

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Eastland Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3825 Durfee Ave El Monte, CA 91732	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review the facility failed to provide dignity for two of two sampled residents (Residents 13 and 55) by failing to: a. Completely close the privacy curtain when Resident 55's back and buttocks were exposed while Certified Nursing Assistant 3 (CNA 3) changed Resident 55's gown and linen. b. Close the privacy curtain when Resident 13's abdominal area was exposed while Registered Nurse 1 (RN 1) checked the resident's gastrostomy tube (GT, surgically placed devised used to deliver supplemental feeding to the stomach) site. This failure had the potential to cause psychosocial (mental and emotional well-being) decline for Residents 13 and 55. Findings: a. During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (condition when the body does not have enough oxygen in the blood) and use of a tracheostomy tube (a tube placed through a surgical opening in the neck to allow air to fill the lungs). During a review of Resident 55's untitled care plan (CP) dated 8/28/2023, the CP indicated for staff to treat the resident with respect and dignity. During a review of Resident 55's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 6/1/2024, the MDS indicated Resident 55's cognitive (ability to understand) abilities were severely impaired. The MDS indicated Resident 55 was dependent (resident does none of the effort to complete the activity) with showering and bathing. During an observation on 8/13/2024 at 10:18 AM in Resident 55's room, Resident 55's curtain was not closed completely, and CNA 3 was changing Resident 55's gown and linen. The gap in the curtain was observed to expose Resident 55's back and buttocks to Resident 55's roommate's family members. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/2024 at 10:25 AM with CNA 3, CNA 3 stated the privacy curtain was not closed completely and the roommate's family members could see through the opening. CNA 3 stated it was important to ensure the privacy curtain was closed completely to respect the resident's dignity and privacy when the resident was exposed when changing gowns or linen. During an interview on 8/16/2024 at 9:26 AM with the Director of Nursing (DON), the DON stated staff should close the curtain completely when providing resident care, especially if the resident was exposed. The DON stated, not closing the curtain completely would compromise the privacy of the resident. 42781 b. During a review of Resident 13's AR, the AR indicated the facility admitted Resident 13 on 9/4/2022 with diagnoses that included unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) and encounter for attention to gastrostomy. During a review of Resident 13's History and Physical (H&P) dated 10/28/2023, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had severely impaired cognition for daily decision making. The MDS indicated Resident 13 was dependent for with eating, oral, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 8/13/2024 at 10:07 am, Resident 13 was in the room awake, lying in bed. RN1 opened Resident 13's gown and checked Resident 13's GT site. RN 1 did not close the privacy curtain to provide Resident 13 privacy exposing Resident 13's abdominal area. The RN 1 stated privacy curtain needed to be closed to provide dignity and privacy to the resident. During an interview on 8/16/2024 at 9:39 am, the facility's DON, the DON stated the privacy curtain needed to be closed to maintain Resident 13's privacy. During a record review of the facility's Policy and Procedure (P&P) titled, Dignity revised on 2/2021, the P&P indicated, staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of need for four of four sampled residents (Resident 5, 21, 24 and 99) by failing to ensure the residents' call light was within reach. These failures had the potential for the residents not to receive or received delayed care that could result in a fall or accident. Findings: a. During a review of Resident 24's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included End Stage Renal Disease (ESRD, a medical condition where a person's kidneys permanently stop functioning), dependence on renal dialysis (HD- procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances) and hypotension (low blood pressure). During a review of Resident 24's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 7/31/2024, the MDS indicated Resident 24 had clear speech, understood others, and made self-understood. Resident 24 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident competes activity) for eating. Resident 24 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for personal hygiene and chair/bed-to-chair transfer. During an observation on 8/13/2024 at 11:18 am, in Resident 24's room, Resident 24 was lying in bed awake. Resident 24's call light was hanging on the headboard of the bed with button (call end) behind the headboard. During a concurrent interview, Resident 24 looked around the bed and stated Resident 24 did not know where the call light was, and Resident 24 was not able to reach the call light. During an interview at the same time with the Director of Nursing (DON), the DON stated, resident's call light should be within reach of Resident 24 for the resident to call help when there was a need, and to prevent potential falls. 40438 b. During a review of Resident 99's AR, the AR indicated Resident 99 was admitted to the facility on [DATE] with diagnoses that included functional quadriplegia (complete immobility due to disability from a medical condition without physical injury or damage to the spinal cord or brain), ankylosing spondylitis (an inflammatory arthritis [joint inflammation] affecting the spine and large joints), and blindness (unable to see) to one eye. During a review of Resident 99's untitled Care Plan (CP), dated 10/22/2023, the CP indicated Resident 99 was at risk for falls/injury related to generalized weakness, impaired cognition, poor body balance/control, poor safety awareness/judgement, and use of medications. The CP interventions included to keep the call light within easy reach of the resident and encourage the resident to use it to get assistance. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/13/2024 at 10:18 am, with Registered Nurse 1 (RN 1), RN 1 stated, Resident 5 was unable to reach the call light because it was clipped on the curtain. RN 1 stated, Resident 5's call light needed to be within reach for Resident 5 to use in order to call staff if Resident 5 needed help or assistance. d. During a review of Resident 21's AR, the AR indicated Resident 21 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included difficulty in walking and muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue). During a review of Resident 21's untitled CP, revised 4/4/2022, the CP indicated Resident 21 was as risk for falls/injury related to dementia, general weakness, impaired cognition, poor body balance/control, poor safety awareness/judgement. The CP interventions indicated for nursing staff to keep the residents call light within easy reach and encourage the resident to use the call light to get assistance. During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21 had moderately impaired cognition for daily decision making. The MDS indicated Resident 21 required partial/moderate assistance (helper did less than half the effort and lifted or held trunk or limbs) with shower and putting on/taking off footwear. During an observation and interview on 8/13/2024 at 10:39 am, together with RN 1, Resident 21 was lying in bed. Resident 21's call light was dangling on the left upper side of the resident's bed. Resident 21 tried reaching her call light but unable to reach. RN 1 stated, Resident 21 was unable to reach her call light. The RN 1 stated the call light was needed to be within reach to maintain Resident 21's safety. During an interview on 8/16/2024 at 9:40 am, with the DON, the DON stated the call light needed to be within reach at all times for the residents to get assistance in a timely manner and to maintain resident's safety. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights revised on 4/2024, the P&P indicated, to ensure that the call light was within the resident's reach when in his/her room or when on the toilet.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to provide information regarding Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) to two of five sampled residents (Residents 23 and 65) in accordance to the facility's policy and procedure (P&P) titled, Advance Directives. This deficient practice had the potential for facility staff to provide treatment and services against Residents 23 and 65's will. Findings: a. During a review of Resident 23's Admission Records (AR), the AR indicated, Resident 23 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interfere with daily functioning). During a review of Resident 23's Advance Directive Acknowledgement (ADA) form signed on 2/25/2018, the ADA form was not filled out completely. During a review of Resident 23's History and Physical (H&P), dated 10/26/2023, the H&P indicated Resident 23 did not have the capacity to make decision due to dementia. During a review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/3/2024, the MDS indicated Resident 23 had severely impaired cognition (ability to understand) and totally dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral and personal hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent interview and record review on 8/14/2024 at 11:44 am with the Social Services Director (SSD), Resident 23's Advance Directive Acknowledgement (ADA) form was reviewed. SSD stated the ADA form was not filled out completely to indicate Resident 23 was given written materials, and information about his rights to accept or refuse treatments and formulate an AD. During an interview on 8/14/2024 at 3:01 pm with the facility's Director of Nursing (DON), the DON stated AD should be filled out completely to ensure the resident or responsible party were informed of the resident's rights to formulate an AD and received information about an AD to determine the resident's preferences and wishes regarding care in the facility. The DON stated an AD was important for the facility to be aware of the resident's preferences and wishes in case of an emergency. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised September 2022, the P&P indicated, the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 48905 b. During a review of Resident 65's AR, the AR indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (condition when the body does not have enough oxygen in the blood) and use of a tracheostomy (tube that is surgically placed through the neck to provide an airway to the lungs) tube. During a review of Resident 65's MDS dated [DATE], the MDS indicated Resident 65's cognitive abilities were severely impaired. During a concurrent interview and record review on 8/14/2024 at 1:04 PM with the SSD, Resident 65's undated ADA form was reviewed. The SSD stated Resident 65's ADA form was not filled out and SSD was unsure why it was not filled out. The SSD stated it was important the ADA form was filled out to ensure staff follow the wishes of the resident if the resident was unable to speak for self. The SSD stated a copy of the AD should be in the chart and stated there should be documentation on why the AD is not in the resident's chart. During an interview on 8/16/2024 at 9:27 AM with the DON, the DON stated the ADA form should have been filled when Resident 65 was admitted or shortly after admission. The DON stated the risk of not filling out the ADA form was that the residents AD's preference would not be followed or indicate if education was provided to the resident or representative party on how to formulate an AD. During a review of the facility's P&P titled, Advanced Directives revised September 2022, the P&P indicated prior to or upon admission of a resident, the SSD or designee will inquire if the resident, and the legal representative or resident is provided with written information about the right to refuse or accept medical or surgical treatment and to formulate an AD.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to follow physician's order to apply heel protector (a device designed to minimize the risk of pressure injuries [pressure ulcer, lesion/wound caused by unrelieved pressure that results in damage of underlying tissue]) for one of two sampled residents (Resident 33). This failure had the potential risk for Resident 33 to develop pressure injuries. Findings: During a review of Resident 33's Admission Record (AR), the AR indicated Resident 33 was readmitted to the facility on [DATE], with diagnoses that including type 2 diabetes mellitus (elevated blood sugar level) and dysphagia (difficulty swallowing) During a review of Resident 33's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 7/26/2024, the MDS indicated Resident 33 had clear speech, did not have the ability to make self-understood and understood others. Resident 33 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for personal hygiene and substantial/maximal assistance (helper does more than half the effort) for chair/bed-to-chair transfer. During a review of Resident 33's Order Summary Report (OSR) dated 8/1/2024, the OSR indicated an order for staff to apply heel protector to Resident 33 for skin integrity. During an observation and concurrent interview on 8/13/2024 at 10:45 am, in Resident 33's room, Resident 33 was lying in bed with eyes closed. Resident 33 did not have heel protector on Resident 33's feet as ordered by the physician. Licensed Vocational Nurse 3 (LVN 3) stated, Resident 33 had a history of skin breakdown and staff should apply heel protectors on Resident 33 to prevent recurrent pressure injury. LVN 3 stated, licensed nurses needed to follow the physician's orders, and if the order was no longer needed by the resident, licensed nurses should call the physician to reevaluate or discontinue the order. During a review of the facility's Policy and Procedure (P&P) titled Prevention of Pressure Injuries, revised 3/2023, the P&P indicated, Support Surfaces and pressure redistribution, select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice. Review the interventions and strategies for effectiveness on an ongoing basis.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview and record review, the facility failed to provide necessary care and services for the resident's Foley catheter (a medical device that helps drain urine from the bladder) in accordance with the facility's Policy and Procedure (P&P) on Indwelling Catheter Urinary Drainage Bag Maintenance for one of one sampled resident (Resident 88). This deficient practice had the potential to result in catheter-related complications. Findings: During a review of Resident 88's Admission Records (AR), the AR indicated Resident 88 was admitted to the facility on [DATE] with the diagnoses that included obstructive (a condition in which the flow of urine is blocked) and reflux (a condition that occurs when urine flows back up the ureters and into the kidneys) uropathy (urine flow obstructed) and acute kidney failure (a condition in which the kidneys suddenly could not filter waste from the blood). During a review of Resident 88's untitled Care Plan (CP) dated 1/30/2023, the CP indicated Resident 88 had alteration in urinary elimination and at risk for urinary tract infection (UTI) secondary to use of Foley catheter due to obstructive uropathy. The CP interventions included to maintain proper alignment of foley catheter to promote proper drainage. During a review of Resident 88's Minimum Data Sheet (MDS, a resident assessment and care screening tool), dated 7/26/2024, the MDS indicated Resident 88 had moderately impaired cognitive (ability to understand) skills and required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, moderate assistance (helper did less than half the effort) with toileting hygiene, upper body dressing and personal hygiene and maximal assistance (helper did more than half the effort) with shower and lower body dressing. The MDS indicated Resident 88 had an indwelling catheter (thin, sterile tube inserted into the bladder to drain urine into a bag outside the body). During a concurrent observation and interview on 8/13/2024 at 9:55 am with Certified Nurse Assistant 2 (CNA 2) inside Resident 88's room, Resident 88 was lying in bed with Foley catheter hanging on the metal frame of a wheelchair next to the resident's bed. CNA 2 stated the Foley catheter collection bag was at the same level with Resident 88's bed. CNA 2 stated Foley catheter collection bag should be placed below the bladder for urine to flow by gravity and to prevent urine from flowing back to the resident. During an interview on 8/13/2024 at 10:22 am with the Infection Preventionist Nurse (IPN - a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) the IPN stated all indwelling catheters should be placed on the frame of the bed below the bladder and not on the same level of the resident to prevent backflow of the urine which would cause Urinary Tract Infection (UTI) to the resident. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/2024 at 10:27 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Foley catheter should be placed below the resident's bladder and not touching the floor to prevent urinary tract infection to the resident. During an interview on 8/14/2024 at 2:59 pm with the facility's Director of Nursing (DON), the DON stated all indwelling catheters should be positioned below the resident's pelvic area (hip bone) to facilitate draining and to prevent backflow of urine which might cause infection to the resident. During a review of the facility's P&P titled, Indwelling Catheter Urinary Drainage Bag Maintenance, revised April 2024, the P&P indicated, Place the urinary collection bag at level that is below the bladder. Ensure that urine moves through tubing based on gravity, i.e., from a higher to a lower level. Connect urinary collection bag to the metal bed frame in position that is above the floor and is within siderails, not over siderails. Metal portion of lower seat level if wheelchair is used, again ensuring that urine flows from higher to lower level, i.e. , a level lower than bladder.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure the head of bed was elevated at 30 to 45 degrees for a resident with G-tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) in accordance with the facility's Policy and Procedure (P&P) titled Enteral Feedings for one of two sampled residents (Resident 36). This failure had the potential risk for aspiration (food, drink, or foreign objects accidentally entered the lungs), resulting to a decline in Resident 36's health. Findings: During a review of Resident 36's Admission Record (AR), the AR indicated Resident 36 was readmitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing) and gastrostomy (an artificial external opening into the stomach for nutritional support). During a review of Resident 36's Minimum Data Set (MDS- a resident assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 36 had no speech, rarely/never made self-understood and rarely/never understood others. Resident 36 was dependent (helper does all of the effort) for personal hygiene and rolling from left and right. During a review of Resident 36's Order Summary Report (OSR) for 8/2024, the OSR indicated an order for staff to elevate Resident 36's HOB (head of bed) at 30-45 degrees at all times during GT feeding. During an observation on 8/13/2024 at 10:13 am, in Resident 36's room, Resident 36 was lying in bed with eyes opened. Resident 36 had an ongoing GT feeding through a GT pump/machine. Resident 36's HOB was slightly elevated. Resident 36 slid down in bed and almost laid flat in bed. During an interview on 8/13/2024 at 10:22 am, Licensed Vocational Nurse 3 (LVN 3) stated, Resident 36's head of bed should be elevated at least 30 degree while GT feeding was on, to prevent Resident 36 from aspiration which could lead to aspiration pneumonia (lung infection) causing a decline in health conditions. During a review of the facility's P&P titled Enteral Feedings, revised 3/2023, the P&P indicated, elevate the head of the bed (HOB) at least 30 degree if the feeding is on.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents on oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with professional standards of practice for four of five sampled residents (Residents 7, 65, 113 and 321) by failing to: a. Ensure Resident 321's nasal cannula (tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) tubing was not touching the floor. b. Ensure Resident 113 receive continuous oxygen therapy as ordered by the physician. Resident 113's oxygen nasal cannula tubing was left hanging on a wheelchair metal frame. c. Ensure Resident 7 received oxygen inhalation via nasal cannula as ordered by the physician. d. Ensure Resident 65's spare tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing) tube was at Resident 65's bedside. These deficient practices placed Residents 7, 65 and 113 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and the risk of the spread of infection to Resident 321 which could lead to serious respiratory complications. Findings: a. During a review of Resident 321's Admission Record (AR), the AR indicated the facility admitted Resident 321 on 8/1/2024 with diagnoses that included Parkinson's Disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) and diabetes mellitus (elevated blood sugar level). During a review of Resident 321's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/4/2024, the MDS indicated, Resident 321 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 321 was dependent with oral hygiene, toileting hygiene, shower, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 321's Order Summary Report (OSR), dated 8/1/2024, the OSR indicated for licensed staff to administer oxygen to Resident 321 at two (2) liters per minute (L/min) via nasal cannula, may titrate (increase) up to five (5) L/min for oxygen saturation (a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) less than 94% every shift. During a review of Resident 321's OSR dated 8/3/2024, the OSR indicated to change oxygen tubing every Sunday at night shift. During a review of Resident 321's OSR dated 8/3/2024, the OSR indicated to change oxygen tubing as needed. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/13/2024, at 9:57 am, Resident 321 was awake, lying in bed with oxygen tubing touching the floor. During an observation on 8/13/2024 at 10:11 am together with Registered Nurse 1 (RN 1), Resident 321 was awake, lying in bed with oxygen tubing touching the floor. RN 1 stated oxygen tubing should be off the floor because the floor was dirty and can cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 8/16/2024 at 9:37 am with the facility's Director of Nurses (DON), the DON stated oxygen tubing should not be touching the floor for infection control. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration dated 4/2024, the P&P indicated, oxygen tubing should be used in a manner that prevents it from touching the floor. 40438 b. During a review of Resident 113's AR, the AR indicated Resident 113 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), pneumonia (infection that inflames air sacs in one or both lungs) and acute bronchitis (inflammation of the bronchi of the lungs). During a review of Resident 113's OSR dated 5/22/2024, the OSR indicated Resident 113 had an order for licensed staff to administer oxygen at 3 liters per minute (l/min) via (through) nasal cannula every shift for COPD. During a review of Resident 113's Care Plan (CP) dated 5/24/2024, the CP indicated Resident 113 was receiving oxygen therapy due to COPD. The CP interventions included to provide oxygen to Resident 113 as ordered. During a review of Resident 113's MDS dated [DATE], the MDS indicated Resident 113 had intact cognition. The MDS indicated Resident 113 required maximal assistance (helper did more than half the effort) with shower and lower body dressing and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting. During a concurrent observation and interview on 8/13/024 at 10:18 am with Certified Nurse Assistant 2 (CNA 2) inside Resident 113's room, Resident 113's oxygen was off and not connected to the resident. CNA 2 stated Resident 113's nasal cannula was hanging on the wheelchair's metal frame and was not in a transparent bag. During an interview on 8/13/2024 at 10:22 am with the Infection Preventionist Nurse (IPN - nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated nasal cannula tubing should be placed inside a transparent bag when not in use to prevent infection. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/2024 at 10:27 am with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the attending physician needed to be notified and the physician's order should be clarified before any orders could be discontinued. During an interview on 8/14/2024 at 2:54 pm with the DON, the DON stated orders could not be discontinued without the physician's order. The DON stated orders should be clarified with the attending physician if the resident did not have a need for it. The DON stated nasal canula tubing should be placed inside a transparent bag when not in use to prevent contamination and risk of infection. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised April 2024, the P&P indicated, Review physician's order(s) for oxygen use. The oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer equipment, etc. When not in use oxygen tubing should be stored in a clean bag, for example, a Ziplock bag, etc. 14330 c. During a review of Resident 7's AR, the AR indicated the facility readmitted the resident on 2/25/2022, with diagnoses that included COPD and diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high). During a review of Resident 7's OSR dated 2/25/2022, the OSR indicated an order for licensed staff to provide Resident 7 up to two liters (unit of measurement) per minute of oxygen continuously through nasal cannula for oxygen saturation (amount of oxygen circulating in the blood) less than 92 percent (%) every shift for diagnosis of COPD. During a review of Resident 7's CP for oxygen therapy dated 2/15/2024, the CP indicated Resident 7 will be free of adverse effects (undesirable or harmful result) related to use of oxygen by providing oxygen at two liters per minute through nasal cannula as ordered by the physician. During a review of Resident 7's Medication Administration Record (MAR) dated 8/13/2024, the MAR indicated Resident 7's oxygen saturation was at 96 percent. During an observation on 8/13/2024 at 11:33 a.m., Resident 7 was lying on her back in bed, alert and coherent. Resident 7 had an ongoing oxygen inhalation at four liters per minute through nasal cannula. During an observation and concurrent interview on 8/13/2024 at 12:10 p.m., Resident 7 was lying on her back in bed. Resident 7's oxygen inhalation was flowing at four liters per minute through nasal cannula. Licensed Vocational Nurse 4 (LVN 4) was in Resident 7's room and LVN 4 observed Resident 7's oxygen level was at four liters per minute. LVN 4 stated she only checked Resident 7's oxygen saturation rate but not the oxygen level at around 8 a.m. today (8/13/24). LVN 4 thought Resident 7's oxygen level was at the correct level of two liters per minute from the previous night shift (11 p.m.-7 a.m.). LVN 4 stated too much oxygen could cause oxygen toxicity (lung damage that happens from breathing in too much extra [supplemental] oxygen) to a resident. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration dated October 2010, the P&P indicated oxygen therapy was to be administered as ordered by the physician for safe oxygen administration. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48905 d. During a review of Resident 65's AR, the AR indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (condition when the body does not have enough oxygen in the blood) and use of a tracheostomy (a tube placed through a surgical opening in the neck to allow air to fill the lungs) tube. During a review of Resident 65's untitled CP dated 9/27/2021, the CP interventions included to keep an extra tracheostomy tube the same size or smaller at the bedside with other tracheostomy supplies. During a review of Resident 65's MDS dated [DATE], the MDS indicated Resident 65's cognition was severely impaired. During a concurrent observation and interview on 8/13/2024 at 11:09 AM in Resident 65's room, there was no extra tracheostomy tube at Resident 65's bedside. Respiratory Therapist 1 (RT 1) stated there was no extra tracheostomy tube at the bedside. RT 1 stated there should always be an extra tracheostomy tube next to the artificial manual breathing unit (Ambu, handheld device used in emergencies to provide ventilation to people who are not breathing) bag. RT 1 stated the risk of not having an extra tracheostomy tube at the bedside was that Resident 65 would not have a patent airway if there was an accidental decannulation (process to remove the tracheostomy tube). During an interview with the DON on 8/16/2024 at 9:33 AM, the DON stated Resident 65 should have a spare tracheostomy tube at the bedside if it was listed in the resident's CP. The DON stated, not having an extra tracheostomy tube at bed side would result in complications during accidental decannulation. During a review of the facility's policy and procedure (P&P) titled, Tracheostomy Care revised 8/2013, the P&P indicated a replacement tracheostomy tube must be available at the bedside at all times.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to perform post (after) hemodialysis (HD, a life-support treatment that uses a special machine to filter harmful wastes, salt, and excess fluid from your blood) assessment on 7/4/2024, 7/30/2024 and 8/10/2024 for one of one sampled resident (Resident 24). This failure had the potential risk for complications caused by unexpected and excessive bleeding from the hemodialysis site. Findings: During a review of Resident 24's Admission Record (AR), the AR indicated the resident was admitted on [DATE], with diagnoses that included End Stage Renal Disease (ESRD, a medical condition where a person's kidneys permanently stop functioning and require dialysis or a kidney transplant to survive), dependence on renal dialysis (HD- procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances) and hypotension (low blood pressure). During a review of Resident 24's untitled Care Plan (CP) dated 11/6/2023, the CP indicated Resident 24 was on HD due to ESRD. The CP interventions indicated for post dialysis, nursing staff needed to document the date, time, and condition of the resident when he/she comes back from HD. The DON stated, a resident could die from bleeding from the HD access site. During a review of Resident 24's Dialysis Communication Record (DCR, a medical record used to document a patient's status between the facility and dialysis center including patient information, treatment information, vital signs before, during and after HD), the DCR indicated there was no post dialysis assessment for Resident 24 on 7/4/2024, 7/30/2024 and 8/10/2024. The post assessments for these three days were left blank. During a review of Resident 24's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 7/31/2024, the MDS indicated Resident 24 had clear speech, understood others, and made self-understood. Resident 24 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident competes activity) for eating. Resident 24 was dependent (helper does all of the effort; resident does none of the effort to complete the activity) for personal hygiene and chair/bed-to-chair transfer. During an interview and concurrent interview on 8/15/2024 at 1:37 pm, Licensed Vocational Nurse 3 (LVN 3) stated, post HD assessment for Resident 24 was missing for 7/4/2024, 7/30/2024 and 8/10/2024. LVN 3 stated, all residents on HD should be assessed upon return to the facility from the HD center. LVN 3 stated, the post HD assessment included skin check, assessment of HD access site for bleeding and vital signs to ensure the resident did not have any change of condition after HD, and the access site was intact without bleeding. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/2024 at 2:11 pm, the Director of Nursing (DON) stated, post HD assessment should be completed when the resident returns from HD center. The DON stated post HD assessment should include checking the resident's vital signs and HD access site for bleeding, to ensure the resident had no change of condition. During a review of the facility's Policy and Procedure (P&P) titled Hemodialysis Access Care, revised 9/2010, the P&P indicated, The general medical nurse should document in the resident's medical record as follows: 5. Observations post-dialysis.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to attempt to use appropriate alternative interventions before installation of bilateral (both sides) bedrails for five of five sampled residents (Residents 14, 24 78, 101, and 373). These failures placed Residents 14, 24, 78, 101, and 373 at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body parts in the tight spaces around the bedrail) and physical injuries. Findings: a. During a review of Resident 373's Admission Record (AR), the AR indicated Resident 373 was admitted to the facility on [DATE] with diagnoses that included respiratory failure (when the body does not have enough oxygen) and use of tracheostomy tube (tube surgical inserted in the neck to provide an airway to the lungs). During a review of Resident 373's History and Physical (H&P) dated 8/12/2024, the H&P indicated Resident 373 was able to make decisions for activities and daily living. During a review of Resident 373's Admission Assessment (AA) dated 8/12/2024, the AA indicated bilateral side rails were up for increased security for Resident 373. During a review of Resident 373's Order Summary Report (OSR) dated 8/12/2024, the OSR indicated the Medical Doctor (MD) ordered for Resident 373 to have bilateral upper half side rails up and locked for resident's safety, activities of daily living changes, mobility, and positioning. During a review of Resident 373's untitled care plan (CP) for both half siderails up for positioning and ease in mobility and as enabler when in bed, dated 8/15/2024, the CP indicated an intervention for staff to attempt to use less restrictive devices on an ongoing basis. During an observation on 8/13/2024 in Resident 373's room, Resident 373 was lying in bed with bilateral side rails installed on Resident 373's bed. During an interview on 8/15/2024 at 11:22 AM with Registered Nurse 2 (RN 2), RN 2 stated the use of the bedrails for Resident 373 was for mobility and stated there was no documentation for the use of appropriate alternative interventions prior to installing bedrails on 8/12/2024. RN 2 stated appropriate interventions should have been attempted and documented in Resident 373's medical record. RN 2 stated, not applying appropriate alternative interventions before installing bedrails could put the resident at risk of unnecessary bedrail use. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/16/2024 at 9:02 AM with the Director of Nursing (DON), the DON stated appropriate alternatives needed to be documented prior to installing bedrails. The DON stated staff needed to evaluate if the alternative intervention was working and document the reason why the intervention was not successful. The DON stated the risk of not implementing appropriate interventions prior to installing bedrails was that immediate use of bedrails could cause entrapment. 14330 b. During a review of Resident 101's AR, the AR indicated the facility admitted the resident on 11/2/2023, with diagnoses that included diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high) and hypertension (high or raised blood pressure). During an observation and concurrent interview on 8/13/2024 at 11:40 a.m., Resident 101 was lying on her back in bed with one fourth length bed rails up on both sides. Resident 101 had left sided weakness, alert and coherent. Resident 101 stated her bed rails were up since the staff (unidentified) transferred her to her room. Resident 101 stated she did know why her bed rails were always up. During a concurrent interview and record review on 8/14/2024 at 3:05 p.m., the Assistant Director of Nursing (ADON) stated Resident 101's medical record had no documented evidence of appropriate alternatives attempted before bed rails were applied for Resident 101. The ADON stated appropriate alternatives to bed rails such as concave mattress would prevent the resident from rolling off the bed and low bed would prevent the resident from getting out of bed unassisted. The facility had no available appropriate alternatives to bed rails other than the low bed that could be utilized by the staff before the bed rails was to be applied for the resident. The ADON stated bed rails would prevent the resident to safely get out of bed when the resident would attempt to climb over the bed rails or foot board that could cause serious injury and /or death of the resident. c. During a review of Resident 78's AR, the AR indicated the facility admitted the resident on 8/22/2023, with diagnoses that included epilepsy (a brain condition that causes recurring seizures) and hypertensive heart disease (a long-term condition that develops over years in people who have high blood pressure). During an observation and concurrent interview on 8/13/2024 at 11:22 a.m., Resident 78 was lying on his back in bed with one fourth length bed rails up on both sides. Resident 78 was alert with periods of confusion. Resident 78 stated his bed rails were always up. Resident 78 did not know why staff had to raise his bed rails. During a concurrent interview and record review on 8/14/24 at 3 p.m., the ADON stated Registered Nurse (RN) Supervisor was responsible to ensure bed rails were not installed for resident's use until appropriate alternatives were attempted and appropriate alternatives were evaluated why it did not meet the needs of the resident. The ADON stated bed rails were a accident hazard when the resident's head or limb was entrapped in between the open space of the mattress or bed rails that could cause serious injury and/or death of the resident. Resident 78's medical record did not contain information that appropriate alternatives were attempted before the bed rails were used for Resident 78. 40438 (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 14's AR, the AR indicated Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interfere with daily functioning) and Alzheimer's (a progressive disease that destroys memory and other important mental functions). During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had severely impaired cognition, required moderate assistance (helper did less than half the effort the effort) with oral hygiene, and required maximal assistance (helper did more than half the effort) with toileting hygiene, shower, upper body dressing and personal hygiene. During a review of Resident 14's OSR dated 6/24/2024, the OSR indicated an order for bilateral upper half side rails up and locked when in bed for activities of daily living (ADL) changes, mobility, positioning, and as enabler. The OSR indicated to monitor placement of alternative devices every shift. During a concurrent observation and interview on 8/15/2024 at 2:19 pm with LVN 2 inside Resident 14's room, Resident 14 was lying in bed on his back with bilateral half-length bedrails up. Resident 14's bed was not in its lowest position. LVN 2 stated Resident 14 was confused. During a concurrent interview and record review on 8/15/2024 at 2:27 pm with LVN 2, Resident 14's Medication Administration Record (MAR) and progress notes were reviewed. LVN 2 stated there was no documentation that placement of alternatives devices were monitored nor appropriate alternatives were used prior to the installation of Resident 14's bedrails. LVN 2 stated the use of appropriate alternatives to bedrails were important to prevent entrapment and injury to the resident. During an interview on 8/16/2024 at 9:13 am with the DON, the DON stated, using bedrails placed the resident at risk of entrapment or injury. The DON stated the facility should have exhausted appropriate alternatives prior to installation of bedrails for Resident 14. 40037 e. During a review of Resident 24's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included End Stage Renal Disease (ESRD, a medical condition where a person's kidneys permanently stop functioning), dependence on renal dialysis (H- procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances) and hypotension (low blood pressure). During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had clear speech, understood others, and made self-understood. Resident 24 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident competes activity) for eating. Resident 24 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for personal hygiene and chair/bed-to-chair transfer. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/13/2024 at 11:18 am, in Resident 24's room, Resident 24 was lying in bed, awake. Resident 24's bedrails were up in the middle part of the bed, on both sides of the bed. During a concurrent interview, the DON stated, there was no physician's order, no consent, and no bedrail assessment for Resident 24's use of bedrails. The DON stated, Resident 24 did not need to have bedrails, and it was inappropriate to have bedrails installed on Resident 24's bed. The DON stated, it was dangerous to have bedrails without proper assessment and placed Resident 24 at risk for fall and injuries. During a review of the facility's Policy and Procedure titled Bed Safety and Bed Rails, revised 8/2022, the P&P indicated, The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.		

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NAME OF PROVIDER OR SUPPLIER Eastland Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3825 Durfee Ave El Monte, CA 91732	
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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 14330 Based on observation, interview and record review, the facility failed to post nurse staffing information of the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily for two of two recertification survey days inspected. This deficient practice misleads the residents and visitors and had the potential to affect the quality of nursing care provided to the residents. Findings: During observations on 8/13/24 at 11 a.m., and 8/14/24 at 9 a.m., the facility's staffing information titled, Census and Direct Care Service Hours Per Patient Day (DHPPD) was posted on the front counter of Stations 1, 2, 3 and consumer board. The DHPPD did not have staffing information of the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily. During a concurrent interview and record review on 8/15/24 at 3 p.m., the Director of Staff Development (DSD) stated she posted the DHPPD as the facility's staffing information every day. The DSD stated DHPPD was the minimum hours required for each resident care per day based on residents' census. The DSD did not know that posting facility's staffing information in accordance with Federal regulation was different from the State required DHPPD posting daily. The DSD stated DHPPD did not have information of the total number of staff and actual hours worked by the licensed and unlicensed nursing staff responsible for resident care per shift. The DSD stated accurate and specific facility's staffing information was important for the resident and/or family to know the facility had enough staff to provide quality of care for each resident. During a review of the facility's Policy and Procedures (P&P) titled, Posting Direct Care Daily Staffing Numbers dated August 2022, the P&P indicated staffing information recorded on the form should include the following: a. The type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility including contract staff. b. The actual time worked during that shift for each category and type of nursing staff. c. Total number of licensed and non-licensed nursing staff working for the posted shift.		

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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. 40037 Based on observation, interview and record review, the facility failed to maintain safe food handling practices by failing to: 1. Discard one bowl of leftover egg salad in one of one facility walk-in refrigerator, stored for more than three days which exceeded food storage time limit in accordance with the facility's policy on Left Over Food. 2. Store one of one ice scoop in a sanitary condition. The ice scoop was stored in the ice scoop container that had some brown stains at the bottom. These deficient practices placed the residents at risk for food borne illnesses (illness caused by consuming contaminated food or beverages) Findings: During an observation and concurrent interview on 8/13/2024 at 9:23 am, in the facility's kitchen, with the Dietary Supervisor (DS), there was one bowl of egg salad dated 8/9/2024 in the facility's walk-in refrigerator. The DS stated the bowl of egg salad was the leftover food from 8/9/2024. The DS stated, leftover food had three days storage limit and should be removed from the refrigerator and discarded by 8/12/2024. During another observation, there were brown stains at the bottom of the ice scoop container. The DS stated, kitchen staff cleaned the ice scoop container and washed the ice scoop daily. The DS stated, the facility should keep ice scoop and its container in a sanitary condition to prevent water-borne illness that would affect residents' health and result in illnesses. During an interview on 8/15/2024 at 10:15 am, Dietary Aid 1 (DA 1) stated, kitchen staff cleaned the ice scoop and washed the ice scoop container daily. DA 1 stated, the last time DA 1 washed the ice scoop container was on 8/12/2024. DA 1 stated, DA 1 probably missed cleaning the inner side of the scoop container. DA 1 stated, the inside and outside of the ice scoop container needed to be cleaned and sanitized thoroughly. During a review of the facility's undated Policy and Procedure (P&P) titled Left-over Food, the P&P indicated, Leftover meat, casseroles, and similar items should be cooled down, refrigerated, and used within 72 hours or frozen for later use. During a review of the facility's P&P titled Ice Machine Cleaning, revised on 4/2024, the P&P indicated, The scoop and container will be cleaned and sanitized daily.		

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure its binding arbitration agreement included selection of a venue convenient to both facility and resident/resident responsible party (RP) for one of three sampled residents (Residents 13). This deficient practice placed Resident 13 at risk for an unjust arbitration and delayed arbitration hearing in an event of an arbitration dispute. Findings: During a review of Resident 13's AR, the AR indicated the facility admitted Resident 13 on 9/4/2022 with diagnoses that included unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) and encounter for attention to gastrostomy. During a review of Resident 13's History and Physical (H&P) dated 10/28/2023, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had severely impaired cognition for daily decision making. The MDS indicated Resident 13 was dependent for with eating, oral, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 8/13/2024 at 10:07 am, Resident 13 was in the room awake, lying in bed. During a concurrent interview and record review on 8/15/2024 at 10:42 pm, with the Admission Coordinator (AC), the binding arbitration agreement for Resident 13 was reviewed. The facility's arbitration agreement form titled Resident-Facility Arbitration Agreement indicated the agreement was signed by Resident 13's responsible party on 2/16/2016. The signed Arbitration Agreement of Resident 13 did not include information regarding selection of a venue convenient to both facility and resident/resident responsible party. The AC stated it was an old Arbitration Agreement form that was used by the previous Admission Coordinator. The AC stated, it was important for both facility and resident/resident's representative to have a convenient location for both parties to be able to attend the hearing.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to ensure seven of 63 resident rooms (Rooms 114, 115, 116, 117, 119, 121 and 123) met the square footage requirement of 80 square feet (sq. ft., unit of measurement) per resident in multiple resident rooms. This deficient practice had the potential for the residents not to have enough space for activities of daily living and hinder staff from providing nursing care to the residents. Findings: During an interview with the facility Administrator (ADM) on 8/13/2024 at 9:44 am, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year for Rooms 114, 115, 116, 117, 119, 121 and 123. The ADM stated nothing was changed and the number of bed occupancy in Rooms 114, 115, 116, 117, 119, 121 and 123. During a review of the facility's letter to request for room waiver dated 8/13/2024, the letter indicated there was reasonable privacy, closet, and storage space provided in each room. The letter indicated there was sufficient room to provide nursing care and resident equipment. The waiver indicated, the rooms were in accordance with the special needs of all the residents, as necessary. The letter indicated all rooms have windows, and no rooms are below ground level. The letter indicated the health and safety of each resident will not be jeopardized by the waiver. The letter indicated the room waiver will not adversely affect the resident's health and safety. The room waiver letter dated 8/13/2024 and Client Accommodation Analysis dated 8/14/2024 indicated the following: Room Sq. Ft. Beds 114 300 4 115 300 4 116 300 4 117 300 4 119 300 4 121 300 4 123 159 2 (continued on next page)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation during the Health Recertification Survey from 8/13/2024 to 8/16/2024, Rooms 114, 115, 116, 117, 119, 121 and 123 had adequate space, nursing care, comfort, and privacy to the residents. The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) and walkers (a device that gives additional support to maintain balance or stability while walking). The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During an interview on 8/15/2024 at 12:08 pm with Resident 113, Resident 113 was sitting on his bed in room [ROOM NUMBER]. Resident 113 stated, Resident 113 was able to move himself in and out of room [ROOM NUMBER] with no concerns or issues. Resident 113 stated, room [ROOM NUMBER]'s space was enough for him. During an interview on 8/15/2024 at 12:10 pm with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated there was enough space in Rooms 114, 115, 116, 117, 119, 121 and 123 and staff were able to provide care to the residents.		