STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056456	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palazzo Post Acute	5400 Fountain Ave Los Angeles, CA 90029

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 9) who did not have the capacity to understand and make decisions had a legal representative to assist in making medical decisions. This failure violated Resident 9's right to make an informed decision (choice that individuals make once they have all the information related to the decision topic) in the resident' care. Findings: During a review of Resident 9's admission Record, the admission Record indicated the facility readmitted Resident 9 on 5/10/2018, with diagnoses that included major depressive disorder (persistent feelings of sadness, low mood, and loss of interest in activities that were once pleasurable), schizophrenia (a mental illness that is characterized by disturbances in thought), age-related incipient cataract (in its early stages, where the lens of the eye is starting to become cloudy but vision is not yet significantly affected), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2025, the MDS indicated the resident was severely cognitively (anything related to thinking, learning, and understanding) impaired for decision making. During a review of Resident 9's History and Physical (H&P), dated 6/17/2024, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's Facility Consent Form for psychotropic medication (drugs that affect the mind and brain), dated 11/1/2024, the Consent Form indicated, Verbal consent obtained from resident with two witnessed signatures on resident/representative signature line, nurse signature and physician signature. During a review of Resident 9's Multidisciplinary Care Conference, dated 4/23/2025, the Multidisciplinary Care Conference indicated, Interdisciplinary Team (IDT, a group of diverse health care professionals from different fields) held with resident at bedside for a careplan meeting to discuss current Plan of Care (POC). Nursing discussed current medication orders. Verbalized understanding, no concerns at this time. Social Services documented resident (Resident 9) has periods of confusion. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's Advance Directive (a written statements of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) Acknowledgment, dated 6/4/2025, the Advance Directive Acknowledgment indicated Resident 9 initialed and signed the document with two witnesses. During an interview on 6/5/2025 at 11:21 AM with Resident 9, Resident 9 stated, I signed a document yesterday with the Social Services Assistant (SSA) and wrote a D because I am unable to sign. I am able to move my fingers but unable to see for quite some time. I have limited vision - I can only see shadows. During an interview on 6/5/2025 at 11:41 AM with SSA, the SSA stated on 6/4/2025 Resident 9 signed the Advance Health Care Directive. During an interview on 6/5/2025 at 12:13 PM with the Director of Nursing (DON), the DON stated Resident had limited visual capacity and needed to have a Witness to sign. During a concurrent interview and record review on 6/5/2025 at 12:20 PM with the DON, Resident 9's H&P dated 6/17/2024 and MDS dated [DATE] were reviewed. The DON indicated the H&P indicated Resident 9 Does not have the capacity to understand and make decisions. The DON stated the MDS indicated Resident 9 was severely cognitively impaired for decision making. The DON stated Resident 9 did not have the capacity to make decisions and sign an Advance Health Care Directive and consents. During an interview on 6/5/2025 at 12:27 PM with SSA, the SSA stated Before a resident signs a document, they (residents in general) need to have the capacity to make decisions. The Resident (Resident 9) has moments of confusion. During an interview on 6/5/2025 at 12:33 PM with SSA, the SSA stated I don't know the advance directives policy. During an interview on 6/5/2025 at 2:30 PM with Medical Director (MD), the MD stated When a resident has cognitive decline, a bioethics (group of physicians, nurses, social workers, other staff members to help patients, families, doctors and other health care provides when they face difficult ethical decisions) meeting needs to be done with the next step being filing for a conservator (legal guarding). During IDT (Intradisciplinary Team, a group of diverse health care professionals from different fields meetings), involve psychiatry (is the branch of medicine that focuses on the prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders). During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated December 2021, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: appoint a legal representative of his or her choice, in accordance with state law.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) for one of five sampled residents (Resident 47) related to the risk for falls after Resident 47 had a fall on 12/26/2024. This failure had the potential for Resident 47 to receive inadequate care. Findings: During a review of Resident 47's admission Record, the admission Record indicated the facility admitted the resident on 8/3/2023 with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movements), encephalopathy (a group of conditions that cause brain dysfunction), unsteadiness on feet (difficulty maintaining balance while walking or standing), lack of coordination (an inability to control and synchronize movements smoothly and efficiently), and a history of falling. During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool) dated 11/10/2024, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 47 required set up or clean up assistance for eating and oral hygiene. The MDS indicated Resident 47 required supervision or touching assistance for toileting hygiene, upper body dressing, or personal hygiene. The MDS indicated Resident 47 required partial/moderate assistance for showering/bathing himself, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 47 did not have any falls since his admission to the facility. During a review of Resident 47's eInteract Change in Condition Evaluation dated 12/26/2024 at 1:48 PM, the eInteract Change in Condition Evaluation indicated the resident had a fall. The eInteract Change in Condition Evaluation indicated Resident 47 was found on the floor sitting and holding onto his walker (a type of mobility aid that offers stability and support while walking). The eInteract Change in Condition Evaluation indicated Resident 47 was assisted back to bed. The eInteract Change in Condition Evaluation indicated Resident 47 denied hitting his head or his bottom. The eInteract Change in Condition Evaluation indicated Resident 47 was found without redness or bruising upon assessment. The eInteract Change in Condition Evaluation further indicated Resident 47's physician was notified and ordered for Resident 47 to have an x-ray (a medical test that takes pictures of bones and soft tissues). During a review of Resident 47's Care Plan Report dated 5/20/2025, the Care Plan Report indicated the resident was at risk for falls related to unsteady and shuffling gait (walking without lifting your feet completely off the ground), a history of falls, and a history of being non-compliant (not acting in accordance with a wish or command) with the use of his front wheel walker when ambulating (walking). The Care Plan Report indicated a goal to minimize Resident 47's risk for falls and injuries. The Care Plan Report indicated interventions that were last revised on 10/9/2023. The Care Plan Report did not indicate any intervention revisions or updates after Resident 47's fall on 12/26/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 11:18 AM with the MDS Coordinator (MDSC), Resident 47's eInteract Change in Condition Evaluation dated 12/26/2024 and Care Plan Report dated 5/20/2025 were reviewed. The MDSC stated Resident 47 had a fall on 12/26/2024. The MDSC stated resident care plans were reviewed and updated after every fall. The MDSC stated after a resident (in general) had a fall a short-term care plan was developed and the care plan was updated with additional interventions for the at risk for falls. The MDSC stated Resident 47's at risk for falls care plan was not updated after the resident fell on [DATE]. The MDSC stated Resident 47's at risk for falls care plan should have been updated after his fall on 12/26/2024. The MDSC stated that it was important for Resident 47's at risk for falls care plan to be revised and updated after each fall so the nursing staff were aware of the interventions they were to provide to the resident. During a concurrent interview and record review on 6/5/2025 at 3:10 PM with the Director of Nursing (DON), Resident 47's eInteract Change in Condition Evaluation dated 12/26/2024 and Care Plan Report dated 5/20/2025 were reviewed. The DON stated Resident 47 had a fall on 12/26/2024. The DON stated Resident 47's at risk for falls care plan was not updated after he (Resident 47) fell on [DATE]. The DON stated Resident 47's at risk for falls care plan should have been updated and revised to include additional interventions to prevent the resident from falling again. The DON stated a resident's care plan (in general) was indicative of the kind of care the resident was to receive. The DON stated if care plans were not updated after a fall there was a potential for the resident to not receive appropriate care because the nursing staff would not be aware of the care the resident was to receive. During a review of the facility's Policy & Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 1/23/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to ensure to provide effective oral hygiene care for one of five sampled residents (Resident 39). This failure resulted in Resident 39 having a tan substance on her teeth, dry lips, and a substance on her reddened, tongue. Findings: During a review of Resident 39's admission Record, the admission Record indicated the facility admitted the resident on 10/19/2022 with diagnoses that included dysphagia (difficulty swallowing), gastrostomy (g-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and malnutrition (lack of proper nutrition). During a review of the Resident 39's Care Plan Report dated 1/3/2025, the Care Plan Report indicated the resident was at risk for decline in range of motion (ROM, the full movement potential of a joint), and required assistance with oral care. The Care Plan Report indicated the nursing interventions were to provide oral care three times a day. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025, the MDS indicated Resident 39 had poor short and long-term memory problems. The MDS indicated Resident 39 had severely impaired cognitive (ability to think and process information) skills. The MDS indicated Resident 39 was dependent for oral and toileting hygiene, and for showering and upper and lower dressing. During an observation on 6/2/2025 at 10:40 AM in Resident 39's room, Resident 39 was sleeping in bed, two side rails (adjustable metal or rigid plastic bars that attach to the bed) were up, the call light (a device used by a patient to signal his or her need for assistance) was within reach. Resident 39 had a gastrostomy tube, and the head of the bed was raised to 30 degrees. Resident 39 had a tan colored substance on her teeth, dry lips, and a substance on her tongue. Resident 39's tongue appeared reddened and swollen. During an interview on 6/4/2025 at 1:20 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 39 was total care and could not do the task herself. CNA 1 stated she (CNA 1) performed oral care on Resident 39 early in the morning using the mouth swab. CNA 1 stated she (CNA 1) performed oral care for Resident 39 twice a day. CNA 1 stated Resident 1's mouth looked that way (had a tan colored substance on her teeth, dry lips, and a substance on her tongue. Resident 39's tongue appeared reddened and swollen) for a while. During an observation and interview on 6/4/2025 at 1:30 PM with Registered Nurse (RN) 1 in Resident 39's room, RN 1 stated Resident 39's mouth looked bad. RN 1 stated if he (RN 1) had a loved who had a mouth appeared as Resident 39's, he (RN 1) would go to the nurse and see what interventions were being done, ask if the doctor was aware. RN 1 would not confirm or deny that Resident 39's mouth did not get consistent oral care. RN1 stated he (RN 1) would do a change of condition (a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains), inform Resident 39's doctor, and place a dental consult. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 39's eINTERACT Change in Condition Evaluation Dated 6/4/25, the eINTERACT Change in Condition Evaluation indicated the CNA notified the Licensed Nurse regarding possible tongue swelling. The eINTERACT Change in Condition Evaluation indicated the nurse tried to do an assessment but was unsuccessful due to Resident 39 not sticking out her tongue and showing discomfort. The eINTERACT Change in Condition Evaluation indicated the doctor was made aware with new orders for a dental follow up and laboratory tests. During an interview on 6/4/25 at 2:32 PM with the Registered Dental Hygienist (RDH), the RDH stated she (RDH) saw Resident 39 in January 2025 and on 5/30/2025 and performed a dental cleaning. The RDH stated Resident 39 was not cooperative. The RDH stated she (RDH) was able to get the plaque off but not the calculus (a hardened form of plaque that forms on teeth when plaque isn't effectively removed with brushing and flossing). The RDH stated she (RDH) did not see that Resident 39's tongue appeared reddened, scaly, or swollen. The RDH stated she (RDH) did not use a bite stick only used hand instruments to retract and no injury was noted. The RDH stated it was hard to say if Resident 39 received consistent oral care. The RDH was informed that Resident 39 does not have anything by mouth. The RDH stated she (RDH) did not give any recommendations to the nursing staff after the examination. During an observation on 6/5/2025 at 8:55 AM in Resident 39's room, Resident 39's mouth showed moisturized lips, teeth had less substance on them, and the resident's tongue appeared less swollen and dry. During an interview on 6/5/2025 at 9:17 AM with the Director of Nursing (DON), the DON stated all residents, especially the residents with g-tubes, should receive oral care every day. The DON stated if her family member's mouth looked like what Resident 39's mouth looked on 6/4/2025 which was dry lips, teeth with a substance on them, it would not be acceptable. The DON stated the risk to Resident 39 would be infection. During a review of Resident 39's Dental Progress Notes dated 6/5/25, the Dental Progress Note indicated the resident's tongue was checked and the resident was sleeping with her mouth opened. The Dental Progress Note indicated Resident 39's mouth and tongue were extremely dry, her togue was not swollen, and there was no abnormality of her tongue. The Dental Progress Noted indicated a recommendation to moisten Resident 39's tongue and to provide good oral hygiene. During a review of the facility's policy and procedures (P&P) titled, Mouth Care, dated 1/23/2025, indicated, that the purpose of the procedures are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection.

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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. Based on observation, interview, and record review, the facility failed to ensure to implement safety measures for one of one sampled residents (Resident 63) by failing to: -Ensure Certified Nursing Assistants (CNA2 and CNA3) locked Resident 63's bed and the Hoyer lift (a specialized lifting device to weigh or safely transfer a patient with limited mobility) prior to placing the sling (a specialized fabric support, acts as a harness) under Resident 63 on 6/2/2025 at 10:58 AM. This failure had the potential to cause physical injury to Resident 63. Findings: During a review of Resident 63's admission Record, the admission Record indicated the facility admitted the resident on 10/3/2024 with diagnoses including hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction affecting right non-dominant side, other sequelae of cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissues), aphasia following cerebral infarction (a language disorder that occurs when a stroke damages brain areas responsible for language processing), and history of falling. During a review of Resident 63's Care Plan dated 10/3/2024, indicated Resident 63 was at risk for falls related to impaired gait/balance and mobility. The Care Plan indicated Resident 63 had a history of falling and was taking medications that may cause falls and the goal was for Resident 63 to minimize the risk of falls or injuries. The Care Plan indicated the nursing interventions included to adapt environment to meet resident's safety needs, assist with all transfers or ambulation (walking), and Resident 63 needs a safe environment with .bed wheels locked . During a review of Resident 63's History and Physical (H&P) dated 10/4/2024, the H&P indicated Resident 63 had fluctuating capacity to understand and make medical decisions. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool) dated 4/10/2025, the MDS indicated Resident 63 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS indicated Resident 63 required one or two staff to assist with Resident 63's 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 63's Physician Progress Note dated 5/11/2025, the Physician Progress Note indicated Resident 63 had an unsteady gait. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 6/2/2025 at 10:58 AM, inside Resident 63's room, CNA2 and CNA 3 did not lock Resident 63's bed and the Hoyer lift prior to placing the sling under Resident 63. CNA 2 stated Resident 63's bed and the Hoyer lift should have been locked prior to placing the sling under Resident 63 to secure Resident 63 from falling off the bed and to prevent accidents such as fracture (break) of the arm, or leg, or an injury requiring hospitalization. CNA 3 stated Resident 63's bed and the Hoyer lift must be locked prior to placing the sling under Resident 63 to prevent from hitting Resident 63's head on the floor and bleed which requires going to the hospital immediately because of (Resident 63's) injury. During an interview on 6/2/2025 at 11:15 AM with Licensed Vocational Nurse (LVN 4), LVN 4 stated both Resident 63's bed and the Hoyer lift must be locked prior to moving Resident 63 to prevent accidents such as falls where Resident 63 may sustain injuries such as broken bones in the extremities (limbs of the body-arms and legs) and altered level of consciousness (a change in a person's awareness of themselves and their surroundings, ranging from mild confusion to a coma). LVN 4 stated Resident 63 may sustain a head bleed that may result in Resident 63 being sent to the hospital. During an interview on 6/2/2025 at 11:28 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 63's bed and the Hoyer lift must be locked to ensure the equipment was stable and not moving. RN 1 stated potential injuries Resident 63 may sustain included head concussion (brain injury caused by a bump, blow, or jolt to the head, or by a hit to the body that can result in a range of symptoms, including headache, dizziness, confusion, and memory problems), pain, discomfort, altered mental status (change in mental function that maybe as a result of illness or injuries), and neurological deficit (injury or changes to how the brain, spinal cord, and nerves work). During a review of the facility's policy and procedures titled Lifting Machine, Using a Mechanical with a revision date of 1/23/2025, indicated when preparing the environment, staff make sure lift is stable and locked.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to perform a bowel and bladder assessment (a process to evaluate a person's bowel and bladder function) quarterly as indicated in the care plan for one of one sampled residents (Resident 66). This failure had the potential for Resident 66 to not receive the appropriate care for her bowel and bladder function. Findings: During a review of Resident 66's admission Record, the admission Record indicated the facility admitted the resident on 11/8/2024 with diagnoses that included congestive heart failure (CHF, a heart disorder which causes the heart to not pump blood efficiently, sometimes resulting in leg swelling), cirrhosis of the liver (a disease where healthy liver tissue is replaced by scar tissue), reduced mobility (an impairment that impacts a person's ability to move or perform tasks), and adult failure to thrive (a condition characterized by a decline in physical, cognitive (ability to understand, think, and reason), and social functioning in adults). During a review of Resident 66's Nursing Bowel and Bladder Evaluation dated 2/14/2025 at 9:37 AM, the Nursing Bowel and Bladder Evaluation indicated Resident 66 had a potential for bowel and bladder retraining (technique used to regain control over urination and bowel movements). The Nursing Bowel and Bladder Evaluation indicated Resident 66 had minor predisposing diseases, was alert and oriented, was able to make needs known, required limited assistance with mobility, had adequate vision and hearing, was frequently incontinent (having insufficient voluntary control) of bladder, and frequently incontinent of bowel. There were no Nursing Bowel and Bladder Evaluations documented after 2/14/2025. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool) dated 5/15/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 66 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene. The MDS indicated Resident 66 was occasionally incontinent of urine and frequently incontinent of bowel. The MDS indicated Resident 66 was not on a bowel program (a structured plan designed to help individuals achieve regular and predictable bowel movements). During a review of Resident 66's Care Plan Report dated 6/2/2025, the Care Plan Report indicated the resident was always incontinent of bowel and always incontinent of bladder. The Care Plan Report indicated Resident 66 was not a good candidate to establish an individualized toileting plan due the resident's complex medical condition. The Care Plan Report indicated a goal for Resident 66 to not develop complications from incontinence such as skin breakdown or infection. The Care Plan Report further indicated interventions that included to perform a bowel and bladder assessment on admission, quarterly, and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 9:20 AM, with Registered Nurse 1 (RN 1), Resident 66's Nursing Bowel and Bladder Evaluation dated 2/14/2025 at 9:37 AM and Care Plan Report dated 6/2/2025 were reviewed. RN 1 stated bowel and bladder assessments were done on admission, quarterly, and annually. RN 1 stated Resident 66's Care Plan Report indicated the resident was to have a bowel and bladder assessment done on admission, quarterly, and as needed. RN 1 stated Resident 66's last bowel and bladder assessment was performed on 2/14/2025. During a concurrent interview and record review on 6/5/2025 at 3 PM, with the Director of Nursing (DON), Resident 66's Resident 66's Nursing Bowel and Bladder Evaluation dated 2/14/2025 at 9:37 AM and Care Plan Report dated 6/2/2025 were reviewed. The DON stated Resident 66's Care Plan Report indicated the resident was to have a bowel and bladder assessment done on admission, quarterly, and as needed. The DON stated Resident 66's bowel and bladder assessment was last done on 2/14/2025. The DON stated Resident 66's bowel and bladder assessment was not done quarterly. The DON stated resident care plans should be followed because the care plans were an indicative of the care the resident needed. The DON stated there was a potential for the resident to not receive the appropriate care the resident needed if their care plan was not followed. During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 1/23/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . During a review of the facility's P&P titled Urinary Continence and Incontinence - Assessment and Management dated 1/23/2025, indicated The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence .As part of the initial and ongoing assessments, the nursing staff and physican will screen for information related to urinary continence .As part of its assessment, nursing staff will seek and document details related to continence .The nursing staff and physician will identify risk factors for becoming incontinent or for worsening of current incontinence .The evaluation will include a review for medications that might affect continence .The staff and physician will summarize an individual's continence status .As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan.

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	056456	A. Building B. Wing	06/05/2025

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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. Based on observation, interview, and record review the facility failed to ensure one of one sampled residents (Resident 1) had a labeled flush bag for the gastrostomy tube (g-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). This failure had the potential for Resident 1 to be exposed to infection. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 05/13/2020 with diagnoses that included aphasia (a communication disorder that impairs a person's ability to process language, affecting their ability to speak, understand, read, or write), dysphagia (difficulty swallowing), and malnutrition (lack of proper nutrition). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/18/2025, the MDS indicated the resident had short and long-term memory problems and severely impaired cognitive (ability to think and process information) skills for daily decision making. During a review of Resident 1's Care Plan Report dated 5/23/2025, the Care Plan Report indicated the resident required tube feeding (g-tube feeding dependent) related to dysphagia, and the nursing interventions were to label the formula container, syringe and administration set with resident's name, date, time, and nurse's initials. During an observation on 6/4/2025 at 10:15 AM with the Treatment Nurse (TN) in Resident 1's room, Resident 1's flush bag was not labeled with the date, time, and nurse's initials which was attached to Resident 1's g-tube pump. During a concurrent observation and interview on 6/4/2025 at 10:35 AM with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, the g-tube feeding and flush were observed. LVN 1 observed that the flush bag was not labeled. LVN 1 stated the flush and feeding were attached to a cassette and placed in the chamber of the pump. LVN 1 stated the risk to Resident 1 without the flush labeled would be not knowing when the flush was hung and possible infection. During an interview on 6/5/2025 at 9:14 AM with the Director of Nursing (DON), the DON stated the g-tube feeding, and flush bag were packaged together and the two should have the date when it was hung for Resident 1. The DON stated the risk to the resident without a labeled flush bag would be possible infection. During a review of the facility's policy and procedures (P&P) titled, Enteral Tube Feeding via Continuous Pump dated 1/23/2025, indicated, on the formula document initials, date and time the formula was hung/administered, and initial that the label was checked against the order. No indication in the policy regarding the labeling of the flush bag.

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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. Based on observation, interview, and record review, the facility failed to: 1. Ensure to receive the receipt of a correct emergency drug supplies (E-kit, a pre-set of medications to provide an immediate service to facility's residents) from the pharmacy upon delivery. As a result, the facility did not have a narcotic (controlled drugs) E-kit available in the facility for roughly twenty-four (24) hours, between 6/2/2025 and 6/3/2025. 2. Ensure an E-kit was replaced within 72 hours of first use. 3. Ensure seven of seven drug disposition forms were filled out with dates of disposition, nurse and witnessing nurse's signatures. 4. Ensure to follow up on Resident 69's Norco (a potent opioid and narcotic that treats pain) 10-325 milligrams (mg, unit to measure mass) ordered on 5/28/2025 until 6/4/2025, after surveyor's inquiry. These failures had the potential to delay treatment and receive medications in error, that may or may not affect the health condition of the residents. Findings: 1. During an interview with the Licensed Vocational Nurse (LVN 1) on 6/03/2025 at 2:13 PM, LVN 1 stated the E-Kit form instructed nurses (in general) to make a copy to keep for facility's record and then place the original form in the kit for pharmacy to retrieve. LVN 1 stated there were separate E-kit log binders for non-narcotic, C-II (controlled drugs class 2, or schedule II-controlled substance, is a type of drug classified by the US drug enforcement administration due to its high potential for abuse and dependence), and narcotic E-kits. During an observation and interview in nursing station 1 medication room on 6/03/2025 at 2:30 PM, there was one drawer labeled CII Ekit and one drawer labeled narcotic e-kit. During a concurrent interview, LVN 1 stated the narcotic E-kit contained non-CII narcotics, such as controlled substance classes 3-5 narcotics. LVN 1 opened the drawer labeled narcotic E-kit and there was a C-II E-kit inside and no narcotic E-kit. During an observation on 6/3/2025 at 2:32 PM, LVN 1 opened the next drawer labeled CII E-kit, and there was a C-II E-kit inside. LVN 1 stated there were a total of two C-II E-kits and no narcotic E-Kit. During an interview on 6/03/2025 at 2:44 PM, with Registered Nurse 1 (RN 1), RN1 stated there was no narcotic E-kit in station 2 (the facility had 2 nursing stations). During a concurrent interview, the Director of Nursing (DON) stated the C-II and narcotic E-kits in station 1 were for both stations to use. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/2025 at 4:09 PM, the DON presented a delivery receipt of a narcotic E-kit dated on 6/2/2025 and stated the facility was supposed to receive a narcotic E-kit, however, the pharmacy delivered a CII E-kit instead. During a review of the facility's undated policy and procedures, Medication order records, indicated that . Medications delivered to the facility will be checked off against the Pharmacy order sheet records . The staff member who receives a delivery of medications . sign, date and time a delivery receipt . one copy will be retained at the facility as proof of receipt . Facilities shall maintain a record that includes . date and amount received . 2. During an interview and a concurrent review of the narcotic E-kit logbook with LVN 1 on 6/3/2025 at 2:35 PM, there was one form with two handwritten entries: -4/10/2025 zolpidem (a hypnotic to treat insomnia) 5 mg, two counts, for Resident 27 -3/16/2025 tramadol (a medication to treat pain) 50 mg 2 counts, for Resident 69 LVN 1 stated the dates on the form were about three weeks apart. During an interview on 6/3/2025 at 3 PM, the DON stated the E-kit should be replaced within 72 hours of use, therefore the dates on the same form should not be more than 72 hours apart. During a review of the facility's undated policy and procedures, Medication Orders indicated that . Pharmacy shall provide to facility emergency . medications to provide an immediate service to facility's residents . Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist . 3. During an observation and inspection of the station 1 medication room on 6/03/2025 at 2:18 PM with Licensed Vocational Nurse (LVN 1), LVN 1 presented a binder containing disposition logs for non-controlled drugs. During a concurrent review of the disposition logs, it appeared seven (7) pages were incompletely filled out with areas indicated for dates and signatures remained blank. During a concurrent interview, LVN 1 stated three of seven pages did not have two nurses' signatures (1 being witness) and four pages did not have any nurses' signatures nor date of disposition recorded. The surveyor requested a policy and procedures of drug disposition on 6/3/2025 and 6/4/2025 but did not receive the policy. 4. During an observation on 6/4/2025 at 12:02 PM at the mid [medication] cart with LVN 3, LVN 3 opened the narcotic drawer. Inside the drawer, there was a bubble pack (a card that packages doses of medication within small, clear, or light-resistant plastic bubbles or blisters) for Resident 69's Norco 5-325 mg and a bubble pack. During a concurrent review of Resident 69's active orders, LVN 3 stated Resident 69 had active orders for Norco 5-325 mg and Norco 10-325 mg, both dated 5/28/2025. LVN 3 then double checked the narcotic drawer and stated there was no Norco 10-325 mg for Resident 69. During an interview on 6/4/2025 at 12:59 PM, LVN 1 stated Resident 69's Norco 10-325 mg tablets (dated 5/28/25) was pending authorization per pharmacy. The surveyor requested record of communication with the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/25 at 4:21 PM, the DON presented an email from the Pharmacy dated 6/4/25 at 1:51 PM, which indicated the pharmacy tried contacting the prescribing doctor on 5/28/2025, 5/29/2025, and 5/30/2025. The DON stated the facility did not have other record of following up with the pharmacy on Resident 69's Norco 10-325mg. During a review of the facility's undated policy and procedures, Medication order records, indicated that The facility shall maintain a record that includes for each drug ordered by prescription . Non-delivery of any item from the Pharmacy will be documented on a 'Non-delivery' form that will identify the reason for the non-delivery and the expected time when the ordered item will be available .

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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 to follow safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1.Ensure to keep the ice scooper holder clean. 2.Ensure the kitchen staff (in general) did not keep their personal perishable food in the facility's refrigerator and did not place their personal belongings anywhere in the kitchen other than the designated area for staff. These failures had potential for residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: 1.During an initial kitchen observation on 6/2/2025 at 7:45 AM and a concurrent interview with the Dietary Food Nutrition Supervisor (DFNS), the DFNS stated the ice scooper holder was dirty. The DFNS stated the facility's Ice Scoop and Container Cleaning Log dated 6/1/2025 and 6/2/2025, indicated the ice scooper and container were cleaned, but the ice scooper holder was dirty. The DFNs stated the ice scooper holder should always be kept clean to prevent contamination. The DFNS stated a dirty ice scooper holder had the potential to cause a break in infection control causing residents to get sick in their stomach. During a review of the facility's Policy and Procedure (P&P) titled Recommended Food Storage Practices - Ice updated on 1/23/2025, indicated all containers used with ice should be kept clean and store in a sanitary manner. 2.During a concurrent interview and observation on 6/2/2025 at 7:45 AM with the DFNS, the surveyor observed a food container covered with aluminum foil with the Dietary Aid (DA) 6/2/2025, handwritten on top of the foil found in the reach-in refrigerator. The DFNS handed the food container to the DA. The DFNS stated the food container belonged to DA. 3.During the concurrent observation on 6/2/2025 at 7:45 AM the surveyor observed a personal tumbler (drink container) sitting on a shelf located in the handwashing station. The DFNS stated a personal tumbler was not allowed in the kitchen area because of contamination. The DFNS stated when personal tumblers were kept in the kitchen area, residents could get sick, they may lose weight when they cannot eat. During a review of the facility's P&P titled Dining Service - Dining Service Overview, updated on 1/23/2025, indicated the facility should offer customers a variety of appetizing, flavorful meals . During a review of the facility's P&P titled Safety and Sanitation: Employee Responsibility for Safety updated on 1/23/2025, indicated employees are not allowed to bring personal items .into the food service production areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 2. During a medication administration (med pass) observation on 6/04/2025 at 9:38 AM, the LVN 3 was sanitizing equipment outside of Resident 32's room. Next to Resident 32's name posted on the wall by the entrance was in orange paper which was different than other residents. During a concurrent interview, LVN 3 stated the orange color meant Resident 32 required enhanced barriers precautions which meant clinicians (staff) needed to gown up before providing care to the resident. Surveyor pointed out the name of the resident observed during the previous med pass (Resident 69) was also on orange paper. LVN 3 stated Resident 69 name was in orange paper and stated she (LVN3) forgot to don (put on) a gown. During an interview on 6/04/2025 at 9:48 AM, RN 1 stated the med pass process was considered direct patient care and thus required the enhanced barrier precautions. During an interview on 6/04/2025 at 4:01 PM, the infection preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment) stated the med pass process including taking vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) were considered direct care, which would require the clinician to don on barrier, as in gown and gloves, before entering the room or attending to the residents. During a review of the facility's policy and procedures, Enhanced Barrier Precautions (dated April 2025), indicated Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents . EBPs employ targeted gown and glove use in addition to standard precautions . 3.During a medication administration (med pass) observation and interview on 6/05/25 at 8:43 AM, RN 2 was preparing for Resident 32's medication administration of vancomycin. RN 2 connected the vancomycin vial with the 250 milliliters (ml, unit to measure volume) bag of normal saline (a 0.9 % sodium chloride solution used to reconstitute medication for intravenous administration) and did not use alcohol swab on vial top. RN 2 also did not disinfect the injection ports before connecting tubing to the ports. RN 2 stated it was not necessary to disinfect with alcohol. During an interview on 6/05/2025 at 10:40 AM, IP stated all injection ports should be disinfected during preparation and administration of the IV medication. During a review of the facility's undated policy, Infection Control Universal Precautions, indicated that . Strict aseptic technique shall be used when accessing all injection ports . All injection ports, peripheral and central, shall be disinfected with a sterile alcohol swab using a vigorous rub for no less than 30 seconds . Based on interview and record review, the facility failed to follow infection control practices by failing to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Develop a sufficient water management plan (a program that identifies hazardous conditions and steps to take to minimize the growth and spread of waterborne pathogens in building water systems) to reduce the growth and spread of Legionella (bacteria that causes Legionnaires Disease, a severe lung infection. Legionella is often found in water systems and is spread by breathing in mist or swallowing water that is contaminated by the bacteria) amongst 97 out of 97 facility residents. 2.Ensure the nursing staff (Licensed Vocational Nurse 3 [LVN3]) followed its enhanced barriers precautions (EBP, an infection prevention protocol) policy during the medication administration observation for one of five sampled residents (Resident 69). 3. Ensure Registered Nurse2 (RN2) would disinfect the injection ports during the preparation of an intravenous (IV, into the vein) vancomycin (an antibiotic to treat certain infections) for one of one sampled resident (Resident 32). These failures had the potential to spread infections and had the potential for Legionella growth and spread amongst the residents. Findings: 1.During a review of the facility's Water Management Plan dated 3/2024, the Water Management Plan indicated the facility was built in 1970, had two floors, one water feature, and a central cooling system. The Water Management Plan indicated the Administrator, Director of Nursing (DON), Infection Preventionist (IP, a healthcare professional who specializes in preventing and controlling the spread of infection), and Environment Services (EVS) Director were part of the water management team. The Water Management Plan indicated a flow diagram (a visual representation of a process or workflow) that showed where the facility's main water source was located and where water exited the building. The Water Management Plan indicated three steps that included identifying the water source, testing areas open to residents, and sharing test results with the IP. The Water Management Plan indicated that it must be reviewed every 12 months to ensure tests were conducted every 90 days, or as required by the water management team. The Water Management Plan indicated every faucet must have aerators (a device that is attached to a faucet or showerhead to mix air with water creating a more softer and consistent water stream) replaced every six to nine months. The Water Management Plan indicated a test would be conducted by the Maintenance Director or Regional EVS technician. The Water Management Plan did not include descriptions of the building, who the building primarily housed, or the building's water system. The Water Management Plan did not identify areas where Legionella could grow and spread, control measures (actions aimed to eliminate hazards and risks), or verification steps to ensure the Water Management Plan was being followed. During a concurrent interview and record review on 6/5/2025 at 2:40 PM with the IP, the facility's Water Management Plan dated 3/2024 was reviewed. The IP stated the Water Management Plan did not include descriptions of the building, who the building primarily housed, or the building's water system. The IP stated the Water Management did not identify areas where Legionella could grow and spread, control measures, or verification steps to ensure the Water Management Plan was being followed. The IP stated the Water Management Plan was not sufficient or personalized to the facility's water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2025 at 3:25 PM with the Administrator, the facility's Water Management Plan dated 3/2024 was reviewed. The Administrator stated the Water Management Plan did not include descriptions of the building, who the building primarily housed, the building's water system, areas where Legionella could grow and spread, control measures, or verification steps to ensure the Water Management Plan was being followed. During a concurrent interview and record review on 6/5/2025 at 3:30 PM with the Director of Nursing (DON), the facility's Water Management Plan dated 3/2024 was reviewed. The DON stated the Water Management Plan did not include descriptions of the building, who the building primarily housed, the building's water system, areas where Legionella could grow and spread, control measures, or verification steps to ensure the Water Management Plan was being followed. The DON stated the Water Management Plan was not sufficient or personalized to the facility. The DON stated that there was a potential for the facility to experience infection control issues if the Water Management Plan was not sufficient or personalized to the facility's water system. During a review of the facility's Policy & Procedure (P&P) dated 1/23/2025 titled Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings: A Practical Guide to Implementing Industry Standards, the P&P indicated Survey your building to determine if you need a water management program to reduce the risk of Legionella growth and spread .Developing a maintain a water management program is a multi-step, continuous process .You need to review the elements of your program at lead once per year .Describe your building water systems using text .You will need to write a simple description of your building water system and devices you answered yes to on page 2. This description should include details like where the building connects to the municipal water supply, how water is distributed, and where pools, hot tubs, cooling towers, and water heaters or boilers are located. An existing as-build diagram of the plumbing system and fixture may be useful in developing this description .In addition to developing a written description of you building water systems, you should develop a process flow diagram .Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in you building water systems .Each potentially hazardous condition should be addressed individually with a control point, measure, and limit .Your written program should include at least the following: Program team, including names, titles, contact information, and roles on the team. Building description, including location, age, uses, and occupants and visitors. Water system description, including general summary, uses of water, aerosol-generating devices (e.g. hot tubs, decorative fountains, cooling towers), and process flow diagrams. Control measures, including points in the system where critical limits can be monitored and where control can be applied. Confirmatory procedures, including verification steps to show that the program is being followed as written and validation to show that the program is effective. Document collection and transport methods and which lab will perform the testing if environmental testing is conducted.