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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 13435 Peach Avenue Livingston, CA 95334	

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 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** 51345 Based on observation, interview, and record review, the facility failed to ensure an accurate assessment was reflective of the resident's status for 1 of 1 sampled residents when Resident 24's diagnosis of hip fracture was not recorded in Minimum Date Set (MDS) Section I. This failure had the potential for Resident 24 not to receive necessary care and services by nursing staff and put Resident 24 at risk of injury. Findings: During a concurrent observation and interview on 3/4/25 at 11:33 a.m. with Resident 24, at the hallway in-front of the nursing station, Resident 24 was sitting in her wheelchair with a boot on her right foot. Resident 24 was alert, oriented to her name only, and pleasantly confused. Resident 24 stated she sprained (a stretching or tearing of ligaments) her foot yesterday, with a smile on her face. During a review of Resident 24's Admission Record (AR), dated 3/6/25, the AR indicated, Resident 24 has a primary diagnosis of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors [shaking or trembling movements in one or more parts of the body]). During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/18/25, the MDS section C indicated, Resident 24 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 5, which indicated Resident 24 was severely impaired. During a review of Resident 24's, Quarterly Interdisciplinary Team (IDT) care conference, dated 2/5/25, indicated major changes related to right hip fracture with surgical correction and right heel unstageable ulcer (an open sore or wound caused by poor blood flow) . During a review of Resident 24's progress note titled, Doctor Visit/Order Note, dated 1/31/25, which indicated Diagnosis: Parkinson's and hip fracture (a break or crack in a bone). (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25 at 10:26 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 Resident was readmitted to the facility on [DATE] from [Name of another facility] after having hip surgery after a fall at the facility. LVN 3 stated Resident 24 requires more assistance with activities of daily living after having the surgery. LVN 3 stated Resident 24 had a recent fall on 3/2/25. During a concurrent interview and record review on 03/7/25 at 2:40 p.m. with the Director of Nursing (DON)/MDS Coordinator, the DON/MDS reviewed Resident 24's MDS significant change assessment, dated 2/18/25, the DON/MDS stated the significant change assessment, Section I, did not indicate a diagnosis of hip fracture. The DON/MDS stated, Right hip fracture should be captured in the MDS. The DON stated Resident 24's hip fracture caused the decline in activities of daily living for Resident 24. During a review of Center for Medicare and Medicaid Services (CMS)'s RAI Version 3.0 Manual CH 3: MDS Items [I] Page 1-7, dated 10/2024, the reference indicated, . Steps for Assessment:1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. 2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

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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 47888

Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 12 residents (Resident 15), when Resident 15 had a specialty mattress (perimeter mattress or raised perimeter mattress refers to a mattress designed with a raised edge or bolster [a long pillow or cushion] along the sides to prevent falls) on her bed without a care plan in place.

This failure of not implementing an individualized care plan for Resident 15 had the potential to place Resident 15's safety at risk and her specific needs not being met.

Findings:

During a review of Resident 15's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/7/25, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE] with a diagnosis of unspecified disorder of psychological development (A disorder diagnosed in childhood that is marked by either physical or mental impairment, or both) and unspecified dementia (a general decline in mental abilities, primarily affecting memory, thinking, and behavior, that interferes with daily life and worsens over time).

During a review of Resident 15's, Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/20/25, the MDS assessment indicated Resident 15's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 99 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS assessment indicated Resident 15 was severely impaired.

During a review of Resident 15's, Progress Notes (PN) 1, dated 3/28/22, the PN 2 indicated, .General Examination: . Musculoskeletal: Patient has contractures [A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. This prevents normal movement of a joint or other body part] of both upper and lower extremities. She is able to move to some extent however the full range of motion is not available. There is quite a bit of stiffness .

During a review of Resident 15's, PN 2, dated 2/6/25, the PN 2 indicated, . History of Present Illness: [AGE] year-old female with a history of dementia . has advanced cognitive decline, requiring full assistance with activities of daily living [ADLs] such as feeding, dressing and personal hygiene. Her dementia is characterized by memory loss, confusion and disorientation and she exhibits signs of significant functional decline. She is unable to recognize familiar people and places consistently. There are no recent changes in her cognitive function .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 2:34 p.m., with the Director of Staff Development (DSD), the DSD stated care plans are an important guide on how staff should take care of a resident. The DSD stated care plans give staff an alert on specific things staff would need to know. The DSD stated if something needed to be care planned for and wasn't, it would be chaos and staff wouldn't know what they were doing. The DSD stated she was unaware Resident 15 had anything special on her bed in terms of bolsters or bumpers around her. During a concurrent observation and interview on 3/7/25 at 10:40 a.m., with Certified Nursing Assistant (CNA) 6, in Resident 15's room, Resident 15 was in her bed that had raised triangle shaped bolsters/bumpers that were attached on both sides of the mattress around the perimeter of her bed. CNA 6 stated Resident 15 had a special mattress that was different than other residents called a perimeter mattress. CNA 6 stated she had this mattress because she had seizures and needed to be safe. CNA 6 stated this mattress should have a care plan associated with it. CNA 6 stated care plans were important to, Know what care to provide. During a review of Resident 15's Electronic Medical Record (EMR), dated 6/30/21 to 3/7/25, the EMR indicated there was no record of Resident 15 having diagnosis of seizures or any recorded seizure activity. The EMR indicated there was no record of a care plan regarding this specialty mattress. During an interview on 3/7/25 at 10:55 a.m., with the DSD stated she was responsible for Resident 15's care plan implementation. The DSD stated Resident 15 has a special mattress because of agitated body movements to help her stay safe. The DSD stated there was not a care plan regarding the Resident 15's specialty mattress, but there should be. The DSD stated the facility policy and procedure (P&P) Care Plans, Comprehensive Person-Centered was not followed. During an interview on 3/7/25 at 11:03 a.m., with the Director of Nursing (DON), the DON stated Resident 15 had a special mattress called a perimeter mattress. The DON stated he was unaware of when Resident 15 received that mattress and there was no paper trail. The DON stated that mattress would be appropriate for Resident 15 due to her spastic (stiff, jerky, and uncontrolled movements caused by increased muscle tone, making it hard to move smoothly or coordinate actions) movements and help keep her centered and comfortable. The DON stated a care plan was not implemented for Resident 15 regarding the perimeter mattress. The DON stated the expectation was that the perimeter mattress was care planned. The DON stated Resident 15's care plans were not individualized or person-centered because the special mattress was not present. The DON stated care plans are important, so all staff are on the same page. The DON stated the P&P Care Plans, Comprehensive Person-Centered was not followed. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical . functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan: . reflects currently recognized standards of practice for problem areas and conditions . care plan interventions are chosen only after data gathering . careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making . assessments of residents are ongoing, and care plans are revised as information about the residents and the residents conditions change . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 51223

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51223 Based on observation, interview and record review, the facility failed to review and revise a comprehensive care plans for four of 12 residents (Resident 1, 4, 7 and 11) when: 1. Resident 1's Care Plan did not identify oxygen treatment interventions when oxygen was ordered by the physician. 2. Resident 4's mattress was changed to a specialty perimeter mattress and the care plan did not reflect this change. 3. Resident 7 was reassigned to another room after Resident 7's spouse passed away on 9/25/24. 4. Resident 11's care plan did not reflect assessment and interventions to address a change of condition in which Resident 11 was no longer able to ambulate (walk) without assistance. . These failures had the potential to result in Residents 1,4,7, and 11 not to receive necessary care and services by nursing staff and to delay the provision of timely individualized physical and psychosocial person-centered care . Findings: 1. During a concurrent observation and interview on 3/4/25 at 11:01 a.m. with Resident 1 in the resident's room, Resident 1 was dressed in street clothes, gray hair neatly in a bun and sitting in her recliner chair. An oxygen concentrator was on the floor near the foot of the resident's bed with one end of oxygen tubing connected to the concentrator and the rest of the tubing was dated and stored in a plastic bag connected to the concentrator. Resident 1 was alert, oriented to self, place, time, and date, and able to understand and answer questions. Resident 1 stated she has used 2 liters (L-the flow of oxygen measured in liters per minute) of oxygen at night for six years prior to her admission to the facility. During a record review of Resident 1's, Admission Record (AR) dated 3/7/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses: chronic pain (pain that lasts longer than three months), acute upper respiratory infection (a short-term viral infection of the nose, throat and airways causing symptoms like runny or stuffy nose, sore throat, cough and possible fever), acute bronchitis (inflammation of the breathing tubes), cough, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1's, Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/3/24, the MDS section C indicated, Resident 1 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 1 was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 1:43 p.m. with the Director of Nurses (DON/MDS) in the conference room, the DON/MDS stated he completed the annual assessments, significant changes and quarterly assessments. DON/MDS stated the DSD led the Care Plan meetings and updated Care Plans. During a concurrent interview and record review on 3/6/25 at 4:48 p.m. with the Director of Staff Development (DSD) in the DSD office, Resident 1's order summary and care plans were reviewed. Resident 1's order summary indicated; on 9/3/24 the physician ordered oxygen 2L via nasal cannula (n/c-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) every night for comfort related to COPD. The DSD stated the physician ordered oxygen therapy was not on the Care Plan. The DSD stated she would expect oxygen to be on the Care Plan as it is focused on resident comfort. The DSD stated care plans should be personalized to guide staff to provide patient-centered care. During an interview on 3/7/25 at 10:09 a.m. with Licensed Vocational Nurse (LVN) 1 at the common seating area, LVN 1 stated the use of oxygen should be reflected on resident's care plan as it is a treatment linked to a diagnosis or condition. LVN 1 stated the care plan is used to communicate direct resident care needs to all staff. LVN 1 stated the risk of care not reflected on the care plan may result in the resident not receiving patient centered care. During a concurrent interview and record review on 3/7/25 at 10:33 a.m. with the Director of Nursing (DON/MDS) in the DON office, Resident 1's order summary and Care Plans were reviewed. Resident 1's order summary indicated on 9/3/24 the physician ordered oxygen 2L via n/c every night for comfort for COPD. The DON stated the Care Plan was the written document to guide staff to provide person-centered resident care. The DON stated if physician ordered treatment was missing from the Care Plan, then the Care Plan would not be personalized or person-centered. The DON stated Resident 1's Care Plan did not follow the facility's Care Plan policy and procedure in this instance. During a review of the facility's policy and procedure titled, Job Description: Charge Nurse, not dated, the duties indicated 18. Assists in initiating and updating resident care plans . During a review of the facility's policy and procedure titled, Job Description: Director of Staff Development, not dated, the duties indicated .14. Chair Patient Care Planning Meetings. Provide assistance to various disciplines in formulating, initiating, and evaluating effective, realistic Patient Care Plans. Review Care Plans quarterly . During a review of the facility's policy and procedures titled, Job Description: Director of Nursing, not dated, the responsibility indicated, 1. Develops and maintains nursing service objectives and standards of nursing practice .2. Organizes, develops and directs nursing administration and resident care. The duties indicated 3. Assists staff in developing nursing care plans for individual residents . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the policy statement indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation indicated, .7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's policy and procedure titled, Oxygen Administration, dated 10/2010, the preparation indicated, 1. Verify that there is a physician order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www. nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 2. During an observation on 3/5/25 at 8:22 a.m. in Resident 4's room, Resident 4 was not in the room. Resident 4's bed was located on the back left corner from the door. The length of the bed was pushed against the wall with two windows and the head of the bed was pushed to the corner of the back wall. The bed was in the lowest setting, a white quilt with pink/peach flowers covered the mattress and was tucked neatly under the mattress, a round embroidered decorative pillow lay at the head of the bed leaning against 3 standard pillows. The right and left edges of the mattress were raised in a triangular shape creating a flatter leveled base in the center of the bed. A blue, white and gray patient lift was stowed over the bed. A gray fall mat was folded in half and stored between the foot of the bed and the nightstand. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 4's Admission Record (AR) dated 3/7/25, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses: cerebral palsy (neurological disorder that appear in infancy or early childhood and permanently affect body movement and muscle coordination), spastic quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) cerebral palsy, epilepsy (a brain condition that causes recurring seizures), aphasia (a disorder that makes it difficult to speak) , dysphagia (difficulty swallowing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), profound intellectual disabilities (individuals that have very limited ability to communicate and physical limitations who require close supervision and help with self-care activities), developmental disorders of speech and language (a communication disorder that interferes with learning, understanding and using language). During a review of Resident 4's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/18/24, the MDS section C indicated, Resident 4 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 99, which indicated Resident 4 was unable to complete the interview due to severely impaired cognitive skills for daily decision making. During an interview on 3/6/25 at 1:43 p.m. with the Director of Nurses (DON/MDS) in the conference room, the DON/MDS stated the Director of Staff Development (DSD) is responsible to lead the Care Plan meetings and update Care Plans as needed. During a concurrent interview and record review on 3/6/25 at 4:48 p.m. with the Director of Staff Development (DSD) in the DSD office, Resident 4's care plan dated 3/5/25 was reviewed. The FALLS-I am at risk for falls due to being profoundly developmentally delayed focused Care Plan indicated an intervention Mattress Bolster on my bed to prevent falling out of bed during seizure activity initiated on 12/16/2020. The DSD stated the facility does not use bolsters and stated the care plan was old and written by the previous DSD 12/2020. DSD stated she had not received Care Plan training. During a concurrent observation and interview on 3/7/25 at 9:03 a.m. with the DSD in Resident 4's room, Resident 4's bed was covered in a pink/white quilt, a lift stored over the bed. Resident 4's mattress had triangular shaped pillows at the outer edges near the foot and head of the bed. The DSD stated the triangular shaped pillows at the head/foot of the bed are not bolsters but a part of the mattress. The DSD uncovered the bedding and exposed a blue mattress with triangular shaped padding sewn along both edges covering approx. 1/3 of the mattress toward the foot and the head. The middle 1/3 of the mattress did not have the triangular shaped padding leaving a flat surface. The DSD stated the mattress that is on the resident's bed was not on Resident 4's Care Plan and was not ordered by a physician. During an interview on 3/7/25 at 10:09 a.m. with Licensed Vocational Nurse (LVN) 1 at the common seating area, LVN 1 stated specialty mattresses should be on a resident's care plan. LVN 1 stated if staff were to identify a short term or long-term issue, the facility would be obligated to initiate a care plan identifying goals and interventions. LVN 1 stated care plans are used to communicate resident needs and direct resident care. LVN 1 stated the specialty mattresses are used for residents who are dependent for care and for resident safety to prevent them from rolling out of bed or as a seizure precaution. LVN 1 stated the lack of a care plan may result in the resident not receiving patient centered care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/7/25 at 10:33 a.m. with the Director of Nursing (DON/MDS) in the DON office, Resident 4's order summary and Care Plans were reviewed. Resident 4's order summary indicated there was no physician order for the specialty mattress. The care plan indicated Resident 4 did not have the specialty mattress on the care plan. The DON/MDS stated the intervention Mattress Bolster to prevent falling out of bed during seizure activity was resolved (no longer an active intervention) by the DSD on 3/6/25. The DON/MDS stated the facility used the Care Plan as the written document to guide staff to provide individualized person-centered care. The DON stated if treatments are missing from the Care Plan, then the Care Plan would not be individualized, or patient centered. DON stated Care Plans are reviewed every three months or if the resident has a change in condition. The DON stated Resident 4's Care Plan did not follow the facility's Care Plan policy and procedure. DON stated the risk of not updating or personalizing the resident's care plan may reduce resident's quality of life. During a review of the facility's policy and procedure titled, Job Description: Charge Nurse, not dated, the duties indicated 18. Assists in initiating and updating resident care plans . During a review of the facility's policy and procedure titled, Job Description: Director of Staff Development, not dated, the duties indicated .14. Chair Patient Care Planning Meetings. Provide assistance to various disciplines in formulating, initiating, and evaluating effective, realistic Patient Care Plans. Review Care Plans quarterly . During a review of the facility's policy and procedures titled, Job Description: Director of Nursing, not dated, the responsibility indicated, 1. Develops and maintains nursing service objectives and standards of nursing practice .2. Organizes, develops and directs nursing administration and resident care. The duties indicated 3. Assists staff in developing nursing care plans for individual residents . During a review of the facility's policy and procedure titled, Assistive Devices and Equipment, dated 2/2001, the Policy Interpretation and Implementation, indicated, 1. Certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents . 3. Recommendations for the use of devices and equipment are .documented in the resident care plan . During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the policy statement indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation indicated, .7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 13435 Peach Avenue Livingston, CA 95334	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 3. During a concurrent observation and interview on 3/4/25 at 11:31 a.m. with Resident 7 in Resident 7's room, Resident 7 had two female roommates (Resident 23 and 26). Resident 7 wore a long-sleeved black shirt, pants and tennis shoes while sitting in her wheelchair reading a book. Resident 7 was alert, oriented to person, place, time and date and was able to understand and answer questions. Resident stated she had resided at the facility for two years and planned to stay long term. During a record review of Resident 7's Admission Record (AR) dated 3/7/25, the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses: Chronic Myeloid Leukemia (CML a type of blood cancer characterized by the bone marrow producing too many abnormal white blood cells), unspecified dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty walking. During a review of Resident 7's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/25/24, the MDS section C indicated, Resident 4 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 7 was cognitively intact. During a review of Resident 7's Care Plan, dated 3/5/25, the active care plan initiated on 4/4/23 indicated Resident 7 shared a room with her husband who was her caregiver. During an interview on 3/6/25 at 1:43 p.m. with the Director of Nurses (DON/MDS) in the conference room, the DON/MDS stated the Director of Staff Development (DSD) led the Care Plan meetings and updated Care Plans. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Home Inc.	13435 Peach Avenue Livingston, CA 95334

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/6/25 at 4:48 p.m. with the Director of Staff Development (DSD) in the DSD office, Resident 7's Care Plan dated 3/6/25 was reviewed. The care plan indicated Resident 7 was rooming with her spouse. The DSD stated Resident 7's spouse passed away 9/25/24. The DSD stated she did not update Resident 7's care plan and needed to remove details about Resident 7's spouse. The DSD stated she would assist with formulating a resident's care plan upon admission, monthly and quarterly. The DSD stated care plans were created for staff to provide person-centered care to residents. DSD stated she had not received Care Plan training. During an interview on 3/7/25 at 10:09 a.m. with Licensed Vocational Nurse (LVN) 1 at the common seating area, LVN 1 stated if staff were to identify a short term or long-term issue, the facility would be obligated to initiate a care plan identifying goals and interventions. LVN 1 stated care plans are used to communicate resident needs and direct resident care. LVN 1 stated the lack of a care plan may result in the resident not receiving patient centered care. During a concurrent interview and record review on 3/7/25 at 10:33 a.m. with the Director of Nursing (DON/MDS), the DON/MDS stated the facility's Care Plan was a written document to guide staff to provide personalized person-centered care. DON stated the Care Plans are reviewed every three months or when the resident had a change in condition. DON stated the risk of not updating or personalizing the resident care plan may reduce resident's quality of life. During a review of the facility's policy and procedure titled, Job Description: Charge Nurse, not dated, the duties indicated 18. Assists in initiating and updating resident care plans . During a review of the facility's policy and procedure titled, Job Description: Director of Staff Development, not dated, the duties indicated .14. Chair Patient Care Planning Meetings. Provide assistance to various disciplines in formulating, initiating, and evaluating effective, realistic Patient Care Plans. Review Care Plans quarterly . During a review of the facility's policy and procedures titled, Job Description: Director of Nursing, not dated, the responsibility indicated, 1. Develops and maintains nursing service objectives and standards of nursing practice .2. Organizes, develops and directs nursing administration and resident care. The duties indicated 3. Assists staff in developing nursing care plans for individual residents . During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the policy statement indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation indicated, .7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 13435 Peach Avenue Livingston, CA 95334	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 4. During a concurrent observation and interview on 3/4/25 at 10:18 a.m. with Resident 11, in Resident 11's room, Resident 11 was lying in his bed in with ongoing tube feeding (a flexible plastic tube placed into the stomach or bowel [intestine] to provide nutrition when a person cannot eat or drink safely by mouth) and indwelling catheter (a tube inserted into the bladder, used to drain urine) bag covered with cloth privacy bag. Resident was alert and oriented, pleasant, and soft spoken. Resident 11 had difficulty hearing and stated he wears hearing aid. Resident was clean and well groomed. Resident 11 stated he had been at the facility for over four years. Resident 11 stated he can only drink and cannot eat food. Resident 11 stated he's been on tube feeding for four years. During a review of Resident 11's Admission Record (AR), dated 3/6/25, the AR indicated, Resident 11 was admitted to the facility on [DATE] with a primary diagnosis of Chronic Obstructive Pulmonary Disease (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood). During a review of Resident 11's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/22/24, the MDS section C indicated, Resident 11 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 11 was cognitively intact. During an interview on 3/4/25 at 4:31 p.m. with Resident 11 in the hallway, Resident 11 was sitting on recliner chair with tube feeding infusing. Resident 11 stated he has not been able to walk for over a year. Resident 11 stated he uses a recliner chair and wheelchair as his primary modes of locomotion. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 13435 Peach Avenue Livingston, CA 95334	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 11:11 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated she's been working as CNA at the facility for [AGE] years. CNA 4 stated she is familiar with Resident 11 and stated, He doesn't walk anymore since he started hospice. CNA 4 stated Resident 11 can stand with the use of stand lift with two persons assist. CNA 4 stated Resident 11 alternates between the use of recliner chair and wheelchair. During a concurrent interview and record review on 3/7/25 at 10:41 a.m. with LVN 3 at the nursing station, LVN 3 reviewed Resident 11's Activities of Daily Living (ADL)'s Care Plan, revised 5/26/23, indicated Ambulation/mobility status: I am able to ambulate with one person assist and a walker. LVN 3 stated care plan should be updated based on resident's current level of mobility. LVN 3 stated Resident 11 was not ambulatory and requires two person assists using stand lift. LVN 3 continued to review Resident 11's care plan and indicated Resident 11's care plan was revised 2/23/23 and 2/6/25. LVN 3 stated care plan must be updated if there's a change of condition to reflect current plan of care. LVN 3 stated care plan is for staff to follow to provide the appropriate care for the residents. During an interview on 3/7/25 at 2:40 p.m. with the Director of Nursing (DON)/Minimum Data Set (MDS) Coordinator, the DON/MDS stated Interdisciplinary Team (IDT) should review and revise care plan after Significant Change of Condition Assessment. The DON/MDS reviewed MDS and indicated Significant Change of Condition Assessment was done on 11/22/24. The DON/MDS stated Resident 11 was admitted to hospice. During an interview on 3/7/25 at 3:30 pm with the Director of Staff Development (DSD), the DSD stated she is responsible for all long-term care plans, and she facilitates care conferences. The DSD stated care plans must be reviewed and revised for significant change of condition assessments to reflect residents' current function. The DSD stated care plan is important to be person-centered to be able to provide the appropriate care and treatment. The DSD stated, So everybody can do what they are supposed to do. During a review of the facility's policy and procedure title, Comprehensive Assessments, dated 3/2022, the policy statement indicated, . 5. A Significant change is a major decline or improvement in a resident's status that: c. requires interdisciplinary review and/or revision on care plan. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the policy statement indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation indicated, . 7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 51345

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview and record review, the facility failed to maintain professional standards of quality for 10 of 32 sampled residents (4, 5, 8, 11, 13, 14, 15, 23, 24, and 28) when: 1. Resident 15 had a specialty mattress (perimeter mattress or raised perimeter mattress refers to a mattress designed with a raised edge or bolster [a long pillow or cushion] along the sides to prevent falls) on her bed without a physician order or care plan in place. This failure of not having a physician order or implementing a comprehensive care plan for Resident 15 had the potential to place Resident 15's safety at risk and her specific needs not being met. 2. The facility failed to obtain a physician order for a specialty mattress for one of six sampled residents (Resident 4) when a pressure reducing mattress was replaced with a perimeter mattress. This failure had the potential to place Resident 4's safety at risk and their specific needs not being met 3. Licensed Vocational Nurse (LVN) 2 and LVN 3 used only one identifier before medication administration for Residents 5, 8, 11, 13, 15, 23, 24, and 28; and did not explain the type of medication being administered for Residents 5, 8, 13, 15, 23, 24, and 28. 4. LVN 2 signed the Electronic Medical Record (EMAR) for Resident 15 and Resident 24 medications when LVN 3 administered the medications. 5. LVN 1 administered medications orally to Resident 14 without using proper identification, without explaining the medications, and not providing water after medication administration. These failures had the potential for medication errors for Residents 5, 8, 11, 13, 14, 15, 23, 24, and 28. Findings: 1. During a review of Resident 15's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/7/25, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE] with a diagnosis of unspecified disorder of psychological development (A disorder diagnosed in childhood that is marked by either physical or mental impairment, or both) and unspecified dementia (a general decline in mental abilities, primarily affecting memory, thinking, and behavior, that interferes with daily life and worsens over time). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/20/25, the MDS assessment indicated Resident 15's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 99 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS assessment indicated Resident 15 was severely impaired. During a review of Resident 15's Progress Notes (PN) 1, dated 3/28/22, the PN 2 indicated, .General Examination: . Musculoskeletal: Patient has contractures [A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. This prevents normal movement of a joint or other body part] of both upper and lower extremities. She is able to move to some extent however the full range of motion is not available. There is quite a bit of stiffness . During a review of Resident 15's PN 2, dated 2/6/25, the PN 2 indicated, . History of Present Illness: [AGE] year-old female with a history of dementia . has advanced cognitive decline, requiring full assistance with activities of daily living [ADLs] such as feeding, dressing and personal hygiene. Her dementia is characterized by memory loss, confusion and disorientation and she exhibits signs of significant functional decline. She is unable to recognize familiar people and places consistently. There are no recent changes in her cognitive function . During an interview on 3/6/25 at 2:34 p.m., with the Director of Staff Development (DSD), the DSD stated care plans are an important guide on how staff should take care of a resident. The DSD stated care plans give staff an alert on specific things staff would need to know. The DSD stated if something needed to be care planned for and wasn't, it would be chaos and staff wouldn't know what they were doing. The DSD stated she was unaware Resident 15 had anything special on her bed in terms of bolsters or bumpers around her, but if she did she would need a physician's order for it. During a concurrent observation and interview on 3/7/25 at 10:40 a.m., with Certified Nursing Assistant (CNA) 6, in Resident 15's room, Resident 15 was in her bed that had raised triangle shaped bolsters/bumpers that were attached on both sides of the mattress around the perimeter of her bed. CNA 6 stated Resident 15 had a special mattress that was different than other residents called a perimeter mattress. CNA 6 stated she had this mattress because she had seizures and needed to be safe. CNA 6 stated this mattress should have a care plan associated with it. CNA 6 stated care plans were important to, Know what care to provide. During a review of Resident 15's Electronic Medical Record (EMR), dated 6/30/21 to 3/7/25, the EMR indicated there was no record of Resident 15 having diagnosis of seizures or any recorded seizure activity. The EMR indicated there was no record of a care plan or physician order regarding this specialty mattress. During an interview on 3/7/25 at 10:55 a.m., with the DSD, the DSD stated she was responsible for Resident 15's care plan implementation. The DSD stated Resident 15 did have a special mattress because of agitated body movements to help her stay safe. The DSD stated there was not a care plan regarding Resident 15's specialty mattress, but there should have been. The DSD stated, I'm assuming the perimeter mattress would need a physician order and there was not one. The DSD stated the facility policy and procedure (P&P) Care Plans, Comprehensive Person-Centered was not followed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/7/25 at 11:03 a.m., with the Director of Nursing (DON), the DON stated Resident 15 had a special mattress called a perimeter mattress. The DON stated he was unaware of when Resident 15 received that mattress and there was no paper trail. The DON stated that mattress would be appropriate for Resident 15 due to her spastic (stiff, jerky, and uncontrolled movements caused by increased muscle tone, making it hard to move smoothly or coordinate actions) movements and help keep her centered and comfortable. The DON stated there was not a physician order and a care plan was not implemented for Resident 15 regarding the perimeter mattress. The DON stated the expectation was that the perimeter mattress was care planned and there was a physician order for it. The DON stated Resident 15's care plans were not individualized or person-centered because the special mattress was not present. The DON stated care plans are important, so all staff are on the same page. The DON stated the P&P Care Plans, Comprehensive Person-Centered was not followed. During a review of CMS.gov Professional Reference titled, National Coverage Determination-Hospital Beds (280.7), Publication Number 100-3, Manual Section Number 280.7, dated 3/12/25, indicated, .A physician's prescription and such additional information . must establish the medical necessity for a hospital bed due to one of the following reasons: The patient's condition requires positioning of the body . e.g. (for example) to alleviate pain, promote good body alignment, prevent contractures . in ways not feasible [possible] in an ordinary bed . The patient's condition requires special attachments that cannot be fixed and used on an ordinary bed . B. Physician's Prescription . The physician's prescription .must establish that a hospital bed is medically necessary. If the stated reason for the need for a hospital bed is the patient's condition requires positioning, the prescription or other documentation must describe the medical condition ., and also the severity and frequency of the symptoms of the condition that necessitates a hospital bed for positioning . During a review of the facility's Job Description: Charge Nurse (JDCN) not dated, the JDCN indicated, .7. initiate treatment as ordered . During a review of the facility's Job Description: Director of Nursing (JDDN) not dated, the JDDN indicated, . 3. Regularly inspects facility and nursing practices for compliance with federal, state and local standards and regulations . During a review of the facility's P&P titled, Physician Services dated 2/2021, the P&P indicated, . 5. The attending physician will determine the relevance of any recommended interventions from other disciplines . During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical . functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan: . reflects currently recognized standards of practice for problem areas and conditions . care plan interventions are chosen only after data gathering . careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making . assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 2. During an observation on 3/5/25 at 8:22 a.m. in Resident 4's room, Resident 4 was not in the room. Resident 4's bed was located on the back left corner from the door. The length of the bed was pushed against the wall with two windows and the head of the bed was pushed to the corner of the back wall. The bed was in the lowest setting, a white quilt with pink/peach flowers covered the mattress and was tucked neatly under the mattress, a round embroidered decorative pillow lay at the head of the bed leaning against 3 standard pillows. The right and left edges of the mattress were raised in a triangular shape creating a flatter leveled base in the center of the bed. A blue, white and gray patient lift was stowed over the bed. A gray fall mat was folded in half and stored between the foot of the bed and the nightstand. During a record review of Resident 4's AR dated 3/7/25, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses: cerebral palsy (neurological disorder that appear in infancy or early childhood and permanently affect body movement and muscle coordination), spastic quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) cerebral palsy, epilepsy (a brain condition that causes recurring seizures), aphasia (a disorder that makes it difficult to speak) , dysphagia (difficulty swallowing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), profound intellectual disabilities (individuals that have very limited ability to communicate and physical limitations who require close supervision and help with self-care activities), developmental disorders of speech and language (a communication disorder that interferes with learning, understanding and using language). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 13435 Peach Avenue Livingston, CA 95334	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 4's MDS dated [DATE], the MDS section C indicated, Resident 4 had a BIMS score of 99 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 4 was unable to complete the interview due to severely impaired cognitive skills for daily decision making. During a concurrent interview and record review on 3/6/25 at 4:48 p.m. with the DSD in the DSD office, Resident 4's care plan and order summary were reviewed. The Care Plan indicated, FALLS-I am at risk for falls due to being profoundly developmentally delayed . Mattress Bolster on my bed to prevent falling out of bed during seizure activity was initiated on 12/16/2020. The order summary indicated there was no order for the mattress bolster or a specialty mattress. The DSD stated the facility does not use bolsters and there was not order for a specialty mattress. During a concurrent observation and interview on 3/7/25 at 8:53 a.m. with the DSD in Resident 4's room, Resident 4's bed was covered in a pink/white quilt, a lift stored over the bed. Resident 4's mattress had triangular shaped pillows at the outer edges near the foot and head of the bed. The DSD stated the triangular shaped pillows at the head/foot of the bed are not bolsters but a part of the mattress. The DSD uncovered the bedding and exposed a blue mattress with triangular shaped padding sewn along both edges covering approx. 1/3 of the mattress toward the foot and the head. The middle 1/3 of the mattress did not have the triangular shaped padding leaving a flat surface. The DSD stated the mattress that is on Resident's 4's bed was not ordered by a physician and deferred to the DON. During an interview on 3/7/25 at 08:58 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 4's room, LVN 1 stated the mattress on Resident 4's bed was not a mattress bolster, and she did not know the name of the specialty mattress. LVN 1 stated she was unsure when the mattress was placed on the Resident's bed. During a concurrent interview and record review on 3/7/25 at 10:33 a.m. with the DON in the DON office, Resident 4's order summary was reviewed. Resident 4's order summary indicated there was no physician order for the specialty mattress. The DON stated the perimeter mattress were used for only two residents (Resident 4, 15) in the facility who were low functioning, developmentally delayed and do not try to stand or walk. The DON stated the perimeter mattress provided extra padding and kept the resident in the center of the bed for protection and enhanced comfort. The DON stated the specialty mattress would need a physician's order, and it would be appropriate for the facility to obtain an order. During a review of Job Description: Charge Nurse, not dated, the duties indicated, .7.initiate treatment as ordered . During a review of Job Description: Director of Nursing, not dated, the responsibility indicated, .3. Regularly inspects facility and nursing practices for compliance with federal, state and local standards and regulations . During a review of the facility's P&P titled, Physician Services dated 2/2021, the policy interpretation and implementation indicated, .5. The attending physician will determine the relevance of any recommended interventions from other disciplines . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of CMS.gov Professional Reference titled, National Coverage Determination-Hospital Beds (280.7), Publication Number 100-3, Manual Section Number 280.7, dated 3/12/25, indicated, .A physician's prescription and such additional information . must establish the medical necessity for a hospital bed due to one of the following reasons: The patient's condition requires positioning of the body . e.g. (for example) to alleviate pain, promote good body alignment, prevent contractures . in ways not feasible [possible] in an ordinary bed . The patient's condition requires special attachments that cannot be fixed and used on an ordinary bed . B. Physician's Prescription . The physician's prescription .must establish that a hospital bed is medically necessary. If the stated reason for the need for a hospital bed is the patient's condition requires positioning, the prescription or other documentation must describe the medical condition ., and also the severity and frequency of the symptoms of the condition that necessitates a hospital bed for positioning . 3. During an observation on 3/5/25 at 8:18 a.m. with LVN 3, LVN 3 prepared all 9:00 a.m. medications for Resident 28 on the top of the medication cart situated inside the nursing station. LVN 3 walked to Resident 28 's room holding a medicine cup and a plastic cup of water. LVN stated, Knock, Knock, here are your meds, what is your name? Resident 28 was able to state her full name. LVN 3 gave all the medications without providing the name and indication for three of six medications for Resident 28. During a review of Resident 28's MDS dated [DATE], the MDS section C indicated, Resident 28 had a BIMS score of 15, which indicated Resident 28 was cognitively intact. During an observation on 3/5/25 at 8:26 a.m., LVN 2 prepared all 9:00 a.m. medications for Resident 13 on the counter of the nursing station with medication cart situated inside the nursing station. LVN 2 walked to Resident 13's room holding a medicine cup and a plastic cup of water. LVN stated, Knock, Knock, . what is your name? Resident 13 was able to state her name. LVN 2 gave all the medications without providing the name and indication for three of five medications for Resident 13. During a review of Resident 13's MDS, dated [DATE], the MDS section C indicated, Resident 13 had a BIMS score of 11, which indicated Resident 13 was moderately impaired. During an observation on 3/5/25 at 8:37 a.m. with LVN 3, LVN 3 prepared all 9:00 a.m. medications for Resident 23 on the top of the medication cart situated inside the nursing station. LVN 3 walked to Resident 23's room holding a medicine cup and a plastic cup of water. LVN stated, Knock, Knock, can you tell me your name I have your medications Senna, Iron . LVN 3 gave all the medications without providing the indications of all medications for Resident 23. During a review of Resident 23's AR unknown date, the AR indicated, Resident 23 has a diagnosis of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 23's MDS, dated [DATE], the MDS section C indicated, Resident 23 had a BIMS score of 6, which indicated Resident 23 was severely impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 3/5/25 at 8:45 a.m. with LVN 2, LVN 2 prepared all 9:00 a.m. medications for Resident 8 on the counter of the nursing station with medication cart situated inside the nursing station. LVN 2 walked to Resident 8's room holding a medicine cup, inhaler with spacer, and a plastic cup of water. LVN 2 stated, Knock, Knock, . what is your name? Resident 8 did not respond. LVN 2 gave all the medications to Resident 8 without providing the name and indication for five of eight medications. During a review of Resident 8's AR, unknown date, the AR indicated, Resident 8 has a diagnosis of Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 8's MDS, dated [DATE], the MDS section C indicated, Resident 8 had a BIMS score of 7, which indicated Resident 8 was severely impaired. During an observation on 3/5/25 at 8:57 a.m. with LVN 2, LVN 2 prepared all 9:00 a.m. medications for Resident 24 on the counter of the nursing station with medication cart situated inside the nursing station. LVN 2 walked to Resident 24's room holding a medicine cup and a plastic cup of water. LVN stated, Knock, Knock, . Are you [stated Resident's name]? Resident 24 answered, I think so. LVN 2 stated, I have pills for you, here's your pills. LVN 2 gave all the medications without providing the name and indication of all medications for Resident 24. During a review of Resident 24's MDS, dated [DATE], the MDS section C indicated, Resident 24 had a BIMS score of 5, which indicated Resident 24 was severely impaired. During an observation on 3/5/25 at 9:05 a.m. with LVN 3, LVN 3 prepared Resident 5's eyedrops on the top of the medication cart situated inside the nursing station. LVN 3 walked to Resident 5's room holding the eyedrops. LVN 3 asked Resident 5's name and Resident 5 responded with a smile. LVN 3 administered Resident 5's eyedrops to left eye and explained the indication of the medication. During a review of Resident 5's AR, dated 2/6/25, the AR indicated, Resident 5 has a primary diagnosis of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 5's MDS, dated [DATE], the MDS section C indicated, Resident 5 had a BIMS score of 3, which indicated Resident 5 was severely impaired. During an observation on 3/5/25 at 9:13 a.m. with LVN 2, LVN 2 prepared all 9:00 a.m. medications for Resident 15 on the counter of the nursing station with medication cart situated inside the nursing station. LVN crushed all the medications and mixed with applesauce. LVN 2 walked to Resident 15's room holding a medicine cup and a plastic cup of water. LVN stated, Knock, Knock, . Are you [stated Resident's name]? Resident 15 did not respond. Certified Nurse Assistant (CNA) 5 verified Resident 15's name. LVN 2 gave seven of eight medications to Resident 15 without providing the name and indication of the medications. LVN 2 did not prepare and give Resident 15's Polyethylene Glycol. LVN 2 signed the EMAR for Polyethylene Glycol. During a review of Resident 15's AR, dated 3/7/25, the AR indicated, Resident 15 has a primary diagnosis of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 15's MDS, dated [DATE], the MDS section C indicated rarely/never understood. Resident 15 had no BIMS score. During an observation on 3/5/25 at 11:01 a.m. with LVN 3, LVN 3 prepared all 12:00 p.m. medications for Resident 11 on the top of the medication cart situated inside the nursing station. LVN crushed all medications separately and put each crushed medications in a separate medicine cup. LVN 3 walked to Resident 11's room holding two round paper plates with all the medications and cups of water. LVN stated, Knock, Knock, I am giving your medications, what is your name? Resident 11 was able to state his full name, but no other identifier was used. LVN 3 put on a gown, gloves, and face shield before medication administration. LVN 3 checked placement of jejunostomy tube (JT-a flexible plastic tube placed into the stomach or bowel [intestine] to provide nutrition when a person cannot eat or drink safely by mouth) and explained all the medications to Resident 11. During a review of Resident 11's MDS, dated [DATE], the MDS section C indicated, Resident 11 had a BIMS score of 15, which indicated Resident 11 was cognitively intact. During an interview and record review on 3/5/25 at 11:31 a.m. with LVN 2, LVN 2 she did not use other resident identifiers like photos of residents before medication administration. LVN 2 stated this place a risk for medication error. During a review of facility's P&P titled Medication Administration General Guidelines (California Specific), dated 2007, the P&P indicated, .Medication Administration: 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include a. Check identification band b. Check photograph attach to medical record c. Verify resident identification with other nursing care center personnel; 12. At least (4 ounces) of water or other acceptable liquid are given with oral medications; 13. Explain to resident the type of medication being administered and the procedure; Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given . 4. During an observation on 3/5/25 at 8:57 a.m. with LVN 2, LVN 2 did not prepare and administer Resident 24's Polyethylene Glycol. LVN 2 signed the EMAR for Polyethylene Glycol. During an observation on 3/5/25 at 9:13 a.m. with LVN 2, LVN 2 did not prepare and administer Resident 15's Polyethylene Glycol. LVN 2 signed the EMAR for Polyethylene Glycol. During an interview and record review on 3/5/25 at 11:31 a.m. with LVN 2 at the nursing station, LVN 2 stated, I signed the EMAR for both residents . for medication Polyethylene Glycol, . I did not give the medication. LVN 2 stated the other nurse administered the Polyethylene Glycol for Resident 15 and Resident 24. LVN stated, I did not give the medication, I don't need to sign. The EMAR was checked by LVN 2 and indicated Resident 15 and Resident 24's Polyethylene Glycol were signed by LVN 2. During an interview on 3/5/25 at 11:34 a.m. with LVN 3 at the nursing station, LVN 3 stated she gave Resident 15 and Resident 24's Polyethylene Glycol and did not sign the EMAR after the administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's P&P titled Medication Administration General Guidelines (California Specific), dated 2007, the P&P indicated, .Medication Administration: 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include a. Check identification band b. Check photograph attach to medical record c. Verify resident identification with other nursing care center personnel; 12. At least (4 ounces) of water or other acceptable liquid are given with oral medications; 13. Explain to resident the type of medication being administered and the procedure; Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given . 5. During a concurrent observation and interview on 3/6/25 at 4:29 p.m. with LVN 1 in the hallway, LVN 1 was holding a medicine cup and used the spoon to orally administer Resident 14's crushed medications. LVN 1 did not properly identify Resident 14 and did not explain the medications. Resident 14 slowly swallowed the medications. LVN did not provide water to Resident 14 after the medication administration. LVN 1 stated, I know her so well, and should give water after giving meds. During a review of Resident 14's AR, unknown date, the AR indicated, Resident 14 has a diagnosis of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 14's MDS, dated [DATE], the MDS section C indicated rarely/never understood. Resident 15 had no BIMS score. During an interview on 3/7/25 at 5:58 p.m., with the DON, the DON stated his expectation is for nurses to follow P&P for medication administration including preparation, administration, and documentation. The DON stated the use of two resident identifiers, and explanation of medications were in the policy. The DON stated, I think all were in the policy. During a review of facility's P&P titled Medication Administration General Guidelines (California Specific), dated 2007, the P&P indicated, .Medication Administration: 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include a. Check identification band b. Check photograph attach to medical record c. Verify resident identification with other nursing care center personnel; 12. At least (4 ounces) of water or other acceptable liquid are given with oral medications; 13. Explain to resident the type of medication being administered and the procedure; Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given . 51223 51345

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47888 Based on observation and interview, the facility failed to have a Registered Nurse (RN) in the facility at least 8 consecutive hours in a day. This failure had the potential to put Residents' safety at risk and their specific needs not being met. Findings: During an interview on 3/5/25 at 11:55 p.m., with the Director of Staff Development (DSD), the DSD stated she was covering for the Director of Nursing because he left at 11 a.m. The DSD stated she was a Licensed Vocational Nurse and not an RN. During an observation on 3/5/25 at 4:30 p.m., while walking throughout the entire facility, there appeared to be no RN currently in the building. During an interview on 3/5/25 at 5:15 p.m., with the Administrator (ADM), the ADM stated there was not an RN currently in the building. The ADM stated the only RN that was working for the day was the Director of Nursing (DON) who left at 11 a.m. due to scheduled time off. The ADM stated he was unaware that an RN had to be in the facility for eight consecutive hours at a time. The ADM stated the facility did not have a waiver regarding the RN not being present. During an interview on 3/7/25 at 11:03 a.m., with the DON, the DON stated he left for scheduled time off at 11 a.m., on 3/5/25 and there was no other RN that worked that day at the facility. The DON stated he had heard before that an RN had to be in the building for eight hours continuous bu,t We didn't center it on our minds when we came up with that plan. The DON stated it was important for the facility for an RN to be there for eight consecutive hours because RN supervises all of the staff and they work under his direction. During a review of the facility's Job Description: Director of Nursing (JD), not dated, the JD indicated, . Qualifications: . The ability to lead and supervise the work of non-professional personnel on his/her shift . Responsibility: . Organizes, develops and directs nursing administration and resident care . Instructs and supervises personnel and functions . Regularly inspects facility and nursing practices for compliance with federal, state and local standards and regulations .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51345 Based on observation, interview, and record review, the facility failed to ensure safe and secure storage of medications when: 1. Medication room was propped open and unattended by authorized staff. This failure had the potential to place facility at risk for unauthorized access to medication room and possible drug diversion. 2. Resident 5's Hydrocortisone 2.5% topical cream was beyond the discard date. This failure had the potential for residents to receive expired medications that were no longer effective. Findings: 1. During an observation on 3/4/25 at 12:45 p.m. at the nursing station, the medication storage room at the nursing station was propped open and unattended. There was no staff inside the medication storage room and no staff sitting at the nursing station. During an interview on 3/4/25 at 2:30 p.m., with Licensed Vocational Nurse (LVN) 2, at the nursing station, LVN 2 stated medication room was wide open and unattended earlier. LVN 2 stated medication room should always be kept locked to prevent residents and unauthorized personnel access to medications. During an observation 3/6/25 at 10:26 a.m., at the nursing station, the medication storage room at the nursing station was propped open. LVN 1 and LVN 3 were sitting at the nursing station facing their computers (not facing the medication room). During an interview on 3/6/25 at 10:32, with Licensed Vocational Nurse (LVN) 1 at the nursing station, LVN 1 stated accessible needles and syringes may potentially harm anyone who had access while the door was open. LVN 1 stated the medication storage door should be closed. LVN 1 stated she did not feel access to the Over the Counter (OTC) medication would be a potential threat. LVN Stated there was unlocked ointment. LVN 1 stated, If the door is open, there is potential for residents to access medication and could ingest medication which had the potential for an allergic reaction, rash and may not taste good. During an interview on 3/7/25 2:40 p.m. with the DON, the DON stated, Medication room must be locked. The DON stated when medication room was open and attended residents and staff will be at risk for injury. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on 3/5/25 at 12:18 p.m. at medication storage room, Resident 5's Hydrocortisone 2.5% topical cream label indicated Discard date after 2/25 and Issued date 11/22/23. The Hydrocortisone 2.5% topical cream jar for Resident 5 was on top of the medication storage counter. During a concurrent observation and interview on 3/5/25 at 12:21 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Hydrocortisone 2.5% label indicated Discard date after 2/25. LVN 3 stated they followed discard date on label, and, It needs to be destroyed, it may not be effective. Resident 5 has a current order for Hydrocortisone 2.5% topical cream. During an interview on 03/06/25 at 4:53 p.m. with the Director of Nursing (DON), the DON stated expired medication should be destroyed. The DON stated, It is less effective. During an interview on 3/7/25 at 3:00 p.m. with the Pharmacist Consultant (PC), the PC stated Resident 5's Hydrocortisone 2.5% label indicated Discard date after 2/25, and stated, Pull it out, based on the label. During a review of facility's policy and procedure titled, Medication Storage, dated 2007, the P&P indicated, 3. Medication rooms should remain locked when not in use or attended by persons with authorized access; . 14. Outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51223 Based on observation, interview, and record review, the facility failed to follow the pureed turkey recipe for four of 31 sampled residents' (Resident 11, 14, 15, and 20) on a pureed (smooth textured food without lumps that does not require chewing, holds shape on a spoon and is not sticky) diet when water was substituted for turkey or chicken stock. This failure had the potential to decrease the food's flavor and nutritive value (providing and containing the nourishment needed for growth, health, and well-being) for all four residents on a pureed diet, and could have led to decreased intake and unexpected weight loss, which may further compromise their medical status. Findings: During a concurrent observation and interview on 3/5/25 at 10:56 a.m. with the cook (COOK) 1 in the kitchen, COOK 1 prepared pureed turkey for lunch. COOK 1 pureed cooked turkey roast with water, instead of turkey or chicken stock, in the blender. COOK 1 stated it was important to follow the recipe to ensure the food tastes good and a pudding like texture was achieved. During a phone interview on 3/6/25 at 11:38 a.m. with the Registered Dietician (RD) in the conference room, the RD stated she would expect the cook to follow the menu and recipe when preparing resident food. RD stated the cook should have used turkey or chicken stock when preparing the pureed turkey roast to maintain flavor and nutritive value. RD stated she would not recommend the use of water as it could decrease the flavor and nutritive value and result in decreased resident intake which may prevent adequate nutrition or may alter food consistency and increase the risk of choking. During an interview on 3/6/25 at 2:46 p.m. with the Dietary Service Supervisor (DSS) in the DSS office, the DSS stated she would expect the cook to follow the menu and recipe when preparing resident food. DSS stated the risk of using water in the pureed turkey roast recipe could lead to decreased flavor which had the potential to reduce resident intake and lead to unexpected weight loss. DSS stated the cook should have followed the recipe. During an interview on 3/7/25 at 8:38 a.m. with COOK 2 in the kitchen, COOK 2 stated meat broth should be used when preparing pureed meat. COOK 2 stated she would follow the puree recipe instructions as residents cannot chew and could choke easily on food. COOK 2 stated a change to the recipe could change the flavor or nutrients of the food and residents may not want to eat and could lose weight. During a review of Diet Extensions, dated 3/5/25, the lunch pureed menu column indicated pureed turkey roast as the entree. During a review of, Turkey Roast recipe, not dated, the pureed diet recipe indicated, PUREE DIET: Process each serving of until smooth, gradually adding 2-4 tablespoons of turkey or chicken stock, or more if necessary . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Grace Home Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE: 13435 Peach Avenue Livingston, CA 95334	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Diet Type Report, dated 3/4/25, diet texture pureed was indicated for Residents 11, 14, 15, and 20. During a review of the facility's policy and procedure titled, Menus Subject: Therapeutic Diet Orders, dated 2023, the procedures indicated, 2. There will be a therapeutic diet spreadsheet which specifically lists the food items to be prepared for each diet served by the facility. During a review of Job Description: Cook, dated 2/2024, the Job Summary indicated, the cook, Prepares and serves meals according to the daily menu and modified diets. The Qualifications indicated, the cook, Must be able to read, write and follow oral and written directions. The Performance Required indicated, the cook, Follows standard recipes and menus . Work Performed: Prepares, cooks and serves meals; follows menus and modified diets. During a review of Job Description: Dietary Supervisor (DSS), not dated, the Job Summary indicated the DSS, Supervises and instructs employees who prepare and serve meals .Assists in maintaining and improving standards of food preparation and service. Responsible for all areas of the food operation . During a review of Registered Dietician Consultant Services Agreement, dated 6/1/24, indicated, II. Mutual Understandings 2.The Facility is responsible for approving, implementing, and maintaining those recommendations made by the RD . 6.the Facility retains authority and complete responsibility for supervision and administration of the Dietetic Services Department . During a review of the facility's policy and procedure titled, Orientation, Inservice & Personnel Management Subject: [NAME] Job Description, dated 2023, the policy indicated, The [NAME] prepares and serves food including texture modified and therapeutic diets according to the facility menu . The responsibilities indicated 2. Prepares food by methods that conserve nutritive value, flavor, and palatability by following the Standardized recipes . During a review of the facility's policy and procedure titled, Orientation, Inservice, & Personnel Management Subject: Director of Food and Nutrition Services Job Description, dated 2023, the responsibilities indicated, 4. Supervises the preparation of food and food service for resident meals according to established menus and standardized recipes . 6. Ensures food is prepared by methods that conserve nutritional value and is palatable and attractive to residents . During a review of the facility's policy and procedure titled, Orientation, Inservice, & Personnel Management Subject: Consultant Dietician Nutritionist Job Description, the responsibilities indicated, .3. Coordinates, implements, and evaluates the facility menus for nutritional adequacy . 6. Evaluates and monitors the food service department to assure that the department is providing adequate, acceptable quality food .

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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. 51223 Based on observation, interview and record review the facility failed to label stored food and properly clean the kitchen for 31 of 33 Residents (Resident 1, 2, 3, 5, 6, 7, 8, 9, 10, 12, 13, 14,15,16, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33) who eat food from the facility when: 1. Pastrami was not labeled with a thaw date after being moved from the freezer to the refrigerator. 2. The quaternary ammonium sanitizer solution used to clean the food preparation surfaces after breakfast tested at 150 ppm (parts per million), below the targeted 200-400 ppm. 3. Staff failed to document the dishwashing machine temperature log, prior to the start of washing, at each meal, to ensure proper sanitation of all dishware and trays. These failures had the potential to result in cross contamination (the unintentional transfer of harmful bacteria or other contaminants from one food, surface, or object to another, often leading to foodborne illnesses) and the growth of microorganisms which could lead to food borne illness for 31 of 33 residents admitted to the facility who receive food from the kitchen. Findings: 1. During a concurrent observation and interview on 3/4/25 at 9:40 a.m.,with the Dietary Services Supervisor (DSS) in the kitchen, packages of frozen pastrami were found without an affixed pull date (the date on perishable products after which it should not be used) or a new use by date label in the refrigerator. The DSS stated the facility does not always place the pull date labels if the food would be used for a specific meal. DSS stated food used after the use by date may have less flavor or nutritive value for the residents. During a concurrent interview and record review on 3/4/25 at 9:56 a.m. with the DSS in the conference room, the facility's policy and procedure (P&P) titled, Food Purchasing, Receiving and Production Subject: Labeling, not dated, was reviewed. The procedures indicated, .3. All food removed from the freezer will have a pull date label affixed with the date on which it is removed from the freezer and be labeled with the new use by date, according to the guidelines from www.stilltasty.com. The DSS stated, We messed up. The DSD stated the labeling policy indicated all food removed from the freezer will have a pull date label affixed. The DSD stated the staff should be following the policy. During a review of Job Description: Dietary Supervisor, not dated, the,Performance requirements responsibilities/duties, indicated, .Adhere to all sanitary regulations governing the handling, preparation, and serving of food. Supervision and training of all employees involved in these activities . The work performed indicated, 6. Maintaining safety standards . (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 Food and Drug Administration (FDA) Food Code 2022, dated 2022, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking indicated on page 419, .Date marking (a mark to indicate the date or day by which food is to be consumed on the premises .or discarded) is the mechanism by which the Food Code requires active managerial control of the temperature and time combinations for cold holding (the practice of keeping food at or below 41 degrees Fahrenheit to prevent bacteria growth and food-borne illness . 2. During a concurrent observation and record review on 3/5/25 9:11 a.m. in the kitchen, the Quaternary (Quat.) Ammonium Log posted on the kitchen door indicated the concentration of the ammonium solution was not recorded for 3/5/25. The log indicated, Test the concentration of the ammonium .at least once per shift, record concentration reading . During a concurrent observation, interview, and record review on 3/5/25 at 9:16 a.m. with Dietary Aide (DA) 2, in the kitchen, the Quaternary Ammonium Log posted on the kitchen door indicated the concentration of the ammonium solution was not recorded for 3/5/25. DA 2 stated staff should test the ammonium concentration three to four times a day or when the bucket was refilled. DA 2 stated the Quat. solution was used to sanitize (to reduce or eliminate germs or bacteria on surfaces using chemicals) counters and appliances and had been used that morning after breakfast. DA 2 tested the Quat. solution using manufacturer test strips which read 150 ppm (parts per million), which is lower than the target ammonium level of 200 ppm. DA 2 stated the ammonium concentration level was too low, and the liquid should be disposed of and replaced. DA 2 stated the targeted 200 ppm ammonium level was to ensure the sanitation solution would kill bacteria. DA 2 stated there could be potential for cross contamination if the targeted level was not achieved, and residents may get sick if bacteria was not eliminated. During an interview on 3/6/25 at 10:48 a.m. with the Dietary Service Supervisor (DSS), in the kitchen, the DSS stated the sanitation solution should be checked three times a day to ensure the concentration meets the targeted sanitation level or the solution would not eliminate bacteria. During a review of Job Description: Dietary Aide, dated 2/2024, the performance required indicated, . Maintains sanitation and safety standards . During a review of Job Description: Dietary Supervisor, not dated, the Performance requirements responsibilities/duties indicated, .Adhere to all sanitary regulations governing the handling, preparation, and serving of food. Supervision and training of all employees involved in these activities . The work performed indicated 5. Supervising sanitation and housekeeping procedures. 6. Maintaining safety standards . During a review of the facility's policy and procedure titled, Orientation, Inservice, & Personnel Management Subject: Department of Food and Nutrition Services Aide/Dishwasher Job Description, dated 2023, the responsibilities indicated, .6. Cleans and sanitizes .food preparation areas after use. 7. Follows posted cleaning schedules utilizing proper sanitation and cleaning methods. 8. Practices safety, infection control, and emergency procedures according to facility policies .10. If assigned, washes dishes, utensils, and wares according to facility policy. May also be assigned to clean dish machine and ware washing areas . (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 titled, Orientation, Inservice, & Personnel Management Subject: Director of Food and Nutrition Services, dated 2023, the responsibilities indicated, .9. Ensures sanitation and safety standards are maintained according to State, Federal, and local regulations . During a review of the facility's policy and procedure titled, Sanitation and Infection Control Subject: Sanitizing Equipment and Surfaces with Quaternary Ammonium Sanitizer (Quat. red sanitizing bucket), dated 2023, the policy indicated, .Equipment and surfaces may be sanitized using Quat. Solution after each use and more often as needed. Quat. levels will be checked and recorded every two hours for buckets .or more often as needed to ensure equipment and surfaces are sanitized appropriately. The procedure indicated, 3. Test strips can range between 200-400 ppm, or per manufacturer's guidelines. 4. Results for buckets will be recorded every 2 hours . During a review of the California Code, Health and Safety Code-HSC 114099.6, dated 1/1/23, the HSC indicated, Manual sanitization shall be accomplished in the final sanitizing rinse by one of the following: .(b) The application of sanitizing chemicals by immersion, manual swabbing, or brushing, using one of the following solutions: .(3) Contact with a solution of 200 ppm quaternary ammonium for at least one minute. 3. During an interview with the Dietary Services Supervisor (DSS) on 3/4/25 at 9:30 a.m. in the kitchen, the DSS stated the facility uses a low temperature (uses cooler water around 120-140 degrees Fahrenheit (F) and relies on chemical sanitizers, rather than high heat, to sanitize dishes) dishwasher. The DSS stated the target temperature is 120-140 degrees F, and staff check the temperature and chemical level prior to each use. During a concurrent observation and interview on 3/5/25 at 9:11 a.m. with Dietary Aide (DA) 1 in the kitchen, DA 1 was washing dishes manually in the sink and using the dishwasher to wash trays, plates, cups, and silverware. DA 1 stated the dishwasher temperature should be 125-135 degrees F, and the dishwasher machine had no chemicals. DA 1 stated chemicals are used for manual dishwashing in the sink. During a concurrent observation, interview, and record review on 3/5/25 at 9:16 a.m. with DA 2, in the kitchen, the Dishwashing Machine Temperature Log Sheet posted on the kitchen door indicated the wash and rinse temperatures, and sanitizing concentration were not logged for 3/5/25. DA 2 stated staff should have checked the dishwasher temperature at breakfast, lunch, and dinner. DA 2 stated the staff have not checked the dishwashing machine temperature or sanitation concentration yet. DA 2 stated the dishwasher temperature should be 120-140 degrees F, and the ammonium concentration should be 50-100 ppm. DA 2 stated staff usually check the dishwashing machine temperature and sanitation concentration levels before washing the silverware. DA 2 stated staff check the temperature level and sanitation level to ensure everything was properly cleaned so residents do not get sick. DA 2 stated staff should probably check the temperature and sanitation concentration level before washing anything to ensure bacteria would be eliminated. During an interview on 3/6/25 at 10:48 a.m. with the Dietary Services Supervisor (DSS), the DSS stated the dishwasher temperature and sanitation level should be checked between every meal, before dishes pass through, to ensure sanitation is achieved. The DSS stated if the dishwasher temperature was not at target, it would not sanitize the dishes and there could be a potential for cross contamination. (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 Job Description: Dietary Aide, dated 2/2024, the Performance Required indicated, Maintains sanitation and safety standards . During a review of, Job Description: Dietary Supervisor, not dated, the Performance Requirements Responsibilities/Duties indicated, Adhere to all sanitary regulations governing the handling, preparation, and serving of food. Supervision and training of all employees involved in these activities . The work performed indicated, 5. Supervising sanitation and housekeeping procedures. 6. Maintaining safety standards . During a review of Orientation, Inservice, & Personnel Management Subject: Department of Food and Nutrition Services Aide/Dishwasher Job Description, dated 2023, the responsibilities indicated, 6. Cleans and sanitizes utensils and food preparation areas after use. 7. Follows posted cleaning schedules utilizing proper sanitation and cleaning methods. 8. Practices safety, infection control, and emergency procedures according to facility policies .10. If assigned, washes dishes, utensils, and wares according to facility policy. May also be assigned to clean dish machine and ware washing areas . During a review of the facility's policy and procedure titled, Orientation, Inservice, & Personnel Management Subject: Director of Food and Nutrition Services, dated 2023, the responsibilities indicate, 9. Ensures sanitation and safety standards are maintained according to State, Federal, and local regulations. During a review of the facility's policy and procedure titled, Sanitation and Infection Control Subject: Dishwashing Procedures (Dishmachine), dated 2023, the procedures indicated, 3. Chemical low temperature dish machines must maintain a water temperature of 120-140 Fahrenheit. Use a chemical sanitizing rinse to achieve and maintain 50-100 PPM (parts per million) of chlorine at the dish surface or according to manufacturer's specifications .5. Dishmachine Temperature Logs must be documented prior to the start of washing at each meal to ensure proper sanitation of all dishware and trays . During a review of Food and Drug Administration (FDA)Food Code 2022, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation-Temperature, pH, Concentration, and Hardness, the FDA Code indicated, The effectiveness of chemical sanitizers can be directly affected by the temperature . concentration of the sanitizer solution used .it is critical to sanitation that the sanitizers are used consistently with the EPA-registered label .that the solutions meet the standards required in the Code .a sanitizing solution that is too weak .too strong would be a violation .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 51223 51345 Based on observation, interview, and record review, the facility failed to follow it's own infection prevention program designed to provide a safe and sanitary environment for three of eleven sampled residents when: 1. Resident 29 and Resident 31's urinals were hanging inside their trash can at bedside. 2. LVN 2 did not perform cleaning of Resident 13's inhaler and bedside table when Resident 13's inhaler was placed on top of bedside table before and after use. These failures had the potential risk in the development and transmission of communicable diseases and infections for Residents 13, 29, and 31. Findings: 1. During an observation on 3/4/25 at 4:20 p.m. in room [ROOM NUMBER], Resident 29 and Resident 31's urinals were hanging inside their trashs can at bedside. Resident 29 and Resident 31 were sitting in wheelchairs beside their beds. During a concurrent observation and interview on 3/4/25 at 4:23 p.m. with Resident 31, in Resident 31's room, Resident 31 was sitting in his wheelchair. Resident 31 was alert and oriented with intermittent periods of confusion. Resident stated he uses urinal and pointed to his urinal hanging inside the trash can at bedside. During a review of Resident 31's Admission Record (AR), dated 3/7/25, the AR indicated, Resident 31 was admitted to the facility on [DATE] with a primary diagnosis of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors [shaking or trembling movements in one or more parts of the body]). During a review of Resident 31's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/25/25, the MDS section C indicated, Resident 31 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 11, which indicated Resident 31 was moderately impaired. During an observation on 3/6/25 at 11:29 a.m. in room [ROOM NUMBER], Resident 29 and Resident 31's urinals were hanging inside their trash can at bedside. Resident's 11 B's trash was touching the urinal. Resident 29 and Resident 31 were not in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 11:32 a.m. with the Infection Preventionist (IP), the IP stated she was aware Resident 29 and Resident 31 use their trash cans to hang their urinals. The IP stated both residents use urinals by themselves. The IP stated trash can come in contact with their skin and can cause an infection. During an interview on 3/6/25 at 2:52 p.m. with the Housekeeping and Laundry Staff (HLS), the HLS stated, Urinal hanging inside the trash can is a normal thing here. The HLS stated, Trash can is not clean; it can cause infection. During an interview on 3/6/25 at 4:53 p.m. with the Director of Nursing (DON), the DON stated urinals hanging inside the trash is a risk for hand contamination and potential infection to the residents. He stated, If hanging outside the trashcan, will be okay. 2. During a concurrent observation and interview on 3/5/25 at 8:31 a.m. with Licensed Vocation Nurse (LVN) 2 in room [ROOM NUMBER]A, LVN 2 did not perform cleaning of bedside table when Resident 13's inhaler was placed on top of bedside table before or after use without a barrier. LVN 2 did not clean and cover Resident 13's inhaler lid after administration. LVN placed Resident 13's inhaler on top of the bedside table with inhaler lid touching the bedside table. LVN 2 stated she did not clean the bedside table before and after giving the inhaler. LVN 2 did not clean the inhaler lid and placed on top of bedside table. LVN 2 stated, I should put a barrier and clean the lid. LVN 2 stated there is a risk for potential spread of infection. During an interview on 3/7/25 at 9:30 a.m. with the IP, the IP stated standard precautions include cleaning of bedside table before and after use. The IP stated during medication administration, We use a paper plate as barrier. The IP stated, If nurses did not use a barrier and did not clean the bedside table, it can transmit bacteria. The IP stated her expectation is to follow the policy and procedure to clean the bedside table before and after use if not using a barrier. The IP stated Hydrogen Peroxide (Chlorox) wipes are used for cleaning the bedside table and other resident equipment. During a review of facility's Policy and Procedure (P&P) titled, Standard Precautions, not dated, the P&P indicated, Standard precautions apply to the care of all residents in all situations regardless of their diagnoses or suspected or confirmed infection status. Standard precaution includes the following practices: 5. Resident-care equipment and 6. Environmental Control a. Environmental surfaces . bedside equipment and other frequently touched surfaces are appropriately cleaned.

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

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation and staff interview during the survey period from 3/4/25 through 3/7/25, the facility failed to ensure each bedroom had 80 square feet of usable living space for residents in three of 14 rooms (room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]). This failure to provide the residents in rooms 4, 6 and 7 with 80 square feet of space had the potential for the residents to not have enough space to accommodate their personal needs and belongings. Findings: During an interview on 3/7/25 at 10:15 a.m., with the Administrator (ADM), the ADM stated he was aware room [ROOM NUMBER], 6, and 7 did not meet the minimum space requirement for two residents. The ADM provided the room measurements for rooms 4, 6 and 7. The room measurements were as follows: Room Number: Number of Beds/Residents: Square Footage per Resident: 4 2 153.12 square feet (sq ft- unit of measurement: 76.56 sq ft per resident) 6 2 152.1 sq ft (76.05 sq ft per resident) 7 2 152.1 sq ft (76.05 sq ft per resident) During an observation throughout the survey period from 3/4/25 through 3/7/25 three resident bedrooms (4, 6 and 7) had two residents per room and had less than 80 square feet of space for each resident. Although the bedrooms accommodated less than 80 square feet for each resident, each room met the required needs of the residents. The residents had a reasonable amount of privacy, and closet and storage space was adequate. Bedside stands were available. There was sufficient room for nursing care and for the mobility of the residents. Wheelchairs, devices, and toilet facilities were accessible. The health and safety of the residents will not be adversely affected by the continuance of this waiver. Recommend waiver to continue in effect. _______________________________________ [NAME], HFES Health Facilities Evaluator Supervisor Date