallowing).During a review of Resident 53's History and Physical (H&P) dated 11/7/2025, the H&P indicated the resident had the capacity to understand and make decisions.During a review of Resident 53's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 53 had severely impaired cognition (ability to think and understand). The MDS indicated Resident 53 was dependent on staff for toileting, dressing and required substantial assistance from staff for eating. The MDS indicated Resident 53 had a weight loss of 5% or more in the last month and not on physician prescribed weight loss regimen. During a review of Resident 53's weights and vitals summary for October 2025, indicated Resident 53's weight on 10/1/2025 (monthly weight) was 224 pounds and on 10/14/2025 (readmission date from the GACH) Resident 53's weight was 184 pounds. During a concurrent interview and record review on 12/3/2025 at 1:44 p.m. with the Dietary Supervisor (DS), The Nutritional assessment dated [DATE] was reviewed. The Nutritional Assessment indicated RD to implement nutritional interventions for Resident 53 including provide liberalized diet and Boost very high calorie (calorically dense nutritional drink) every day for 30 days. ICC dated 10/22/2025 was reviewed, the ICC indicated Resident 53 was not placed on weight variance. The DS stated residents with significant weight loss should be placed on weight variance and Resident 53 should be on it. The DS stated the nutritional interventions from the Nutritional assessment dated [DATE] were not included in the ICC dated 10/22/2025. The DS stated failure to place Resident 53 on weight variance or discuss nutritional interventions during ICC meeting places resident at risk for continued weight loss. During a concurrent interview and record review on 12/5/2025 at 8:38 a.m. with the Director of Nursing (DON), Resident 53's weight and vitals summary for October 2025 was reviewed, the DON stated Resident 53 had a weight loss of 40 pounds following GACH admission [DATE]. The Nutritional assessment dated [DATE] was reviewed, the DON stated Resident 53 was not placed on weight variance. The DON stated Resident 53 had a significant weight loss and per facility policy, should have been placed on weight variance. The DON stated the RD's recommendations for Resident 53's significant weight loss to provide a liberalized diet and Boost very high calorie every day for 30 days. The DON stated the RD's nutritional interventions were not included in the ICC dated 10/22/2025. The DON stated failure to place Resident 53 on weight variance or discuss nutritional interventions during ICC meeting places resident at risk for continued weight loss.During a review of facility policy and procedure (P&P) titled Weight Management Policy dated 1/20/2023, the P&P indicated, The facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight. The P&P indicated, A significant change in weight is defined as 5% change in weight in 1 month (30 days). Documentation of significant weight changes shall be completed in accordance with the facility's documentation policies and procedures and acceptable standards of practice.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure the Infection Prevention Nurse (IPN) demonstrated competency in implementing infection control practices related to antibiotic usage for one of one sampled residents (Resident 2). The facility failed to:1.Monitor Resident 2 who was administered two antibiotics (medications used to treat an infection) since admission on [DATE] with no end date to stop treatment. This failure resulted in Resident 2 receiving two antibiotics for an extended period without appropriate monitoring or reassessment, placing the resident at risk for adverse effects, including potential worsening of chronic kidney disease (condition in which the kidneys are damaged and gradually lose their ability to filter waste and excess fluids from the blood effectively), which could lead to fluid retention (condition where excess fluid accumulates in the body's tissues, leading to swelling), swelling, and cognitive (ability to think, understand, learn, and remember) impairment.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease (your kidneys are damaged and slowly lose their ability to clean waste from your blood), urinary tract infections (UTI- an infection of the bladder/urinary tract), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/17/2025, the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review of Resident 2's general acute care hospital (GACH) Discharge Note dated 10/6/2025, the GACH Discharge Note indicated for the treatment of Helicobacter pylori (H. Pylori- stomach infection) continue metronidazole (antibiotic used to treat a variety of infections caused by bacteria) and tetracycline (antibiotic used to treat a variety of infections caused by bacteria) for a duration of 14 days. Confirmation of eradication should be conducted at least four weeks after completing the antibiotic regimen.During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of metronidazole 500 milligrams (mg- unit of measurement), via gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every eight hours for H. Pylori prophylaxis (preventative care to stop disease before it starts) with a stop date to follow.During a review of Resident 2's Order Details dated 10/11/2025, the Order Details indicated an order of tetracycline 250 mg via gastrostomy tube every 12 hours for H. Pylori prophylaxis with a stop date to follow. During an interview with the IPN on 12/4/2025 at 2:00 p.m., the IPN was unable to locate Resident 2's antibiotic orders and stated she was unaware that Resident 2 had been receiving antibiotics since 10/22/2025. The IPN stated that because the antibiotics were prescribed prophylactically, she did not believe they needed to be included in the facility's antibiotic stewardship program (refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use). When asked about the potential impact of long-term antibiotic use on residents, the IPN was unable to provide an explanation. She also acknowledged that she did not follow the physician's order indicating stop date to follow and admitted that she does not consistently review hospital discharge records upon a resident's admission but stated she should have done so in Resident 2's case.During a review of the facility's Infection Preventionist (IP) Job Description dated 2022, the IP Job Description indicated, Major Duties and Responsibilities include: develops and implements an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe, sanitary, and comfortable environment; oversees the facility's antibiotic stewardship program; maintains documentation of infection prevention and control program activities. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated 12/19/2022, the P&P indicated, Infection Preventionist coordinates all antibiotic stewardship activities, maintains documentation, and serves as a source for all clinical staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that expired enteral nutrition products (specialized liquid formulas used in tube feeding to provide essential nutrients to residents unable to eat by mouth) were removed from the medication storage room after their expiration date. This failure had the potential to result in adverse side effects, including gastrointestinal distress, infection, and loss of potency (strength of a drug or its effectiveness in achieving a desired result), compromising the health and safety of residents receiving enteral nutrition.Findings:During an observation on 12/3/2025 at 2:17 p.m. in Medication Storage room [ROOM NUMBER], one expired 1500 milliliter (mL-unit of measurement) container of Diabetes source (enteral nutrition formula) was found in a red basket. The product had an expiration date of 11/24/2025.During a concurrent observation and interview on 12/3/2025 at 2:45p.m. with Registered Nurse (RN) 3 in the central supply room (where nurses obtain medications and necessary items for resident care), observed seven Glucerna feeding source with expiration date of 12/1/2025. During an interview on 12/3/25 at 2:47 p.m. with RN 3, RN 3 stated she had checked Medication Storage room [ROOM NUMBER] on 12/1/2025 and did not observe any expired enteral feeding products at that time. RN 3 stated that if residents were to receive expired feeding formulas, it could result in adverse reactions. RN 3 stated expired feeding formula should be discarded promptly and should not be stored in medication storage areas.During an interview on 12/4/2025 at 8:33 a.m. with the Director of Nursing (DON), the DON statedregular monitoring of the supply room was necessary to ensure expired items were identified and removed. The DON stated both the Registered Nurse and central supply staff were responsible for checking the medication storage room, with central supply personnel expected to conduct weekly inspections and additional checks as needed. The DON stated administering expired medications or enteral feeding products to residents could result in harmful effects or reduced potency, potentially compromising the effectiveness of treatment. The DON stated all expired supplies should be promptly removed from the medication storage room to maintain resident safety.During an interview on 12/4/25 at 9:04 a.m. with Maintenance Supervisor (MS) 1, MS 1 stated he was responsible for overseeing maintenance and central supply operations. MS 1 stated part of his job duties include checking supplies for expiration dates. He reported conducting weekly checks, particularly on Tuesdays when new supplies were restocked, and performing a full inventory review at the end of each month. MS 1 stated that expired items should not be kept in stock and recognized the importance of removing them promptly. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility dated 4/2008, the P&P indicated Outdated , contaminated , or deteriorated medications and those containers that are cracked, soiled, expired, or with out secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review the facility failed to ensure consent to treatment documentation was completed with all required elements for one of 14 sampled residents (Resident 44).This deficient practice has the potential to result in residents receiving treatments or interventions without understanding the risks, benefits, or alternatives. Findings:During a review of Resident 44's admission Record (Face sheet), the admission Record indicated the facility admitted the patient on 10/26/2001 with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), hypertension (HTN- high blood pressure), and major depressive disorder (feel very sad, empty or hopeless most days and interferes with daily life).A review of Resident 4's History and Physical (H&P) dated 8/16/2025, the H&P indicated Resident 4 has the capacity to understand and make decisions.During a record review on 12/03/2025 at 9:15 a.m. of Resident 44's medical record (chart), the documentation of consent to treatment was missing Resident 44's date, facility representative's name, signature, and date. During an interview on 12/03/2025 at 9:25 a.m. with Resident 44 about his recollection in signing consent to treatment form, Resident 44 stated he signed the consent to treatment, and he was informed about the risk and benefits for treatments.During a concurrent interview and record review on 12/3/2025 at 9:33 a.m. with the Infection Preventionist (IP), the IP stated the consent to treatment for Resident 44 was incomplete and missing was Resident 44's date, facility representative name, signature and date. The IP stated completed consent to treatment was necessary to inform Resident 44 of the risks and benefits of the recommended treatment. The IP stated an incomplete consent to treatment fails to provide this information and may place Resident 44 at risk if treatment was given without Resident 44's knowledge and understanding. During a concurrent interview and record review on 12/04/2025 at 4:25 p.m. with the Director of Nursing (DON), the DON stated the consent to treatment for Resident 44 was incomplete and was missing Resident 44's date, facility representative's name, signature and date. The DON stated a completed consent to treatment allows the facility to treat residents based on their consent. The DON stated an incomplete informed consent fails to provide this information and may place Resident 44 at risk if treatment was given without his knowledge and understanding. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, dated 12/19/2022, indicated, It is the policy of the facility to uphold the rights of residents to participate in the planning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify that.consent has been obtained prior to any medical intervention or treatment is initiated .If a form is used to document that informed consent was verified, the licensed nursing staff will complete the Verification of Informed Consent Form and place it under the consent section in the clinical record.