STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Healthcare Center	2222 Santa Ana Blvd. Los Angeles, CA 90059

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 - Few	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** Based on observation, interview, and record review, the facility failed to honor a resident's preference regarding personal care by assigning a male certified nursing assistant (CNA) to provide showers to one of eight sampled residents (Resident 86) when the resident requested to have female CNAs assigned on her shower days. This failure resulted in a violation of Resident 86's personal dignity and right to make decisions about her care. Findings: During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension ([HTN] - high blood pressure), metabolic encephalopathy (brain dysfunction), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (loss of muscle strength). During a review of Resident 86's Minimum Data Set ([MDS]- a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 86's cognition (ability to think and reason) was intact. The MDS indicated Resident 86 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 6/2/2025 at 11:41 a.m., with Resident 86, Resident 86 stated her scheduled shower days were twice a week, on Mondays and Thursdays. Resident 86 stated she repeatedly informed staff that she did not want a male staff to assist her with showers. Resident 86 stated despite her request male CNAs continue to be assigned to her. Resident 86 stated the most recent incident occurred two weeks ago and again on 6/2/2025. Resident 86 stated she felt uncomfortable and embarrassed. Resident 86 stated the facility did not respect her wishes or her privacy. During a concurrent observation and interview on 6/5/2025 at 7:30 a.m., with Resident 86, in Resident 86's room, Resident 86 was observed siting on her bed, visibly upset. Resident 86 stated she had once again been assigned a male CNA on her shower day. Resident 86 stated she felt embarrassed and experienced a loss of dignity due to the facility's continued disregard for her expressed preferences. (continued on next page)

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 - Few	During a concurrent observation and interview on 6/5/2025 at 7:35 a.m., with CNA 2, who was male, stated he had been assigned to assist Resident 86 on her most recent shower days and on 6/5/2025. CNA 2 stated he was not aware Resident 86 was uncomfortable receiving assistance from a male CNA during her showers. CNA 2 stated if the resident preferred a female CNA, it was the responsibility of the Director of Staff Development (DSD) to ensure such preferences were reflected in the daily assignment. During a concurrent interview and record review on 6/5/2025 at 7:50 a.m., with the DSD, the facility's staff assignment records titled Nursing Staffing Assignment and Sign in Sheet, dated 5/1/2025 through 6/5/2025, were reviewed. The staff assignment records indicated on 5/19/2025, 6/2/2025, and 6/5/2025, a male (CNA 2) was assigned to assist Resident 86 with her shower. The DSD stated she was aware of Resident 86's preference for female CNAs during showers, which had been communicated verbally by the resident, however she overlooked the CNA assignment and did not include any instructions or notations in the daily assignment sheet to ensure that the resident's preference was followed. The DSD stated this failure to honor the resident's preferences could lead to emotional distress and loss of dignity. During an interview on 6/5/2025 at 9:30 a.m., with the Director of Nursing (DON), the DON stated resident's preferences such as care preferences should be honored and clearly communicated during staff assignments. The DON stated repeated exposure to the male CNA, against the resident's preferences, could lead to emotional discomfort and that the resident's personal care preferences were not valued or respected. The DON stated this compromised the resident's well-being and quality of life. During a review of the facility's policy and procedure (P&P) titled Privacy and Dignity, revised 5/1/2018, the P&P indicated To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity and overall quality of live. During a review of the facility's P&P titled Resident Rights, revised 5/1/2023, the P&P indicated the facility would protect the right of all residents at the facility. The P&P indicated The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely submit the referral for probate conservatorship (referral to the court to appoint a conservator [an appointed person to act or make decisions for a person who cannot make decisions for themselves]) for one of three sampled residents (Resident41), who did not have the capacity to make decisions. This deficient practice resulted in the delay in the process of obtaining a conservator, which resulted in the Interdisciplinary Team ([IDT], a coordinated group of experts from several different fields) overseeing Resident 41's care. Findings: During a review of Resident 41's admission Record (Face Sheet), the Face Sheet indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), cerebral infarction (loss of blood flow to a part of the brain), and schizophrenia (a mental illness that is characterized by disturbances in thought). The Face Sheet indicated the clinical IDT was Resident 41's responsible party. During a review of Resident 41's Minimum Data Set ([MDS], a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 41's cognition (process of thinking) was severely impaired. The MDS indicated Resident 41 was dependent on staff's assistance with toileting, bathing, and putting on/taking off footwear. During a concurrent interview and record review on 6/3/2025 at 2:48 p.m., with the Social Services Director (SSD), Resident 41's History and Physical (H&P), dated 11/26/2024, was reviewed. The SSD stated Resident 41 did not have the capacity to understand and make decisions. The SSD stated Resident 41 did not have any family or friends involved in her care. The SSD stated since Resident 41 was assessed by their physician to not having the capacity to make medical decisions and no other person was involved in their care, the Resident 41 was supposed to be referred for probate conservatorship. The SSD stated while the referral was processed, the Resident 41's care would be overseen by the clinical IDT until a conservator was appointed. The SSD stated the process for appointing a conservator was a lengthy process and it was important to initiate the referral timely. During a concurrent interview and record review on 6/3/2025 at 2:54 p.m., with the SSD, Resident 41's IDT Conference Meeting, dated 2/27/2025, was reviewed. The SSD stated Resident 41's referral for probate conservatorship was made that day after the IDT met to discuss Resident 41's need for conservator. The SSD stated the process for appointing a conservator could be lengthy and the referral should be sent as soon as possible. The SSD stated three months was too long to wait to submit the referral for probate conservatorship. The SSD stated due to delaying the referral, the rest of the process for probate conservatorship was delayed, therefore the clinical IDT had overseen Resident 41's care for potentially a longer than necessary. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 2:13 p.m., with the Director of Nursing (DON), the DON stated Resident 41 was unable to make medical decisions for herself, therefore was currently under the care of the clinical IDT. The DON stated Resident 41 was deemed to not having decision making capacity in November 2024 and should have been referred for probate conservatorship at that time. The DON stated once the social services department determined Resident 41 did not have any family or friends involved in her care, the process should have immediately started. The DON stated waiting three months to submit Resident 41's referral was too long and during those three months, Resident 41's referral could have been processed. The DON stated due to the delay; Resident 41 could have had a conservator appointed but instead stayed under the care of the clinical IDT. During a review of the facility's policy and procedure (P&P) titled, Bioethics Committee, revised 1/31/2025, the P&P indicated, A personal representative must be appointed for each resident lacking decision-making capacity and without a surrogate decision-maker. If the resident has no family or friends willing to participate in the Bioethics Committee meeting on his/her behalf, the Facility must find another person unaffiliated with the nursing home to serve as the resident's representative.

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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 interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the residents prior to treatment with psychotropic (medications that affect brain activities associated with mental processed and behavior) medications for two of six sampled residents (Residents 77 and 86) by failing to: 1. Obtain informed consent from Resident 77, for the use Chlorpromazine (an antipsychotic medication [a medication that effects the mind, emotion, and behavior]). 2. Ensure Resident 86's informed consent for Risperidone (an antipsychotic medication), and Seroquel (an antipsychotic medication) was renewed every six months. The deficient practice of failing to obtain informed consent prior to initiating treatment with psychotropic medications could have prevented Residents 77 from exercising the right to decline treatment with psychotropic medications. This increased the risk that Residents 86 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 77's admission Record, the admission Record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 77's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 77 cognition (process of thinking) was moderately impaired. The MDS indicated Resident 77 required moderate assistance (helper does less than half the effort) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 77 received antipsychotic medication. During a review of Resident 77's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated on 3/26/2025, Resident 77's attending physician prescribed Chlorpromazine 25 milligrams ([mg]-metric unit of measurement, used for medication dosage and/or amount) via 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)every six hours as needed for HICCUPS (involuntary spasms of the diaphragm [muscle that separates the chest from the abdomen]). During a review of Resident 77's available informed consent documentation and clinical record, the informed consent documentation and clinical record did not indicate there was documentation Resident 77 received education regarding the risks and benefits of Chlorpromazine prior to initiation on 3/26/2025. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025 at 3:10 p.m., with the Director of Nursing (DON), the DON stated the facility failed to obtain informed consent related to Resident 77's Chlorpromazine. The DON stated even though this medication was being used to treat HICCUPS for Resident 77, it was still a psychotropic medication which affects the brain and needed informed consent prior to initiation. The DON stated there was a risk that Resident 77 would not be able to exercise their right to opt out of the treatment with Chlorpromazine if the informed consent was not done. The DON stated this increased the risk that Resident 77 could have experienced adverse effects related to the treatment with Chlorpromazine. b. During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia and metabolic encephalopathy (brain dysfunction). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86's cognition was intact. The MDS indicated Resident 86 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for activities of daily living ([ADLs]-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 86 received antipsychotic medications. During a review of Resident 68's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated to give: 1. Risperidone 0.25 mg, one tablet by mouth, one time a day for schizophrenia as manifested by (m/b) verbal aggression and angry outbursts. 2. Seroquel 50 mg, one tablet by mouth, at bedtime for schizophrenia as m/b auditory (hearing) hallucination (sensory experiences that a person perceives as real, but are not actually present in the environment). During a concurrent interview and record review on 6/4/2025 at 9:50 a.m., with Registered Nurse (RN) 2, Resident 86's Psychotherapeutic Drugs Informed Consent Form, dated 10/27/2024, was reviewed. The Psychotherapeutic Drugs Informed Consent Form indicated consent was obtained for Risperidone 0.25 mg and Seroquel 50 mg for schizophrenia. RN 2 stated Resident 86's psychotherapeutic drugs informed consent form for Risperidone and Seroquel were outdated. RN 2 stated current regulation required the psychotherapeutic drugs informed consent to be renewed every six months. RN 2 stated Resident 86's psychotherapeutic drugs informed consent should have been renewed for Risperidone and Seroquel on 4/2025. RN 2 it was important to ensure informed consents were renewed every six months so the resident would be aware of the medication's continued use, risks, or benefits. During a review of the Health and Human Services Agency California Department of Public Health All Facilities Letter (AFL), dated 2/28/2024, the AFL indicated the following: 1. All facilities were to obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and consent renewal every six months. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. 3. The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures. During a review of the facility's policy and procedure (P&P) titled Informed Consent, revised 1/1/2012, the P&P indicated the facility would ensure a resident's informed consent would be obtained for the use of psychotherapeutic drugs.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was kept within reach for two of 25 sampled residents (Resident 23 and Resident 34). This deficient practice removed Resident 23's and Resident 34's ability to exercise their right to request assistance from staff and created the potential for accidents and/or delays in care. Findings: a. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was originally admitted on [DATE] and most recently readmitted on [DATE]. Resident 23's admitting diagnoses included generalized muscle weakness, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (when blood flow to the brain is interrupted, leading to a lack of oxygen and nutrients to brain tissue) affecting left non-dominant side, symptoms and signs involving the musculoskeletal system, and dementia (progressive state of decline in mental abilities). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 23 had severe cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 23 had upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hips, knees, ankles, feet) impairments on one side of the body. The MDS indicated Resident 23 was dependent on staff for getting dressed and putting on/taking off footwear. The MDS indicated Resident 23 required partial assistance from staff for movement while in bed. During an observation on 6/2/2025 at 10:35 a.m., at Resident 23's bedside, Resident 23's call light was observed on the ground, behind the head of his bed, tangled in the bed frame. During an observation on 6/2/2025 at 12:41 p.m., at Resident 23's bedside, Resident 23's call light was observed on the ground, behind the head of his bed, tangled in the bed frame. During a concurrent interview and record review, on 6/4/2025 at 10:46 a.m., with Registered Nurse (RN) 1, the facility's policy and procedure (P&P) titled Communication - Call System, revised 10/2022, was reviewed. The P&P indicated all residents were to be provided with a call system to enable them to alert nursing staff. RN 1 stated this was for the safety of the resident, and to allow the resident to call for help if needed. RN 1 stated an out of reach call light created the potential for delayed provision of care. During an interview on 6/5/2025 at 11:07 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNAs did room rounds (visual check-ins on the residents) every hour or more frequently. CNA 1 stated the purpose of room rounds was to ensure the residents' needs were met, and to ensure their environment was safe and equipped to meet their needs. CNA 1 stated call light placement was part of the room rounds. CNA 1 stated if a call light was observed out of reach, the CNAs should have placed it within reach of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 34's admission Record, the admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnosis which included hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), and diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34's cognition was severely impaired. The MDS indicated Resident 34 was totally dependent (helper does all the effort) on staff for 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 34's care plan titled Resident at high risk for falls and injuries ., initiated 6/17/2021, the care plan indicated the facility would ensure the call light was within reach for the resident to use to request assistance. During an observation on 6/2/2025 at 10:05 a.m., in Resident 34's room, observed Resident 34 lying in bed. Resident 43's call light was observed on the floor behind the resident's bed. Resident 34's call light was not within reach. During a concurrent observation and interview on 6/2/2025 at 1:40 p.m., with Certified Nursing Assistant (CNA) 3, in Resident 34's room, Resident 34 was observed lying in bed in a semi-Fowler's position (lying on the back with head and upper body raised). CNA 3 stated the call light was observed on the floor behind the resident's bed, not within reach. CNA 3 stated Resident 34's call light should have been attached to the resident's bed and within reach. CNA 3 stated it was important the resident was able to reach and use the call light when needed and for an emergency. During an interview on 6/5/2025 at 9:15 a.m., with Registered Nurse (RN) 1, RN 1 stated the call light should be placed within resident reach and near the resident's bedside. RN 1 stated the call light was important for resident's to be able to communicate with the staff. RN 1 stated the facility's licensed staff were responsible for checking the residents' call light and placing it within resident reach at the bedside. RN 1 stated if the call light not within the resident's reach, the residents would not be able to use the call light and would not be able to call for help and assistance when needed. RN 1 stated the call light not within reach was a resident safety issue and placed residents at risk for falls and injury. During a review of the facility's policy and procedure (P&P) titled Communication-Call System, revised 10/24/2022, the P&P indicated the facility would provide a call system to enable residents to alert the nursing staff from their beds. The P&P indicated the call cords would be placed within the resident's reach in the resident's room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Sets (MDS, a resident assessment tool) for three of 25 sampled residents (Residents 72, 76, and 83) accurately reflected the care and services they received. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding the above residents' health status and unique healthcare needs. This deficient practice also created the potential for Residents 72, 76, and 83 to not receive the interventions needed monitor the effectiveness of the care received. Findings: 1. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 76's admitting diagnoses included dementia (a progressive state of decline in mental abilities) and epilepsy (a condition causing recurring seizures [sudden, uncontrolled electrical disturbances in the brain causing uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had severe cognitive impairments (ability to think and reason). The MDS indicated Resident 76 was dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS did not indicate Resident 76 received oxygen therapy while a resident. During an interview on 6/4/2025 at 9:18 a.m., with Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated it was important to ensure the MDS was coded correctly because it guided the resident's individualized plan of care. During a concurrent interview and record review, on 6/4/2025 at 9:22 a.m., with MDSN 1, Resident 76's MDS dated [DATE] was reviewed. MDSN 1 stated the MDS did not indicate Resident 76 received oxygen therapy while a resident. During a concurrent interview and record review, on 6/4/2025 at 9:23 a.m., with MDSN 1, Resident 76's physician order, dated 4/19/2025 was reviewed. MDSN 1 stated the order indicated Resident 76 had orders for oxygen therapy. During a concurrent interview and record review, on 6/4/2025 at 9:25 a.m., with MDSN 1, Resident 76's vital sign (measurement of the body's most basic functions) flowsheet for oxygen saturation (level of oxygen in the blood), dated 5/2025, MDSN 1 stated the flowsheet indicated Resident 76 was receiving oxygen therapy. MDSN 1 stated Resident 76's MDS dated [DATE] was not accurate. MDSN 1 stated it was important for Resident 76's MDS to accurately reflect her use of oxygen therapy because there were special precautions required when a resident was on oxygen therapy.2. During a review of Resident 72's admission Record (Face Sheet), the Face Sheet indicated Resident 72 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72's cognition was intact. The MDS indicated Resident 72 required setup or clean-up assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 72's History and Physical (H&P), dated 3/10/2025, the H&P indicated Resident 72 had the capacity to understand and make decisions. During an interview on 6/4/2025 at 9:49 a.m., with MDSN 1, MDSN 1 stated the purpose of the MDS was to assess each resident to create an individualized plan of care to manage the resident's diagnoses or problems. MDSN 1 stated the MDS had to be accurate to ensure the resident received the best care possible. MDSN 1 stated a resident's medical diagnoses were included into the MDS upon admission to the facility based on their hospital paperwork and interview with the resident. During a concurrent interview and record review on 6/4/2025 at 9:53 a.m., with MDSN 2, Resident 72's MDS, dated [DATE], was reviewed. MDSN 2 stated Resident 72's MDS indicated he had Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) as a diagnosis. MDSN 2 stated Resident 72's MDS was inaccurate because Resident 72 was not medically diagnosed with Alzheimer's Disease and did not have any issues with his mental abilities. MDSN 2 stated due to Resident 72's inaccurate MDS, Resident 72 was at risk for unnecessary treatment and prescribed medications to treat Alzheimer's Disease. 3. During a review of Resident 83's admission Record, the admission Record indicated was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included malignant neoplasm (cancer) of liver (organ in the body), schizophrenia. During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83's cognition was severely impaired. The MDS indicated Resident 83 was totally dependent (helper does all the effort) on staff for ADLs. The MDS indicated Resident 83 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 6/3/2025 at 10:43 a.m., in Resident 83's room, was observed Resident 83 did not have any natural teeth. Resident 83 stated, I do not have any real teeth left, and I do not have dentures either. I just eat soft food. During a concurrent interview and record review on 6/5/2025 at 7:40 a.m., with MDSN 1, Resident 83's MDS, dated [DATE], was reviewed. MDSN 1 stated she was aware that the resident did not have any natural teeth. MDSN 1 stated Resident 83's MDS oral/dental assessment was coded incorrectly and did not reflect the resident's actual oral and/or dental status. MDSN 1 stated because Resident 83 did not have natural teeth, the MDS should have been coded correctly. MDSN 1 stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument (RAI) Process, revised 5/2025, the P&P indicated each MDS section was to be completed and all information within the MDS assessment was to reflect the resident's status at the time of the Assessment Reference Date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a care plan for five of 25 sampled residents (Resident 94, 101, 121, 83 and 77) by failing to: 1. Develop a care plan to address Resident 94's use of valproic acid (an anticonvulsant medication, a medication used to prevent or treat seizures and can be used to treat behavioral disorders). 2. Develop a care plan for Resident 101's wearable external heart defibrillator (a device that provides an electric shock to the heart to allow it to treat a potentially fatal abnormal heart rhythm). 3. Develop a care plan for the refusal for Restorative Nurse Aid services (nursing interventions that promote a person's ability to adapt and adjust to living as independently and safely as possible) for Resident 121, a resident diagnosed with an extremely painful bone disorder that severely affected his mobility. 4. Develop a care plan for Resident 83's missing natural teeth. 5. Develop a care plan to address Resident 77's use of chlorpromazine (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]). These deficient practices had the potential to negatively affect Residents 94, 101, 121, 83, and 77's physical, mental, and psychosocial well-being and had the potential to delay the delivery of necessary care and services. Findings: 1. During a review of Resident 94's admission Record (Face Sheet), the Face Sheet indicated Resident 94 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 94's Minimum Data Set ([MDS], a resident assessment tool), dated 4/4/2025, the MDS indicated Resident 94's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 94 required supervision with toileting, dressing, and personal hygiene. During a review of Resident 94's History and Physical (H&P), dated 1/6/2025, the H&P indicated Resident 94 had the capacity to understand and make decisions. During a review of Resident 94's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated to give valproic acid 5 milliliters (ml, unit of measurement) by mouth, once time a day for schizoaffective disorder as manifested by verbal angry outburst. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 9:58 a.m., with Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated care plans were developed to dictate the individualized plan of care for each resident. MDSN 1 stated care plans should be developed for residents who received medications to treat behaviors. MDSN 1 stated the manifested behavior, and the medication had to be care planned. During a concurrent interview and record review on 6/4/2025 at 10 a.m. with MDSN 1, Resident 94's Care Plan titled, Risk for aggression, dated 3/24/2022, was reviewed. MDSN 1 stated the Care Plan indicated Resident 94 had schizoaffective disorder manifested by verbal angry outbursts. MDSN 1 stated the Care Plan did not address Resident 94's use of valproic acid to treat his behaviors. MDSN 1 stated the purpose of addressing Resident 94's use of valproic acid was to provide guidance on how to properly monitor, assess, and treat for any potential side effects of the medication. MDSN 1 stated without a care plan, the staff may not know how to properly care for Resident 94. During an interview on 6/4/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated care plans were used as a communication tool between the staff to dictate the care each resident received in the facility. The DON stated Resident 94 should have had a care plan that addressed his use of valproic acid due to the potential side effects that could occur. The DON stated the care plan would indicate the staff's interventions to monitor for potential side effects and for the efficacy of the medication to treat Resident 94's behaviors. The DON stated these interventions would then allow the psychiatrist to determine if any changes to the medication was required. The DON stated without a care plan for Resident 94's use of valproic acid, the staff may not be informed of the necessary care Resident 94 had to receive. 2. During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included coronary angioplasty (procedure to open narrowed or blocked coronary arteries, which supply blood to the heart), tachycardia (fast heart rate), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and anxiety (an overwhelming feeling of uneasiness). During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101's cognitive skills for daily decision making were intact. The MDS indicated Resident 101 required partial moderate assistance (helper does less than half of the effort) for bathing, toileting, lower body dressing, putting on footwear, and bed mobility. The MDS indicated Resident 101 had an active diagnosis of a stroke (when blood supply to part of the brain is interrupted). During a review of Resident 101's Order Summary Report, dated 6/3/2025, there were no orders for Resident 101 to physically wear an external defibrillator (a device that provides an electric shock to the heart to allow it to treat a potentially fatal abnormal heart rhythm) vest, no specified parameters that outlined how long the vest should be worn, and there were no orders to monitor, check the functionality of, and assess the cardiac device. During observations made on 6/2/2025 at 10:00 a.m.,11:56 a.m., and 6/3/2025 at 1:42 p.m., in Resident 101's room, Resident 101 was observed wearing a gray external defibrillator vest. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2025 11:49 a.m. with Registered Nurse (RN) 1, Resident 101's care plan titled, Cardiac Distress, dated 5/2/2025, and all of Resident 101's active care plans, dated 5/2025, were reviewed. The care plan did not indicate interventions specific to the care and monitoring of Resident 101's wearable defibrillator. There were no other care plans that outlined specific interventions for the care of Resident 101's defibrillator. RN 1 stated it was very important to know the functionality, brand of the device, and how often a cardiologist (a physician that specializes in treating conditions of the heart) appointment should be scheduled for the maintenance of Resident 101's defibrillator to ensure proper care was rendered. RN 1 stated the lack of a care plan for Resident 101's defibrillator placed Resident 101 at risk for an adverse cardiac-related emergency. During an interview on 6/4/2025 at 12:10 p.m. with the DON, the DON stated care plans were important to ensure a proper plan of care was in place for a resident. The DON stated proper nursing interventions for the care of Residents 101's defibrillator were to know how to operate the defibrillator and to ensure that the defibrillator operated correctly. The DON stated a care plan specific to the care of Resident 101's defibrillator was necessary to ensure proper nursing interventions were communicated and implemented. 3. During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included disorder of bone, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and muscle weakness. During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121's cognitive skills were intact. The MDS indicated Resident 121 was entirely dependent on staff for toileting, bathing, upper and lower body dressing, and performing personal hygiene. During a review of Resident 121's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated Resident 121 was ordered for the restorative nurse aid (RNA) to perform ambulation (walking) every day three times a week using the front wheeled walker to maintain current levels of mobility. During a review of Resident 121's RNA Progress Note, dated 5/30/2025, the Progress Note indicated Resident 121 refused all (three) RNA sessions that week. During a concurrent observation and interview on 6/2/2025 at 10:10 a.m., in Resident 121's room, Resident 121 was in his bed, positioned on his right side. Resident 121 stated he had bone issues that caused him pain all over his body, predominantly in his hip and arms. Resident 121 stated this affected his overall mobility and limited his ability to participate in physical activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2025 at 11:20 a.m. with RN 2, Resident 121's care plans, dated 5/2025 to 6/2025, were reviewed. There were no care plans for Resident 121's refusals for RNA therapy. RN 2 stated it was important for a refusal care plan to be developed and implemented for Resident 121 to ensure proper interventions were in place to prevent physical decline and to ensure reasons for Resident 121's refusals, like pain, were addressed. RN 2 stated nursing interventions for RNA refusals typically included notifying the physician, identifying the reason why the resident refused the RNA session, and implementing care plan interventions to prevent any functional decline. During an interview on 6/4/2025 at 12:10 p.m. with the Director of Nursing (DON), the DON stated care plans were important to ensure a proper plan of care was in place for a resident. The DON stated Resident 121 should have had an At High Risk for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Decline Secondary to RNA Therapy Refusals care plan after Resident 121 had persistent episodes of refusals. The DON stated the lack of a care plan that addressed the risk of ADL decline secondary to RNA therapy refusals placed Resident 121 at risk for ADL decline due to a lack of communicated interventions amongst the departments involved in his care. 4. During a review of Resident 83's admission Record, the admission Record indicated was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included malignant neoplasm (cancer) of the liver (organ in the body), schizophrenia (a mental illness that is characterized by disturbances in thought), and muscle weakness (loss of muscle strength). During a review of Resident 83's MDS, dated [DATE], the MDs indicated Resident 83's cognition was severely impaired. The MDS indicated Resident 83 was totally dependent (helper does all the effort) on staff for ADLs. The MDs indicated Resident 83 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 6/3/2025 at 10:43 a.m., in Resident 83's room, observed Resident 83 without any natural teeth. Resident 83 stated, I do not have any real teeth left, and I do not have dentures either. I just eat soft food. During a concurrent interview and record review on 6/3/2025 at 3:20 p.m., with MDSN 1, Resident 83's care plans, dated 2024 through 2025, were reviewed. MDSN 1 stated she was aware that the resident did not have any natural teeth. MDSN 1 stated there was no care plan addressing the resident's edentulous (absence of the natural teeth) status. MDSN 1 stated a care plan should have been initiated upon resident's admission to the facility to address oral care needs. MDSN 1 stated care planning serves as a communication tool among facility staff to ensure consistent and effective care. MDSN 1 stated without a care plan in place, staff would not be able to provide care that meets the resident's individualized needs. During an interview on 6/5/2025 at 9:15 a.m., with the DON, the DON stated developing a care plan based on a resident's oral/dental status it was essential to ensure the resident received the appropriate care. The DON stated that without a comprehensive care plan to guide staff in managing the resident's oral care, the resident would be at increased risk for discomfort and decreased quality of life. The DON stated it was important to develop a care plan with individualized interventions to help support or maintain each resident's overall health. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During a review of Resident 77's admission Record, the admission Record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, encephalopathy (disease that affects the brain), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77 cognition was moderately impaired. The MDS indicated Resident 7 required moderate assistance from staff for ADLs. The MDS indicated Resident 77 received antipsychotic (a medication that affects the mind, emotions, and behavior) medication. During a review of Resident 77's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated on 3/26/2025, Resident 77's attending physician prescribed Chlorpromazine 25 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) via 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) one tablet every six hours as needed for HICCUPS (involuntary spasms of the diaphragm [muscle that separates the chest from the abdomen]). During a concurrent interview and record review on 6/3/2025 at 3:21 p.m., with RN 1, Resident 77's care plans, dated 3/2025 through 6/2025, were reviewed. RN 1 stated there was no care plan addressing the resident's use of Chlorpromazine. RN 1 stated it was important to include Chlorpromazine medication in Resident 77's care plan to ensure appropriate monitoring for potential side effects such sedation (sleepiness), extrapyramidal symptoms (tremors), and guide overall resident care. RN 1 stated without a person-centered care plan addressing this medication the facility would not be able to monitor Resident 77's response to treatment, prevent avoidable complications, and provide quality care. During a review of the facility's policy and procedure (P&P) titled, Care Planning, revised 12/10/2009, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT, a group of different disciplines working together towards a common goal for a resident) shall develop a comprehensive care plan for each resident. During a review of the facility's P&P, titled, Care and Services, dated 5/1/2018, the P&P indicated the facility staff were to ensure residents were provided with the necessary care and services to maintain the highest level of practicable functioning in an environment that enhances quality of life in the scope of a long term care facility.

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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 revise one of five sampled resident's (Resident 5) care plan and interventions after Resident 5 had an unwitnessed fall on 11/24/2025. This deficient practice had the potential to result in Resident 5 sustaining a major injury after another fall. Findings: During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 5 had impairment on one side of her upper extremities (limbs of the upper body such as shoulder, elbow, wrist, and hand). The MDS indicated Resident 5 was dependent on staff's assistance with toileting, bathing, and personal hygiene. During a review of Resident 5's History and Physical (H&P), dated 11/26/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Fall Risk Evaluation, dated 11/24/2024, the Fall Risk Evaluation indicated Resident 5 was a high risk for falls. During a review of Resident 5's Situation, Background, Assessment, Recommendation (SBAR, communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 11/24/2024, the SBAR indicated Resident 5 was found on her left side, lying on the floor on the left side of the bed. The SBAR indicated Resident 5 stated she was trying to go to the other side. During an interview on 6/4/2025 at 10:03 a.m., with Minimum Data Set Nurse (MDSN) 1, MDSN 1 stated after a fall, a short-term care plan was developed to address the current situation and acute interventions for 72 hours, however, the long-term care plan had to be revised to address the ongoing interventions to help prevent further falls and/or injuries from a fall. During a concurrent interview and record review on 6/4/2025 at 10:03 a.m., with MDSN 1, Resident 5's Care Plan titled, High Risk for Falls, dated 9/10/2024, was reviewed. MDSN 1 stated Resident 5's care plan was not revised after her fall on 11/24/2025. MDSN 1 stated an Interdisciplinary Team ([IDT], a coordinated group of experts from several different fields) meeting was conducted after Resident 5's fall where the IDT consulted other departments to determine additional interventions to address Resident 5's fall and risk for falls. MDSN 1 stated new interventions were put into place to help prevent Resident 5 from falling again and those interventions should have been added to Resident 5's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 10:17 a.m., with the Quality Assurance (QA) Nurse, the QA Nurse stated the IDT would meet after a resident fall incident to determine the root cause and develop additional interventions to prevent further falls. The QA Nurse stated additional interventions had to be included into the resident's care plan to communicate to the rest of the staff. During a concurrent interview and record review on 6/4/2025 at 11:20 a.m., with the QA Nurse, Resident 5's Post Fall Assessment and Investigation, dated 11/24/2025, was reviewed. The QA Nurse stated the social services, rehab, nursing, and activities department made up the IDT who conducted Resident 5's Post Fall Assessment and Investigation. The QA Nurse stated the IDT recommended bed rails (short rails on one or both sides of the bed) for safe bed mobility. The QA Nurse stated Resident 5's use of bed rails should have been included into a revised care plan. During an interview on 6/4/2025 at 2:26 p.m., with the Director of Nursing (DON), the DON stated once the IDT recommended new interventions after Resident 5's fall, Resident 5's care plan should have been revised. The DON stated revising the care plan was important to communicate to the staff of the interventions to properly care for Resident 5. The DON stated revising the care plan was essential to reevaluate whether Resident 5's goals were met in relation to the interventions set forth in the care plan. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention and Management, revised 2018, the P&P indicated, The IDT will initiate, review, and update resident fall risks and Plan of Care at the following intervals: Admission, Quarterly, Annually, upon Significant Change of Condition Identification, and post fall.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain good grooming and personal hygiene for two of 25 sampled residents (Resident 29 and 68) by failing to: 1. Ensure Resident 29 was bathed. 2. Keep Resident 68's fingernails clean and trimmed. These deficient practices had the potential to negatively impact Resident 29 and 68's quality of life and self-esteem. These deficient practices also had the potential to result in the development of infection. Findings: 1. During a review of Resident 29's admission Record (Face Sheet), the Face Sheet indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), generalized muscle weakness (lack of strength in many muscles throughout the body), and neuromuscular dysfunction of the bladder (lacking bladder control leading to difficulty empty the bladder). During a review of Resident 29's Minimum Data Set ([MDS], a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 29's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 29 was dependent on staff's assistance with toileting, bathing, and lower body dressing. The MDS indicated Resident 29 had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 29's History and Physical (H&P), dated 5/6/2025, the H&P indicated Resident 29 had the capacity to understand and make decisions. During a review of Resident 29's Care Plan titled, Activities of Daily Living (ADL) Self-Care Performance Deficit, dated 5/14/2025, the care plan indicated staff were to encourage Resident 29 to shower as scheduled and per Resident 29's preference. During an interview on 6/3/2025 at 8:58 a.m., with Resident 29, Resident 29 stated with the exception of two times, the certified nursing assistants (CNAs) did not bring him to the shower room nor give him a proper bed bath. Resident 29 stated the bed baths he received would not be considered an actual bed bath because the CNA would lightly wet the washcloth and wipe the washcloth on his body. Resident 29 stated the CNAs would not have a basin of water to rewet the washcloth nor would the CNAs rewet the washcloth in the sink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 8:28 a.m., with CNA 4, CNA 4 stated the residents follow a shower schedule, however, they can request to shower on any day. CNA 4 stated residents have the option to take a shower in the shower room or a bed bath in their room. CNA 4 stated when giving a bed bath, the CNA was responsible for grabbing a basin of water, fresh towels, and the resident's preferred soap. CNA 4 stated throughout the bed bath, new towels would be used in each section of the body being washed. CNA 4 stated providing perineal care (cleaning and maintenance of the genital and anal area) was very important, especially for a resident with an indwelling urinary catheter. CNA 4 stated perineal care was provided every day and during a resident's shower day. CNA 4 stated after a shower or bed bath was provided to a resident, the CNA was responsible for documenting on the resident's Task sheet on the electronic health record (eHR). During a concurrent interview and record review on 6/4/2025 at 8:39 a.m., with CNA 4, Resident 29's Bathing Task, dated May and June 2025 were reviewed. The Bathing Task indicated Resident 29 only had one documented shower on 5/13/2025. CNA 4 stated without documented showers, there was no way to prove Resident 29 received a shower or a bed bath. CNA 4 stated this was in issue because Resident 29 was at risk for infection due to the presence of the indwelling urinary catheter and bathing was essential to keep Resident 29 clean and free of dirt and bacteria. CNA 4 stated not only are showers essential for infection prevention, but showers were also important for Resident 29's self-esteem by feeling clean and not malodorous (smelling unpleasant). During an interview on 6/4/2025 at 2:34 p.m., with the Director of Nursing (DON), the DON stated all CNAs were expected to provide routine showers or bed baths to the residents. The DON stated a bed bath consisted of a water filled basin and towels to ensure the resident was clean. The DON stated the CNA was responsible for documenting in the resident's eHR after completing the bed bath to communicate to other staff members the date of the bath and the level of assistance the resident required. The DON stated Resident 29 should have been bathed either in the shower room or in his room. The DON stated bathing Resident 29 was essential for cleanliness, self-esteem, and infection prevention. The DON stated perineal care would also be provided during a bath and perineal care was essential for Resident 29 due to the presence of an indwelling urinary catheter. The DON stated not only was Resident 29 at risk for self-esteem issues, Resident 29 was also at risk for developing an infection. During a review of the facility's policy and procedure (P&P) titled, Showering a Resident, revised 5/1/2018, the P&P indicated, A shower bath is given to the residents to provide cleanliness, comfort, and to prevent body odors. 2. During a review of Resident 68's admission Record, the admission Record indicated Resident 68 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), and muscle weakness. During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68's cognition was intact. The MDS indicated Resident 83 required moderate (helper does less than half the effort) assistance from staff for ADLs. During a concurrent observation and interview of 6/2/2025 at 9:52 a.m., in Resident 68's room, with Resident 68, the resident was observed with visibly long, irregular in shape fingernails. The fingernails had dark brown debris underneath and curled over the fingertips. Resident 68 stated her nails were dirty and too long. Resident 68 stated no one had cut and/or cleaned her nails in a while. (continued on next page)

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	056478	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/2/2025 at 3:30 p.m., in Resident 68's room, with CNA 3, Resident 68 was observed with a dark brown substance underneath her fingernails. CNA 3 stated Resident 68's fingernails were dirty and required cleaning and trimming. CNA 3 stated nail care was one of the CNA's responsibilities, which included observing the resident's nails and trimming and cleaning when long and dirty. CNA 3 stated residents' nails should be checked daily to ensure nails remain clean and neat. CNA 3 stated residents sometimes scratch their skin, and if they scratch hard enough, they could break the skin and create an open wound. CNA 3 stated if a resident had dirty fingernails and scratched themselves, this increased the risk of infection. CNA 3 stated having dirty fingernails was unsanitary because the residents use their hands to eat, and any bacteria present could be transferred to their mouth. CNA 3 stated if Resident 68 was to touch shared objects, bacteria from under her fingernails could be transferred to those items and potentially to other residents. During an interview on 6/5/2025 at 9:30 am., with the DON, the DON stated fingernail care was a part of the resident's ADLs routine. The DON stated if a resident had long and dirty fingernails, CNAs were expected to clean and trim them. The DON stated dirty fingernails was not acceptable, as they increase the risk of infection, especially if residents touch food or share items. During a review of P&P titled Grooming Care of the Fingernails and Toenails, revised 5/1/2018, the P&P indicated facility would provide nail care to keep residents' nails clean and trim. The P&P indicated CNAs would trim residents' fingernails.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 76) had floor mats (cushioned floor pads designed to help prevent injury should a person fall) placed appropriately to prevent injury related to potential falls. This deficient practice placed Resident 76 at risk of experiencing injuries related to falls, such as bruises and/or broken bones. Findings: During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 76's admitting diagnoses included epilepsy (a brain condition that causes recurring seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and dementia (a progressive state of decline in mental abilities). During a review of Resident 76's Minimum Data Saet (MDS, a resident assessment tool), dated 5/13/2025, the MDS indicated Resident 76 had severely impaired cognition (a significant decline in a person's ability to think, learn, and remember, resulting in a substantial impact on their daily life and independence). The MDS indicated Resident 76 had impairments to her upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles, feet) on both sides of her body. The MDS indicated Resident 76 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and movement while in bed. During a review of Resident 76's physician order, dated 6/3/2025, the order indicated Resident 76 was to have floor mats at bedside to prevent injury related to a behavior of rolling out of bed and/or placing herself on the floor. The order also indicated staff were to check placement of the floor mats every shift. During a review of Resident 76's care plan titled [Resident 76] has need for floor mats at bedside to prevent injury related to behavior of sliding and rolling out of bed and/or placing self on the floor, poor safety awareness, and high risk for fall, dated 6/3/2025, the care plan indicated goals of care were for Resident 76 to have no significant injuries. The care plan interventions included checking placement of the floor mats every shift. During an observation on 6/3/2025 at 10:45 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed. One fall mat was observed to the left side of her bed, and the other was underneath the bed, and not at the bedside. During an observation on 6/4/2025 at 8:39 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed. One fall mat was observed to the left side of her bed, and the other was underneath the bed, and not at the bedside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/4/2025 at 8:41 a.m., with Registered Nurse (RN) 1, Resident 76's physician order dated 6/4/2025 was reviewed. The order indicated Resident 76 required floor mats at the bedside to prevent injury related to the behavior of rolling out of bed and/or placing herself on the floor. RN 1 stated the order indicated staff were to check placement of the floor mats every shift. RN 1 stated staff were to start this at 7:00 a.m. on 6/3/2025. RN 1 stated the purpose of the floor mats was to prevent injury. RN 1 stated if the floor mats were not in place, Resident 76 could sustain fall-related injuries. During a concurrent interview and record review, on 6/4/2025 at 8:45 a.m., with RN 1, the photo taken on 6/3/2025 at 10:45 a.m. was reviewed. RN 1 stated Resident 76 had one functional floor mat, and stated the other was under the bed. RN 1 stated this was not effective because if Resident 76 were to fall, she would fall directly onto the floor which could cause injury. During a concurrent observation and interview, on 6/4/2025 at 8:46 a.m., with RN 1, at Resident 76's bedside, Resident 76's floor mats were observed. RN 1 stated the floor mat was still under the bed and was not placed effectively. During a review of the facility's policy and procedure (P&P) titled Fall Prevention and Management, revised 2018, the P&P indicated it was the facility's policy to provide a safe environment that minimizes complications associated with falls. The P&P indicated staff were to develop a plan of care according to the identified risk factors and root causes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** b. During a review of Resident 29's admission Record (Face Sheet), the Face Sheet indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), generalized muscle weakness (lack of strength in many muscles throughout the body), and neuromuscular dysfunction of the bladder (lacking bladder control leading to difficulty empty the bladder). During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognition was moderately impaired, and the resident was dependent on staff's assistance for toileting, bathing, and lower body dressing. The MDS indicated Resident 29 had an indwelling urinary catheter. During an interview on 6/4/2025 at 8:54 a.m., Resident 29 stated the urinary catheter was not secured to his leg and that he often felt the tubing go under his genital area and his leg. Resident 29 stated when the tubing went underneath him, he would feel it poking him and would be very uncomfortable. Resident 29 stated at times the tubing felt like it was pulling, and he would have to try to readjust it. During a concurrent observation and interview on 6/4/2025 at 9:02 a.m., with TN 1 in Resident 29's room, Resident 29 was observed lying in bed with his urinary catheter exposed. Resident 29's indwelling urinary catheter exited from Resident 29's urethra (the tube that carries urine from the bladder out of the body) and the tubing was not secured to Resident 29's leg. TN 1 stated Resident 29's urinary catheter tubing should always be secured to his leg. TN 1 stated securing the tubing to Resident 29's leg offered protection from accidental pulling and dislodgement. TN 1 stated securing the tubing offered protection to Resident 29's genital area and legs to prevent any unnecessary pressure and poking. During an interview on 6/4/2025 at 2:42 p.m., the Director of Nursing (DON) stated indwelling urinary catheters should always be secured to the resident's leg. The DON stated Resident 29 was able to move around in bed and his urinary catheter could move under him or get stuck. The DON stated without the proper urinary catheter securement, Resident 29 was at risk of the urinary catheter pulling and dislodging which could be very painful. During a review of the facility's P&P titled, Catheter- Care of, revised 5/1/2018, the P&P indicated, Anchor the catheter with a leg strap to protect excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter. Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Residents 89 and 29) received the necessary care and services to maintain normal bladder function. Resident 89 did not receive daily urinary catheter care and Resident 29's urinary catheter was not secured with a leg strap. These deficient practices had the potential to result in a urinary tract infection (UTI- an infection in the bladder/urinary tract), urethral injury and / or unnecessary discomfort for Resident 89 and Resident 29. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: a. During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including retention of urine, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, severe sepsis (a life-threatening blood infection) with septic shock (a near-fatal condition that occurs with sepsis), and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 89's Care Plan titled, Resident Requires Use of Foley Catheter, dated 10/18/2024, the care plan indicated the facility's interventions were to cleanse the foley catheter and urethral opening with normal saline daily or as needed. During a review of Resident 89's Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 89's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 89 was entirely dependent on staff for Activities of Daily Living and the resident had an indwelling catheter. During an observation made on 6/2/2025 at 10 a.m., in Resident 89's room, Resident 89 was in bed with his urinary catheter in place. During a concurrent interview and record review on 6/4/2025 at 9:41 a.m., with the Treatment Nurse (TN) 1, Resident 89's Physician's Orders, dated 4/2025 to 6/4/2025, and Resident 89's Treatment Administration Record (TAR), dated 4/2025 to 6/2/2025, were reviewed. The Physician's Orders indicated Resident 89 had a urinary catheter in place from 4/2025 to 6/4/2025. The Physician's Orders indicated there was no order for daily urinary catheter care since 4/2025. The TAR indicated there was no documentation of daily urinary catheter care since 4/2025. TN 1 stated the facility's normal practice to prevent the occurrence of UTI's was to ensure urinary catheter care was provided daily. This included the catheter bag was changed twice a week or as needed, and the resident's output was monitored and documented. TN 1 stated there was no documentation to indicate Resident 89 received daily urinary catheter care since 4/2025. TN 1 stated it was important to maintain documentation of daily urinary catheter care because the documentation served as proof that the task was completed. TN 1 stated if the care was not done daily, then there was potential for Resident 89 to develop a urinary catheter associated infection or a UTI. During a review of the facility's Policy and Procedure (P&P), titled, Catheter- Care Of, dated 5/1/2018, the P&P indicated the facility was to prevent catheter-associated urinary tract infections. The P&P indicated documentation of catheter care would be maintained in the resident's medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to change the nasal cannula (device used to deliver supplemental [extra] oxygen placed directly on a resident's nostrils) and humidifier (water used to increase the moisture while providing oxygen therapy) weekly and store an oxygen mask (mask placed over the nose and mouth and connected to a supply of oxygen) inside a plastic bag in accordance to the facility's policy and procedure for one of three sampled residents (Resident 29). This deficient practice had the potential to result in an increased the risk for Resident 29 to acquire a respiratory infection. Findings: During a review of Resident 29's admission Record (Face Sheet), the Face Sheet indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), generalized muscle weakness (lack of strength in many muscles throughout the body), and neuromuscular dysfunction of the bladder (lacking bladder control leading to difficulty empty the bladder). During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 29 had moderately impaired cognition (ability to think, remember and use judgement), and was dependent on staff's assistance with toileting, bathing, and lower body dressing. During an observation on 6/2/2025 at 9:36 a.m., in Resident 29's room, Resident 29 had a nasal cannula at two liters. The humidifier bottle and tubing were dated 5/24/2025 (one week and two days prior) and the oxygen mask hung from Resident 29's bed, almost touching the floor. During a concurrent observation on 6/3/2025 at 8:58 a.m., in Resident 29's room, Resident 29 was observed lying in bed with the nasal cannula, at two liters. The humidifier bottle and tubing were dated 5/24/2025 and the oxygen mask hung from Resident 29's nightstand. During a concurrent interview, Resident 29 stated his nasal cannula and humidifier were changed when the humidifier bottle was empty. During a review of the Physician's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated Resident 29 was to receive two liters (L, unit of measurement) of oxygen via nasal cannula for oxygen saturation (the percentage of oxygen in a person's blood, normal oxygen saturation level between 95 and 100 percent [%]) of 92 percent (%) or below. May increase to 4L to keep saturation levels at 92% or higher, as needed for shortness of breath. The Physician's Order Summary Report indicated to give albuterol sulfate (medication used to relax and open air passages to the lungs to make breathing easier), 3 (mL, milliliters), inhaled orally via nebulizer (drug delivery device to administer medication in the form of a mist inhaled into the lungs), every six hours as needed for shortness of breath and/or wheezing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 10:49 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated nasal cannulas and humidifiers were to be changed weekly or if they become dirty. LVN 2 stated she changed Resident 29's nasal cannula and humidifier because they were being used longer than a week. LVN 2 stated Resident 29 received nebulizer treatments and when the oxygen mask was not in use, the oxygen mask should be stored inside a plastic bag. During an interview on 6/4/2025 at 11:51 a.m., the Infection Preventionist Nurse (IPN) stated all oxygen tubing and humidifiers had to be changed weekly or when visibly dirty. The IPN stated changing the oxygen tubing and humidifier weekly would prevent the resident from breathing in old secretions or dirt accumulated into the oxygen tubing. The IPN stated the oxygen tubing had the potential to grow bacteria that could enter the resident via their nose. The IPN stated keeping the oxygen tubing and humidifier in use longer than a week placed the resident at risk for respiratory infection. The IPN stated all unused oxygen tubing and masks had to be stored inside a plastic bag to protect the device from collecting dust and prevent it from touching the floor. The IPN stated if oxygen devices were kept exposed when unused, dirt and bacteria could enter the oxygen device, thus entering the resident once it was back in use. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 5/1/2018, the P&P indicated, All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen are for single resident use only and will be changed weekly and when soiled. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Registered Nurse (RN) 1, RN 2, and Licensed Vocational Nurse (LVN) 4 practiced the necessary competencies when providing care and services when the following occurred: 1. RN 1 did not correctly interpret or carry out Resident 115's physician order to change the resident's urinary catheter (thin tube inserted into the bladder) drainage bag (a medical device used to collect urine that is drained from the bladder). 2. RN 2 and LVN 4 did not know the facility policy and procedure (P&P) for replacing a resident's humidifier bottle (a device that adds moisture to the oxygen being delivered). These deficient practices placed the residents at risk for infection and illness. Findings: 1. During a review of Resident 115's admission Record, the admission Record indicated Resident 115 was originally admitted on [DATE] and most recently readmitted on [DATE]. Resident 115's admitting diagnoses included urinary retention (the inability to fully or partially empty the bladder, leaving urine trapped inside), acute kidney failure (a sudden and significant loss of kidney function), and benign prostatic hyperplasia (BPH, a condition in which the prostate gland grows larger than normal) with lower urinary tract (bladder and urethra in both males and females, and the prostate in males) symptoms. During a review of Resident 115's Minimum Data Set (MDS, a resident assessment tool), dated 4/19/2025, the MDS indicated Resident 115 had moderate cognitive impairments (a stage of cognitive decline where individuals experience more noticeable problems with thinking, learning, and memory compared to normal aging). The MDS indicated Resident 115 was dependent on staff for toileting hygiene (a set of practices that are necessary to prevent the spread of disease and preserve health related to urination and defecation). During a review of Resident 115's physician order, dated 1/11/2025, the order indicated staff were to change Resident 115's urinary catheter drainage bag every two (2) weeks and as needed every day shift every 14 day(s). During a review of Resident 115's care plan titled Risk for infection related to indwelling catheter, dated 1/12/2025, the care plan indicated the goal of care was that Resident 115 would not have signs or symptoms of a urinary tract infection. The care plan indicated staff were to change Resident 115's catheter drainage bag as ordered. During a concurrent interview and record review, on 6/3/2025 at 3:30 p.m., with RN 1, Resident 115's physician order dated 1/11/2025 was reviewed. RN 1 stated the physician order indicated staff were to change Resident 115's urinary catheter drainage bag every two weeks if needed. RN 1 stated the order did not indicate staff were to change the urinary catheter drainage bag every two weeks and as needed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 10:59 a.m., with RN 1, RN 1 stated she spoke with the Director of Nursing (DON) and clarified Resident 115's physician order, dated 1/11/2025. RN 1 stated she now understood staff were to change Resident 115's urinary catheter drainage bag every two weeks and as needed. RN 1 stated she was not previously following the order to change the urinary catheter drainage bag every two weeks. RN 1 stated the purpose of changing the drainage bag at least every two weeks was to prevent infection. During a concurrent interview and record review, on 6/4/2025 at 1:41 p.m., with the Director of Nursing (DON), Resident 115's physician order, dated 1/11/2025, was reviewed. The DON stated the order indicated the drainage bag was to be changed every two weeks and as needed. The DON stated the order was written clearly and licensed nursing staff, including RNs and licensed vocational nurses (LVNs) should have the competency to interpret and carry out the order. The DON stated it was a competency issue if licensed nursing staff could not interpret the order as it was written. During an interview on 6/5/2025 at 1:38 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated unchanged drainage bags could harbor bacteria and lead to infection. The IPN stated this was why it was important to ensure the urinary catheter drainage bags were changed the frequency ordered. During a review of the facility's job description for Registered Nurse Supervisor, undated, the job description indicated RNs were to be able to demonstrate knowledge of and ability to apply basic principles of nursing care. During a review of the facility's P&P titled Catheter - Care Of, revised 5/2018, the P&P indicated staff were to ensure residents with a catheter received appropriate care and services to prevent infections to the extent possible. 2. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 76's admitting diagnoses included dementia (a progressive state of decline in mental abilities). During a review of Resident 76's MDS, dated , the MDS indicated Resident 76 had severely impaired cognition (a significant decline in a person's ability to think, remember, learn, and use judgment). The MDS indicated Resident 76 was dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 76's physician order, dated , the physician order indicated Resident 76 was to receive oxygen therapy (a medical treatment that involves administering supplemental oxygen to individuals who have difficulty getting enough oxygen through normal breathing). During an observation on 6/3/2025 at 11:05 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed receiving oxygen therapy via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 76's nasal cannula was connected to a humidifier bottle dated 5/2/2025. (continued on next page)

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Lighthouse Healthcare Center	2222 Santa Ana Blvd. Los Angeles, CA 90059

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/4/2025 at 8:48 a.m., at Resident 76's bedside, Resident 76 was observed lying in bed receiving oxygen therapy via nasal cannula. Resident 76's nasal cannula was connected to the same humidifier bottle. The date read 6/2/2025, and the previous month of 5 (May), had been written over. During an interview on 6/4/2025 at 8:50 a.m., with Registered Nurse (RN) 1, RN 1 stated humidifier bottles were to be changed every week. During a concurrent interview and record review, on 6/4/2025 at 8:53 a.m., with RN 1, a photo of Resident 76's humidifier bottle, taken on 6/3/2025 at 11:05 a.m., was reviewed. RN 1 stated the humidifier bottle was dated 5/2/2025. RN 1 stated the humidifier bottle should have been changed multiple times since 5/2/2025. RN 1 stated the purpose of replacing the humidifier bottle weekly was to prevent infection. During a concurrent interview and record review, on 6/4/2025 at 9:14 a.m., with LVN 4, a photo taken of Resident 76's humidifier bottle taken on 6/3/2025 at 11:05 a.m. was reviewed. LVN 4 stated the initials on the humidifier bottle were hers, and stated the date on the humidifier bottle was 5/2/2025. When asked how frequently the humidifier bottle was to be changed, LVN 4 stated she was not sure. During a concurrent interview and record review, on 6/4/2025 at 9:16 a.m., with LVN 4, a photo taken of Resident 76's humidifier bottle taken on 6/4/2025 at 8:49 a.m., was reviewed. LVN 4 stated the initials on the humidifier bottle were hers and stated the date on the humidifier now read 6/2/2025. LVN 4 stated she wrote over the previous month of 5 (May) and made it a 6 (June). During an interview on 6/4/2025 at 9:44 a.m., with LVN 4, LVN 4 stated the facility policy was to change humidifier bottles as needed. LVN 4 stated this meant the bottles would be changed once nearly empty or empty. LVN 4 stated she received this guidance from RN 2. During an interview on 6/4/2025 at 12:56 p.m., with the IPN, the IPN stated that weekly replacement of humidifier bottles was for infection control. The IPN stated that failure to change the humidifier bottle in accordance with the facility policy created the potential for respiratory infections. During an interview on 6/5/2025 at 10:16 a.m., with the DON, the DON stated staff were trained on facility policies and procedures. During a concurrent interview and record review, on 6/5/2025 at 10:17 a.m., with the DON, RN 2's and LVN 4's signed job descriptions dated 3/30/2023 and 12/2/2024, were reviewed. The DON stated RN 2's job description indicated she should be able to remember and recall facility policies and procedures. The DON stated LVN 4's job description indicated she should be able to remember, recall, and implement facility policies and procedures. During a concurrent interview and record review, on 6/5/2025 at 10:19 a.m., with the DON, the facility's P&P titled Oxygen Administration, revised 2018, was reviewed. The DON stated the P&P indicated humidifier bottles were to be to be changed weekly and as needed. The DON stated the purpose of this practice was for infection control. The DON stated failure to implement this policy created the potential for respiratory infection.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services and routine medications for two of six sampled residents (Resident 23 and Resident 60). Resident 23 and Resident 60 did not receive medications per Physician's Order, nor did the pharmacy have the medication available for Resident 23. These deficient practices had the potential to cause adverse outcomes to the residents such as low blood pressure and cerebral hypoperfusion (inadequate blood flow to the brain) for Resident 23, and gastric upset for Resident 60. Findings: a. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was re-admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (an interruption in blood flow to the brain), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), and 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). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 23 was entirely dependent on staff for activities of daily living. During a review of the Physician's Order Summary Report, dated 6/3/2025, the Order Summary Report indicated Resident 23 was originally ordered isosorbide mononitrate (a medication used to prevent chest pain [angina] caused by coronary artery disease) oral tablet 30 milligrams (mg, unit of measurement) via g-tube one time a day for hypertensive (high blood pressure) heart disease on 5/20/2025. During a concurrent observation, interview, and record review on 6/3/2025 at 8:43 a.m. with LVN 1, Resident 23's isosorbide bubble pack was observed, Resident 23's isosorbide bubble pack medication label was reviewed and Resident 23's Physician Orders, dated 5/20/2025, were reviewed. The bubble pack had 11 tablets remaining out of the 31 doses dispensed. The bubble pack label indicated the contents of the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg extended release. The Physician's Orders indicated Resident 23 was ordered isosorbide mononitrate oral tablet 30 mg via g-tube one time a day on 5/20/2025. LVN 1 stated she did not notice the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg extended release and stated extended-release medication was not to be crushed and administered via g-tube unless prescribed by the physician. LVN 1 stated the order should have been clarified by the physician and the pharmacy should have been made aware. LVN 1 stated Resident 23's physician medication order of isosorbide mononitrate oral tablet 30 mg was not prepared or ordered as prescribed, which could have placed Resident 23 at risk for a sudden drop in blood pressure and, or decreased heart rate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review at 6/3/2025 at 8:45 a.m. with LVN 1, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated Resident 23 received 14 doses of isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 1 stated the only supply of isosorbide mononitrate oral tablet 30 mg was the extended-release dose. LVN 1 stated she was Resident 23's assigned nurse the day before (6/2/2025) and stated she crushed and administered Resident 23's isosorbide mononitrate oral tablet 30 mg extended-release dose via g-tube. LVN 1 stated she did not notice the physician orders did not match the labeling on the bubble pack supply of isosorbide for the five times she had administered it since 5/20/2025. During a concurrent interview and record review on 6/4/2025 at 11:11 a.m. with LVN 2, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated LVN 2 administered six doses of the 14 doses of Resident 23's isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 2 stated she crushed and administered the medication that was dispensed by the pharmacy (isosorbide mononitrate oral tablet 30 mg extended release) and did not notice the physician's orders did not match the labeling on the bubble pack supply for the six times she had administered it since 5/20/2025. LVN 2 stated by not comparing the bubble pack supply to the physician's order, and by crushing the extended-release dose of isosorbide, this placed Resident 23 at risk for death or hospitalization. During an interview on 6/3/2025 at 11:42 a.m. with Pharmacist 1, Pharmacist 1 stated the pharmacy had not delivered Resident 23's bubble pack supply of isosorbide mononitrate oral tablet 30 mg (immediate release) to the facility. Pharmacist 1 stated isosorbide mononitrate oral tablet 30 mg was only available in ER form and not in immediate release form. Pharmacist 1 stated the pharmacy delivered isosorbide mononitrate oral tablet 30 mg ER to the facility and the error was not noticed by the pharmacy technicians or the licensed nursing staff. During an interview on 6/4/2025 at 12:10 p.m. with the Director of Nursing (DON), the DON stated she expected the pharmacy to communicate with the licensed nursing staff to make them aware the isosorbide mononitrate oral tablet 30 mg (immediate release) was not available so that the licensed nursing staff could call the physician. The DON stated she expected the licensed nurse to compare the medication bubble pack with the physician's order prior to the administration of medications. The DON stated if any issues were identified, then the licensed staff would have to communicate with the physician and the pharmacy. The DON stated once an ER medication was crushed, the medication was immediately released into the blood stream and the effects of the medication would start right away. The DON stated an ER medication was intended to be released slowly (over 12-24 hours) into the blood stream throughout the day. The DON stated this placed Resident 23 at risk for a hypotensive (low blood pressure) or bradycardic (slow heart rate) event because medication was crushed and not administered per the physician's order. b. During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was re-admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrointestinal hemorrhage, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive skills for daily decision making were moderately impaired. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/3/2025 at 7:45 a.m. with LVN 3, LVN 3's medication pass was observed. LVN 3 dispensed one metformin oral tablet 1000 mg in a medication cup. LVN 3 entered Resident 60's room and attempted to administer Resident 60 the tablet without his breakfast tray or food. During a concurrent interview and record review on 6/3/2025 at 7:50 a.m. with LVN 3, Resident 60's eMAR, dated 6/3/2025, was reviewed. The eMAR indicated Resident 60 was to receive the dose of metformin with food or a meal. LVN 3 stated she should have waited until Resident 60's breakfast tray was delivered to administer the medication. LVN 3 stated the administration of the metformin would have placed Resident 60 at risk for gastric upset and it did not align with the physician's order. During a review of Resident 60's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated Resident 60 was ordered metformin oral tablet 1000 mg one time a day by mouth and to give with food or meal. During an interview on 6/4/2025 at 12:10 p.m., the DON stated she would have expected the licensed nurses to compare the medication bubble pack with the physician's order prior to administering medications. The DON stated metformin was usually administered with food because some medications were sensitive to gastric acid. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, dated 5/1/2018, the P&P indicated the licensed nurse was to administer medications per the order of the attending physician or licensed independent practitioner. The P&P indicated the licensed nurses were to keep in mind the seven rights of medication when administering medication: a. The right medication b. The right amount c. The right resident d. The right time e. The right route f. Right indication g Right outcome The P&P also indicated the licensed nurse were to perform three checks [which include]: comparing the physician's order, pharmacy label and the medication administration record. The P&P indicated if any discrepancies were identified during the first, second and third check, it must be resolved prior to the administration of any medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that its medication error rate was less than five percent (%). There were two medication errors out of 31 total opportunities which contributed to an overall medication error rate of 6.45% affecting two of five residents observed for medication administration (Resident 23 and Resident 60). Resident 23 and Resident 60 did not receive medications per Physician's Order, nor did the pharmacy have the medication available for Resident 23. The deficient practice of failing to administer medications in accordance with the physician's orders, including pharmacy not having the prescribed medication available, increased the risk that Residents 23 and 60 may have experienced medical complications possibly resulting in hospitalization. Cross Reference F755 Findings: a. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was re-admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (an interruption in blood flow to the brain), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), and 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). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 23 was entirely dependent on staff for activities of daily living. During a review of the Physician's Order Summary Report, dated 6/3/2025, the Order Summary Report indicated Resident 23 was ordered isosorbide mononitrate (a medication used to prevent chest pain [angina] caused by coronary artery disease) oral tablet 30 milligrams (mg, unit of measurement) via g-tube one time a day for hypertensive (high blood pressure) heart disease on 5/20/2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 6/3/2025 at 8:43 a.m. with LVN 1, Resident 23's isosorbide bubble pack was observed, Resident 23's isosorbide bubble pack medication label was reviewed and Resident 23's Physician Orders, dated 5/20/2025, were reviewed. The bubble pack had 11 tablets remaining out of the 31 doses dispensed. The bubble pack label indicated the contents of the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg extended release. The Physician's Orders indicated Resident 23 was ordered isosorbide mononitrate oral tablet 30 mg via g-tube one time a day on 5/20/2025. LVN 1 stated she did not notice the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg extended release and stated extended-release medication was not to be crushed and administered via g-tube unless prescribed by the physician. LVN 1 stated the order should have been clarified by the physician and the pharmacy should have been made aware. LVN 1 stated Resident 23's physician medication order of isosorbide mononitrate oral tablet 30 mg was not prepared or ordered as prescribed, which could have placed Resident 23 at risk for a sudden drop in blood pressure and, or decreased heart rate. During a concurrent interview and record review at 6/3/2025 at 8:45 a.m. with LVN 1, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated Resident 23 received 14 doses of isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 1 stated the only supply of isosorbide mononitrate oral tablet 30 mg was the extended-release dose. LVN 1 stated she was Resident 23's assigned nurse the day before (6/2/2025) and stated she crushed and administered Resident 23's isosorbide mononitrate oral tablet 30 mg extended-release dose via g-tube. LVN 1 stated she did not notice the physician orders did not match the labeling on the bubble pack supply of isosorbide for the five times she had administered it since 5/20/2025. During a concurrent interview and record review on 6/4/2025 at 11:11 a.m. with LVN 2, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated LVN 2 administered six doses of the 14 doses of Resident 23's isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 2 stated she crushed and administered the medication that was dispensed by the pharmacy (isosorbide mononitrate oral tablet 30 mg extended release) and did not notice the physician's orders did not match the labeling on the bubble pack supply for the six times she had administered it since 5/20/2025. LVN 2 stated by not comparing the bubble pack supply to the physician's order, and by crushing the extended-release dose of isosorbide, this placed Resident 23 at risk for death or hospitalization. During an interview on 6/3/2025 at 11:42 a.m. with Pharmacist 1, Pharmacist 1 stated the pharmacy had not delivered Resident 23's bubble pack supply of isosorbide mononitrate oral tablet 30 mg (immediate release) to the facility. Pharmacist 1 stated isosorbide mononitrate oral tablet 30 mg was only available in ER form and not in immediate release form. Pharmacist 1 stated the pharmacy delivered isosorbide mononitrate oral tablet 30 mg ER to the facility and the error was not noticed by the pharmacy technicians or the licensed nursing staff. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 12:10 p.m. with the Director of Nursing (DON), the DON stated she expected the pharmacy to communicate with the licensed nursing staff to make them aware the isosorbide mononitrate oral tablet 30 mg (immediate release) was not available so that the licensed nursing staff could call the physician. The DON stated she expected the licensed nurse to compare the medication bubble pack with the physician's order prior to the administration of medications. The DON stated if any issues were identified, then the licensed staff would have to communicate with the physician and the pharmacy. The DON stated once an ER medication was crushed, the medication was immediately released into the blood stream and the effects of the medication would start right away. The DON stated an ER medication was intended to be released slowly (over 12-24 hours) into the blood stream throughout the day. The DON stated this placed Resident 23 at risk for a hypotensive (low blood pressure) or bradycardic (slow heart rate) event because medication was crushed and not administered per the physician's order. b. During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was re-admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrointestinal hemorrhage, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive skills for daily decision making were moderately impaired. During a concurrent observation and interview on 6/3/2025 at 7:45 a.m. with LVN 3, LVN 3's medication pass was observed. LVN 3 dispensed one metformin oral tablet 1000 mg in a medication cup. LVN 3 entered Resident 60's room and attempted to administer Resident 60 the tablet without his breakfast tray or food. During a concurrent interview and record review on 6/3/2025 at 7:50 a.m. with LVN 3, Resident 60's eMAR, dated 6/3/2025, was reviewed. The eMAR indicated Resident 60 was to receive the dose of metformin with food or a meal. LVN 3 stated she should have waited until Resident 60's breakfast tray was delivered to administer the medication. LVN 3 stated the administration of the metformin would have placed Resident 60 at risk for gastric upset and it did not align with the physician's order. During a review of Resident 60's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated Resident 60 was ordered metformin oral tablet 1000 mg one time a day by mouth and to give with food or meal. During an interview on 6/4/2025 at 12:10 p.m., the DON stated she would have expected the licensed nurses to compare the medication bubble pack with the physician's order prior to administering medications. The DON stated metformin was usually administered with food because some medications were sensitive to gastric acid. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, dated 5/1/2018, the P&P indicated the licensed nurse was to administer medications per the order of the attending physician or licensed independent practitioner. The P&P also indicated the licensed nurse were to perform three checks [which include]: comparing the physician's order, pharmacy label and the medication administration record. The P&P indicated if any discrepancies were identified during the first, second and third check, it must be resolved prior to the administration of any medication. The P&P also indicated the licensed nurse were to perform three checks [which include]: comparing the physician's order, pharmacy label and the medication administration record. The P&P indicated if any discrepancies were identified during the first, second and third check, it must be resolved prior to the administration of any medication. The P&P indicated the licensed nurses were to keep in mind the seven rights of medication when administering medication: a. The right medication b. The right amount c. The right resident d. The right time e. The right route f. Right indication g Right outcome

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the licensed nursing staff failed to ensure a resident was free from significant medication errors when staff failed to ensure the following for one of six sampled residents (Resident 23): 1. Resident 23's blood pressure medication was administered as ordered when the licensed nursing staff crushed and administered isosorbide mononitrate (a blood pressure medication) oral tablet 30 milligrams (mg- a unit of measurement) extended-release (ER- a medication that is formulated so that the drug is released slowly over time) in place of the prescribed isosorbide mononitrate 30 mg immediate release (IR- medication that allows for immediate absorption) on 14 occasions. 2. The pharmacy supplied the facility the correct form and dose of isosorbide mononitrate oral 30 mg for Resident 23, as ordered. These failures resulted in 14 instances of improper administration over a two-week period, which had the potential to cause rapid release of the drug, leading to hypotension (low blood pressure) dizziness, and other adverse cardiovascular effects for Resident 23. Findings: 1a. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (an interruption in blood flow to the brain), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), and 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). During a review of Resident 23's Minimum Data Set ([MDS], a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 23's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 23 was entirely dependent on staff for 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 23's Order Recap Report, dated 6/3/2025, the Order Recap Report indicated on 5/20/20205 Resident 23 was ordered isosorbide mononitrate (a blood pressure medication) oral tablet 30 milligrams (mg- a unit of measurement) via g-tube one time a day for hypertensive (high blood pressure) heart disease. During a concurrent observation and interview on 6/3/2025 at 8:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1's medication pass was observed. LVN 1 compared Resident 28's bubble pack, which was labeled as isosorbide mononitrate oral tablet 30 mg ER to Resident 28's Electronic Medication Administration Record (eMAR) and proceeded to place one pill from the bubble pack into a medication cup. LVN 1 proceeded to place the medication in a plastic medication bag to prepare to crush the tablet of isosorbide mononitrate oral tablet 30 mg ER. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 6/3/2025 at 8:43 a.m. with LVN 1, Resident 23's isosorbide bubble pack was observed, Resident 23's isosorbide bubble pack medication label was reviewed and Resident 23's Physician Orders and eMAR, dated 6/3/2025, were reviewed. The bubble pack had 11 tablets remaining out of the 31 doses dispensed. The bubble pack label indicated the contents of the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg ER. The Physician Orders and eMAR indicated Resident 23 was ordered isosorbide mononitrate oral tablet 30 mg via g-tube one time a day. LVN 1 stated she did not notice the bubble pack contained doses of isosorbide mononitrate oral tablet 30 mg ER and stated ER medication was not to be crushed and administered via g-tube unless prescribed by the physician. LVN 1 stated the order should have been clarified by the physician and the pharmacy should have been made aware. LVN 1 stated Resident 23's physician medication order of isosorbide mononitrate oral tablet 30 mg was not prepared or ordered as prescribed, which could have placed Resident 23 at risk for a sudden drop in blood pressure and, or decreased heart rate. During a concurrent interview and record review at 6/3/2025 at 8:45 a.m. with LVN 1, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated Resident 23 received 14 doses of isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 1 stated the only supply of isosorbide mononitrate oral tablet 30 mg was the ER dose. LVN 1 stated she was Resident 23's assigned nurse on 6/2/2025 and stated she crushed and administered Resident 23's isosorbide mononitrate oral tablet 30 mg ER dose via g-tube. LVN 1 stated she did not notice the physician orders did not match the labeling on the bubble pack supply of isosorbide for the total of five times she administered the medication since 5/20/2025. During a concurrent interview and record review on 6/4/2025 at 11:11 a.m. with LVN 2, Resident 23's eMAR, dated 5/20/2025 to 6/3/2025, was reviewed. The eMAR indicated LVN 2 administered six doses of the 14 doses of Resident 23's isosorbide mononitrate oral tablet 30 mg via g-tube. LVN 2 stated she crushed and administered the medication that was dispensed by the pharmacy (isosorbide mononitrate oral tablet 30 mg ER) and did not notice the physician orders did not match the labeling on the bubble pack supply for the total of six times she administered the medication since 5/20/2025. LVN 2 stated this placed Resident 23 at risk for death or hospitalization by not comparing the bubble pack supply to the physician order and crushing the ER dose of isosorbide. 2a. During an interview on 6/3/2025 at 11:42 a.m. with Pharmacist 1, Pharmacist 1 stated the pharmacy had not delivered Resident 23's bubble pack supply of isosorbide mononitrate oral tablet 30 mg (IR) to the facility. Pharmacist 1 stated isosorbide mononitrate oral tablet 30 mg was only available in ER form and not in IR form. Pharmacist 1 stated the pharmacy delivered isosorbide mononitrate oral tablet 30 mg ER to the facility and the error was not noticed by the pharmacy technicians or the licensed nursing staff. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 12:10 p.m. with the Director of Nursing (DON), the DON stated she expected the pharmacy to communicate with the licensed nursing staff to make them aware the isosorbide mononitrate oral tablet 30 mg (IR) was not available so that the licensed nursing staff could call the physician. The DON stated she expected the licensed nurse to compare the medication bubble pack with the physician's order prior to the administration of medications. The DON stated if any issues were identified, then the licensed staff would have to communicate with the physician and the pharmacy. The DON stated once an ER medication was crushed, the medication was immediately released into the blood stream and the effects of the medication would start right away. The DON stated an ER medication was intended to be released slowly (over 12-24 hours) into the blood stream throughout the day. The DON stated this placed Resident 23 at risk for a hypotensive (low blood pressure) or bradycardic (slow heart rate) event because medication was crushed and not administered per the physician's order. During a review of the facility's Policy and Procedure (P&P), titled, Medication Administration, dated 5/1/2018, the P&P indicated the licensed nurse was to administer medications per the order of the attending physician or licensed independent practitioner. The P&P indicated the licensed nurse were to perform three checks [which include]: comparing the physician's order, pharmacy label and the medication administration record. The P&P indicated if any discrepancies were identified during the first, second and third check, it must be resolved prior to the administration of any medication. The P&P indicated the licensed nurses were to keep in mind the seven rights of medication when administering medication: a. The right medication b. The right amount c. The right resident d. The right time e. The right route f. Right indication g Right outcome

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of one sampled resident (Resident 5) with weighted utensils (eating tools designed to be heavier, providing added weight to help stabilize shaking hands and reduce hand tremors) in accordance with the physician's order. This deficient practice had the potential for Resident 5 to become discouraged in self-feeding due to difficulty handling regularly weighted utensils. Findings: During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 5 had impairment on one side of her upper extremities (limbs of the upper body such as shoulder, elbow, wrist, and hand). The MDS indicated Resident 5 was dependent on staff's assistance with toileting, bathing, and personal hygiene. The MDS indicated Resident 5 was a mechanically altered diet (change in texture of food or liquid). During a review of Resident 5's History and Physical (H&P), dated 11/26/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated the following: 1. Serve Resident 5 a fortified (food that has added nutrients to increase calories), mechanical soft (foods that are easily chewed and swallowed due to their soft texture), pureed (cooked food that has been ground, pressed, blended or sieved to the consistency of a creamy paste or liquid) meat texture, and double portion of protein. 2. Resident 5 to use adaptive feeding equipment (specialized devices and tools designed to make eating easier and more independent) such as a divided plate (dish designed with separated compartments with raised dividers to assist with mobility and coordination issues) and weighted utensils for every meal. During a review of Resident 5's Care Plan titled, Difficulty with Self-Feeding, dated 5/13/2025, the care plan's goal indicated to increase Resident 5's independence with self-feeding. The care plan indicated staff interventions were to provide adaptive feeding equipment such as a divided plate and weighted utensils for every meal. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/2/2025 at 12:37 p.m., in Resident 5's room, Resident 5 received her lunch tray. Observed a weighted fork, a regular spoon, and a regular knife. Resident 5 attempted to use the spoon to scoop Jello from the cup to her mouth. Resident 5's hand shook while Resident 5 brought the spoon to her mouth. During an observation on 6/3/2025 at 12:40 p.m., in Resident 5's room, Resident 5 received her lunch tray. Observed a weighted fork, a regular spoon, and a regular knife. During an interview on 6/3/2025 at 3:24 p.m., with Director of Rehab (DOR) 1, DOR 1 stated adaptive utensils were used to make eating easier for residents, whether it be with a thicker handle for easier grabbing or weighted handle to help stabilize their hand from tremors. DOR 1 stated Resident 5 had an order for weighted utensils due to her hand tremors. DOR 1 stated all utensils provided to Resident 5 during her meals should be weighted. DOR 1 stated the weight assisted in stabilizing her hand which would result in Resident 5 having an easier time self-feeding. DOR 1 stated Resident 5 had the tendency to hold the utensils with her elbow bent and arm parallel to the ground. DOR 1 stated without the weighted utensils; Resident 5 would drop the food before the food could enter her mouth. DOR 1 stated Resident 5 was very motivated to self-feed, however, without the ordered weighted utensils, Resident 5 could become frustrated and discouraged. DOR 1 stated this could lead to Resident 5 not wanting to feed herself and require assistance from another staff member. During an interview on 6/3/2025 at 3:33 p.m. with the Dietary Supervisor (DS), the DS stated when a resident had an order for adaptive feeding equipment, the kitchen was responsible for providing the equipment to the resident. The DS stated Resident 5 had an order for weighted utensils, therefore Resident 5 should receive weighted utensils instead of regular ones. The DS stated the kitchen was responsible for preparing the correct utensils for the residents to ensure they can reach their highest practicable level in eating. During a review of the facility's policy and procedure (P&P) titled, Restorative Dining Program, revised 5/1/2018, the P&P indicated the facility was to provide the opportunity for residents to attain their highest level of independence in feeding, improve appropriate mealtime behavior, self-image, and socialization skills. The P&P indicated indications to use adaptive equipment include when a Resident spills food or liquid from utensils or cup, Resident exhibits trouble holding onto utensils while eating, [and] Resident exhibits difficulty scooping, bringing utensil from plate to mouth or bringing cup to mouth. The P&P indicated, Special adaptive equipment may be recommended by the Occupational Therapist and will be provided by the Facility. The P&P indicated adaptive equipment may include built-up handled utensils, weighted utensils, and divided plates. The P&P indicated, The equipment will be the responsibility of the Dietary Department and will be distributed on the meal trays.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 safe and sanitary food storage practices in the kitchen that affected 123 residents out of 125 sampled residents when: 1. One container that contained margarine, one opened bottle of whipped cream, one opened bottle of chocolate syrup, one box of dairy creamer, and one bag of parmesan cheese with no use by date (date the food item must be consumed by), were stored in the refrigerator. 2. The can opener was not maintained in a sanitary manner. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 123 of 125 residents who received food from the kitchen. Findings: During an observation during the initial kitchen tour on 6/2/2025 at 8:35 a.m., observed food items in the refrigerator with no opened date or use by date. Observed one container of margarine, one opened bottle of whipped cream, one opened bottle of chocolate syrup, one box of dairy creamer, and one bag of parmesan cheese with no label indicating the date those items were placed in the refrigerator and the date of when items must be used by. During an observation during the initial kitchen tour on 6/2/2025 at 9:00 a.m., observed a can opener attached to the food preparation table in the kitchen. The surface of the can opener was blackened and covered with black stains and dried residue. The area surrounding the can opener blade and gear were heavily stained with dark, hardened food debris. During an interview on 6/2/2025 at 9:10 a.m. with the Dietary Supervisor (DS), in the kitchen, the DS stated food items should be labeled with three dates. The DS stated food was labeled with a received date, opened date, and expiration date. The DS stated food items were labeled to identify if food was safe to consume. The DS stated when a food item was not labeled, the dietary staff would not know if the food was safe to consume. The DS stated refrigerators were checked daily. The DS stated when dietary staff checked the refrigerators, they were supposed to make sure all items were properly labeled, check the condition of the food, and check for expired items. During an interview on 6/2/2025 at 9:25 a.m. with the DS, the DS stated the can opener should be clean and kept in sanitary condition to prevent contamination and growth of harmful bacteria. The DS stated this had the potential for foodborne illness, placing residents at risk for harm. During a review of Food Code 2017, Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) Nonfood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled Labeling and Dating of Foods, undated, the P&P indicated all food items in the refrigerator need to be labeled and dated. The P&P indicated food delivered to the facility needs to be marked with a received date. The P&P indicated newly opened food items need to be labeled with an open date and use by date. During a review of the facility's P&P titled Can Opener and Base, undated, the P&P indicated proper sanitation and maintenance of the can opener was important to sanitary food preparation. The P&P indicated The can opener must be thoroughly cleaned each work shift and when necessary, more frequently.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, infection control measures were not maintained for two of 25 sampled residents (Resident 13 and Resident 78) when Certified Nursing Assistant (CNA) 5 failed to implement enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] that employs targeted gown and glove use during high-contact resident care activities that are associated with a high risk of MDRO colonization, such as presence of a gastrostomy tube) and failed to perform hand hygiene (hand washing with soap or using alcohol-based hand rubs) while providing direct patient care. These deficient practices placed the residents at risk for infection and illness. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 13's admitting diagnoses included generalized muscle weakness and dementia (progressive state of decline in mental abilities). During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 13 had severely impaired cognition (a significant decline in a person's ability to think, learn, and remember, resulting in a substantial impact on their daily life and independence). The MDS indicated Resident 13 required partial to moderate assistance from staff for personal hygiene and was dependent on staff for bed mobility. b. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 78's admitting diagnoses included presence of a gastrostomy tube (a feeding tube that is inserted directly into the stomach through the skin and abdominal wall). During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78 had severely impaired cognition. The MDS indicated Resident 78 had impairments to his upper extremities (shoulders, elbows, wrists, and hands) and lower extremities (hips, knees, ankles, feet) on both sides of his body, and was dependent on staff for personal hygiene and dressing and required substantial to maximal assistance from staff for bed mobility. During a review of Resident 78's physician order, dated 5/14/2025, the physician order indicated staff were to place Resident 78 on enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] that employs targeted gown and glove use during high-contact resident care activities that are associated with a high risk of MDRO colonization, such as presence of a gastrostomy tube). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 78's care plan titled [Resident 78] on Enhanced Barrier Precautions secondary to presence of .gastrostomy tube, dated 9/17/2024, the care plan indicated the goal of care was to prevent Resident 78 from acquiring any healthcare-associated infections. Care plan interventions indicated staff were to perform hand hygiene when entering and leaving the room, and in between each residents' care. Care plan interventions also indicated staff were to wear gown and gloves in the resident room when providing high contact resident care activities such as changing linens and providing hygiene. During an observation on 6/3/2025 at 10:03 a.m., in the doorway of Resident 13 and Resident 78's room, CNA 5 was observed at the bedside assisting Resident 78 with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily), then was observed adjusting and tucking in his bedsheets. CNA 5 was not wearing a gown or gloves. CNA 5 was then observed going to Resident 13's bedside to provide ADL assistance. CNA 5 did not perform hand hygiene following Resident 78's care or before Resident 13's care. During an observation, on 6/3/2025 at 10:08 a.m., in the doorway of Resident 13 and Resident 78's room, CNA 5 exited the room without performing hand hygiene. CNA 5 walked down the hall and retrieved plastic bags from the housekeeping cart. CNA 5 then re-entered the room without performing hand hygiene and proceeded to continue providing care to Resident 13. During an interview on 6/3/2025 at 2:03 p.m., with CNA 5, CNA 5 stated hand hygiene was required whenever staff entered and exited a resident's room. CNA 5 stated staff were also required to perform hand hygiene between care of multiple residents. CNA 5 stated it was important for infection control. CNA 5 stated that if hand hygiene was not performed, infection could spread from one resident to another. During an interview on 6/3/2025 at 3:36 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated performing hand hygiene was the best intervention for the prevention of the spread of infection. The IPN stated hand hygiene was to be performed between the care of two different residents to prevent transmission of infection between residents. The IPN stated if hand hygiene was not performed between residents, there was the potential for illness and disease outbreak (a sudden increase in occurrences of a disease when cases are in excess of normal expectancy). The IPN stated that when providing ADL care to someone with orders for EBP, staff should be wearing a gown and gloves. The IPN stated that after removing the gloves, hand hygiene should be performed. The IPN stated the purpose of EBP was to prevent healthcare-associated infections in the facility. During a review of the facility's policy and procedure (P&P) titled Standard and Enhanced Precautions, dated 4/2024, the P&P indicated staff were to implement EBP when performing high-contact resident care activities such as providing hygiene and changing linens. During a review of the facility's P&P titled Hand Hygiene, revised 2/2025, the P&P indicated the facility considered hand hygiene the primary means to prevent the spread of infections. The P&P indicated staff were to perform hand hygiene immediately upon entering and/or exiting a resident occupied area and before moving to another resident in the same room or exiting the room.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure one of 25 sampled residents (Resident 6) had a functioning call light. This deficient practice resulted in Resident 6's inability to call for staff assistnace or express his needs, and placed him at risk for delayed care and/or accidents. Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 6's admitting diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting his left side, generalized muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 6 had severely impaired cognition (ability to think and reason). The MDS indicated Resident 6 was dependent on staff for personal hygiene, and required substantial to maximal assistance from staff for repositioning while in bed. During a review of Resident 6's care plan titled [Resident 6] has an activities of daily living (ADL, activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit ., dated 1/15/2025, the care plan indicated staff were to ensure Resident 6's call light was within reach and explain to him the importance of utilizing the call light for assistance. During a concurrent observation and interview, on 6/3/2025 at 10:12 a.m., at Resident 6's bedside, Resident 6 was observed lying in bed. Resident 6 stated he wanted to have the head of his bed elevated for comfort. Resident 6 pressed his call light. The indicator light outside of the room did not turn on. During an observation on 6/3/2025 at 10:15 a.m., at Resident 6's bedside, Resident 6 pressed his call light a second time. The indicator light outside of the room did not turn on. During an observation on 6/3/2025 at 10:16 a.m., at Resident 6's bedside, Resident 6 pressed his call light a third time. The indicator light outside of the room did not turn on. During a concurrent observation and interview on 6/3/2025 at 10:17 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 6's call light was not functional. CNA 6 stated Resident 6's call light should be functional to allow him to call for help. During an interview on 6/4/2025 at 10:56 a.m., with Registered Nurse (RN) 1, RN 1 stated call lights should always be functional. RN 1 stated that if the call light was not functional, there was a potential for delays in care and attending to the needs of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056478	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Healthcare Center	2222 Santa Ana Blvd. Los Angeles, CA 90059

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Communication - Call System, revised 10/2022 , the P&P indicated it was the facility's policy to provide a mechanism for residents to promptly communicate with nursing staff.