STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the care and services necessary to relieve the pain for one of three sampled residents ' , Resident 1. This deficient practice resulted in the resident ' s discomforts, affecting his participation with physical therapy (PT) and his activities of daily living and had the potential to affect the resident ' s quality of life and recovery. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included obstructive and reflux uropathy, unspecified (urinary tract condition where urine flow is obstructed and refluxes [flows backward] into the urinary tract) and difficulty walking. During a review of Resident 1 ' s History and Physical (H&P) dated 3/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care screening and assessment tool) dated 3/25/2025, the MDS indicated Resident 1 could understand and be understood by others. The MDS indicated Resident 1 required set-up for eating and oral hygiene. The MDS indicated Resident 1 required substantial assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bath, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 1 had an indwelling catheter. The MDS indicated Resident 1 had obstructive uropathy. During a review of Resident 1 ' s Order Summary Report for 4/1/2025 to 4/30/2025, the Order Summary Report indicated acetaminophen (medication to treat pain and fever) tablet 325 milligrams ([mg] unit of measurement), 1 tablet by mouth every six (6) hours as needed for moderate to severe pain 1-10/10. The Order Summary Report did not indicate to monitor the resident ' s pain level. The Order Summary Report indicated an order dated 4/24/2025 for an indwelling catheter ([foley] a thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine) 16 French ([f] unit of measurement), change for blockage, leaking, pulled out, excessive sedimentation and to change catheter drainage bag as needed and with every change of indwelling catheter (for obstructive and reflux uropathy). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s PT Treatment Encounter Note dated 4/29/2025, the note indicated Resident 1 sat at the end of the bed and reported increased penile pain due to the foley. During a review of Resident 1 ' s PT Treatment Encounter Note dated 4/30/2025, the note indicated Resident 1 complained his foley catheter (FC) was hurting and the resident did not want to sit on the wheelchair. During a review of Resident 1 ' s Medication Administration Record (MAR) for the month of 4/2025, the MAR did not indicate Resident 1 was provided pain medication on 426/2025, 4/29/2025 and 4/30/2025. During an interview on 5/2/2025 at 8:43 a.m. with Family Member (FM 1) and Family Member 2 (FM 2), FM 1 stated Resident 1 called him on 4/26/2025 and was complaining of pain. FM 1 stated Resident 1 told Certified Nurse Assistants (CNAs [unidentified]) and the Licensed Vocational Nurses (LVNs) that he was in so much pain all day, but no one did anything. FM1 stated he did not know the names of the nurses Resident 1 had spoken to about the pain. FM 2 stated, when he went to visit Resident 1 on 4/29/2025, he saw the resident ' s catheter was pulling when he moved and probably, was the reason why the resident was in pain. FM 2 stated the pain was affecting the resident to get better. During a concurrent observation and interview on 5/2/2025 at 11:33 a.m. with Resident 1, CNA 1 and Registered Nurse (RN 1), Resident 1 stated the tip of where the catheter was inserted was hurting since 4/26/2025. Resident 1 stated he had reported it to the CNAs and LVNs, but no one did anything. Resident 1 stated the FC kept pulling and caused the pain every time the staff touched it or whenever he moved. CNA 1 stated she did not know why the FC was not secured with the FC securing device. CNA 1 removed the resident ' s diaper and Resident 1 started screaming and moaning of pain. CNA 1 stated Resident 1 had complained of pain whenever his FC was touched in the last four days and was reported to LVN 1. CNA 1 observed redness and white spots around the tip of the penis and reported to RN1. RN 1 stated the reason Resident 1 complained of pain was because the FC was pulling on his penis. During an interview on 5/2/2025 at 1:49 p.m. with LVN 1, LVN 1 stated she found out about Resident 1 ' s pain from the FC the morning of 5/2/2025 and was given Tylenol. During a concurrent interview and record review on 5/2/2025 at 2:27 p.m. with the PT, Resident 1 ' s PT Treatment Encounter Note dated 4/29/2025 and 4/30/2025, were reviewed. The PT stated on 4/29/2025 and 4/30/2025, Resident 1 declined therapy due to penile pain related to his FC. The PT stated Resident 1 ' s pain and refusal to participate with PT was reported to LVN 1 and RN 1. The PT stated that he did not know if the nurses had given the resident his pain medicine because when he offered the resident his therapy again, the resident refused. PT stated not managing the resident ' s pain properly could delay the resident ' s recovery. During a concurrent interview and record review on 5/2/2025 at 3:26 p.m. with the Director of Nursing (DON), Resident 1 ' s MAR for April 2025 was reviewed. The DON stated the MAR did not indicate Resident 1 was given Tylenol from 4/1 to 4/24/2025, and from 4/26 to 4/30/2025. The DON stated the MAR indicated Resident 1 was administered Tylenol once on 4/25/2025. The DON stated the resident ' s pain should always be addressed immediately because it can affect the residents ' ability to participate in activities of daily living (ADLs), therapy, and it could delay the resident ' s recovery and can lead to feelings of anger and sadness. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/2025 at 4:00 p.m. with RN 1, RN 1 stated she did not assess Resident 1 ' s pain and did not offer pain medication because she was focused on attempting to secure the FC. During an interview on 5/5/2025 at 12:20 p.m. with Resident 1, Resident 1 stated he refused PT because of the pain. Resident 1 stated it made him angry not to be able to move without hurting. Resident 1 stated the staff did not understand he was in pain. During a review of the facility ' s Policies and Procedures (P&P) titled, Quality of Life - Dignity, dated 2/2020, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the care and services of one of three sampled residents (Resident 2) needed for the suprapubic catheter (a type of urinary catheter inserted into the bladder through a small incision in the lower abdomen, rather than through the urethra, to drain urine) was provided promptly. This deficient practice resulted in Resident 1 experiencing bladder spasm and discomfort. Findings: During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included quadriplegia C5-C7 (paralysis of all four limbs and the torso, resulting from a spinal cord injury at the cervical [neck] region) and muscle weakness. During a review of Resident 2 ' s care plan titled, Indwelling catheter (suprapubic), dated 8/10/2017, the care plan indicated to lavage (wash out) suprapubic catheter per physician order. During a review of Resident 2 ' s History and Physical (H&P) dated 4/11/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set ([MDS] a standardized care screening and assessment tool) dated 4/11/2025, the MDS indicated Resident could understand and be understood by others. The MDS indicated Resident 2 was dependent (helper does all the effort to complete activity) for eating, oral hygiene, with toileting hygiene, shower/bath, upper/lower dressing, and putting on/taking off footwear. The MDS indicated Resident 2 was dependent to roll left and right and going from sitting to lying. The MDS indicated Resident 2 had an indwelling catheter (thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine) and always had bowel incontinence. The MDS indicated Resident 2 had neurogenic bladder (condition where bladder function is disrupted due to a neurological problem, causing issues with emptying or controlling the bladder). During a review of Resident 2 ' s Order Summary Report for 4/1/2025 to 4/30/2025, the Order Summary Report indicated to lavage suprapubic catheter with 200 cubic centimeter ([cc] unit of liquid measure) every day shift, every Monday, Wednesday, Friday for 30 days. During an interview on 5/2/2025 at 11:00 a.m. with Resident 2, Resident 2 stated she had been requesting her supra-pubic catheter to be flushed since 10:00 a.m. but no one had done it yet and she was not sure what time the nurse would be able to do it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/2/2025 at 3:20 p.m. with Registered Nurse (RN 1) and Resident 2, while this HFEN was exiting the conference room, Resident 2 stated her supra-pubic catheter was still not flushed and the treatment nurse was still missing. Resident 2 stated she was starting to feel spasms (cramps) and tightness in her abdomen. Resident 2 stated she did not feel pain, but the tightness gave her discomfort. Resident 2 stated she always chased the treatment nurse to get her treatment, and she could not wait any longer today. Resident 2 stated she had been asking the staff to flush the catheter, and no one had done it. RN 1 stated the treatment nurse called out today and another nurse was supposed to come to cover but she was not sure what time she was going to come in. RN 1 stated she was going to flush the catheter earlier, but she had another admission and discharge and got too busy and was not able to do it. RN 1 stated it was important to tend to Resident 2 ' s need to flush her catheter because it may cause the resident discomfort. During a review of the facility ' s Policy and Procedure (P&P) titled Activities of Daily Living, dated 3/2018, the P&P indicated residents should be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly assess one of three sampled residents ' (Resident 1), who had an indwelling foley catheter ([FC] a thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine) pain and provide interventions to alleviate the pain. This failure resulted in not identifying the cause of the resident ' s pain, resulting in delayed interventions to alleviate the pain. This failure had the potential to affect in maintaining the highest practicable, physical, mental and psychosocial well-being of the resident. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included obstructive and reflux uropathy, unspecified (urinary tract condition where urine flow is obstructed and refluxes [flows backward] into the urinary tract) and difficulty walking. During a review of Resident 1 ' s Order Summary Report dated 3/18/2025, the Order Summary Report indicated acetaminophen (medication to treat pain and fever) tablet 325 milligrams ([mg] unit of measurement), 1 tablet by mouth every six (6) hours as needed for moderate to severe pain 1-10/10 During a review of Resident 1 ' s History and Physical (H&P) dated 3/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care screening and assessment tool) dated 3/25/2025, the MDS indicated Resident could understand and be understood by others. The MDS indicated Resident 1 required sept for eating and oral hygiene. The MDS indicated Resident 1 required substantial assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bath, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 1 had an indwelling catheter (thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine). The MDS indicated Resident 1 had obstructive uropathy. During a review of Resident 1 ' s Order Summary Report for 4/1/2025 to 4/30/2025, the Order Summary Report indicated acetaminophen (medication to treat pain and fever) tablet 325 milligrams ([mg] unit of measurement), 1 tablet by mouth every six (6) hours as needed for moderate to severe pain 1-10/10. The Order Summary Report did not indicate to monitor the resident ' s pain level. The Order Summary Report indicated an order dated 4/24/2025 for an indwelling catheter ([foley] a thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine) 16 French ([f] unit of measurement), change for blockage, leaking, pulled out, excessive sedimentation and to change catheter drainage bag as needed and with every change of indwelling catheter for obstructive and reflux uropathy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Physical Therapy Treatment Encounter Note dated 4/29/2025, the note indicated Resident 1 sitting at end of bed today and reports increased penile pain due to foley. Resident 1 declined transfer and returned to supine. During a review of Resident 1 ' s PT Treatment Encounter Note dated 4/30/2025, the note indicated Resident 1 complained his FC was hurting and the resident did not want to sit on the wheelchair. During a review of Resident 1 ' s Medication Administration Record (MAR) for the month of 4/2025, the MAR did not indicate Resident 1 was provided pain medication on 426/2025, 4/29/2025 and 4/30/2025. During an interview on 5/2/2025 at 8:43 a.m. with Family Member (FM 1) and Family Member 2 (FM 2), FM 1 stated Resident 1 called him on 4/26/2025 and was complaining of pain. FM 1 stated Resident 1 told Certified Nurse Assistants (CNAs [unidentified]) and the Licensed Vocational Nurses (LVNs) that he was in so much pain all day, but no one did anything. FM1 stated he did not know the names of the nurses Resident 1 had spoken to about the pain. FM 2 stated, when he went to visit Resident 1 on 4/29/2025, he saw the resident ' s catheter was pulling when he moved and probably, was the reason why the resident was in pain. FM 2 stated the pain was affecting the resident to get better. During a concurrent observation and interview on 5/2/2025 at 11:33 a.m. with Resident 1, CNA 1 and Registered Nurse (RN 1), Resident 1 stated the tip of where the catheter was inserted was hurting since 4/26/2025. Resident 1 stated he had reported it to the CNAs and LVNs, but no one did anything. Resident 1 stated the FC kept pulling and caused the pain every time the staff touched it or whenever he moved. CNA 1 stated she did not know why the FC was not secured with the FC securing device. CNA 1 removed the resident ' s diaper andResident 1 started screaming and moaning of pain. CNA 1 stated Resident 1 had complained of pain whenever his FC was touched in the last four days and was reported to LVN 1. CNA 1 observed redness and white spots around the tip of the penis and reported to RN1. RN 1 stated the reason Resident 1 complained of pain was because the FC was pulling on his penis. During an interview on 5/2/2025 at 1:49 p.m. with LVN 1, LVN 1 stated she found out about Resident 1 ' s pain from the FC the morning of 5/2/2025 and was given Tylenol. LVN 1 stated Resident 1 complained of pain whenever they moved his FC. LVN 1 stated Resident 1 did not want to do physical therapy (PT) due to penile pain. LVN 1 stated the doctor was notified of the pain and the redness on Resident 1 ' s penis and the instructed to discontinue FC, but Resident 1 did not want the FC removed because of pain. LVN 1 stated she had not asked the doctor to prescribe stronger pain medicine to assist Resident 1 with the pain when removing the FC and to help resident get out of bed. During a concurrent interview and record review on 5/2/2025 at 2:27 p.m. with the PT, Resident 1 ' s PT Treatment Encounter Note dated 4/29/2025 and 4/30/2025, were reviewed. The PT stated on 4/29/2025 and 4/30/2025, Resident 1 declined therapy due to penile pain related to his FC. The PT stated Resident 1 ' s pain and refusal to participate with PT was reported to LVN 1 and RN 1. The PT stated that he did not know if the nurses had given the resident his pain medicine because when he offered the resident his therapy again, the resident refused. PT stated not managing the resident ' s pain properly could delay the resident ' s recovery. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/2/2025 at 3:00 p.m. with the Director of Rehabilitation (DOR), Resident 1 ' s Physical Therapy Treatment Encounter Note dated 5/2/2025 was reviewed. The DOR stated the note indicated Resident 1 refused therapy multiple times due to penile pain and nurses were made aware. The DOR stated Resident 1 ' s pain was reported to staff during stand-up meetings but did not know if the resident was providedpain medication. During a concurrent interview and record review on 5/2/2025 at 3:26 p.m. with the Director of Nursing (DON), Resident 1 ' s MAR for April 2025 was reviewed. The DON stated the MAR did not indicate Resident 1 was given Tylenol from 4/1 to 4/24/2025, and from 4/26 to 4/30/2025. The DON stated the MAR indicated Resident 1 was administered Tylenol once on 4/25/2025. The DON stated it was important to address the pain first with non-pharmacological interventions, then call the physician if the interventions did not work. The DON stated there were no notes indicating Resident 1 reported to the nurse about the penile pain and if anyone had followed up on the pain. The DON stated that the resident ' s pain should always be addressed immediately because it can affect the residents ' ability to participate in activities of daily living (ADLs), therapy, and it could delay the resident ' s recovery and can lead to feelings of anger and sadness. During an interview on 5/2/2025 at 4:00 p.m. with RN 1, RN 1 stated she did not assess Resident 1 ' s pain and did not offer pain medication because she was focused on attempting to secure the FC. During a review of the facility ' s P&P titled Pain Management, dated 8/25/2025, the P&P indicated the purpose of policy was to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. Enter comment here

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff was competent to apply a device to secure the foley catheter ([FC] a thin, flexible tube inserted into the bladder to drain urine) from moving or pulled. This failure resulted in the delay of securing Resident 1 ' s FC, causing more pain and discomfort to the affected resident. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included obstructive and reflux uropathy, unspecified (urinary tract condition where urine flow is obstructed and refluxes [flows backward] into the urinary tract) and difficulty walking. During a review of Resident 1 ' s History and Physical (H&P) dated 3/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care screening and assessment tool) dated 3/25/2025, the MDS indicated Resident could understand and be understood by others. The MDS indicated Resident 1 required sept for eating and oral hygiene. The MDS indicated Resident 1 required substantial assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bath, upper/lower dressing and putting on/taking off footwear. The MDS indicated Resident 1 had an indwelling catheter (thin, flexible tube inserted into the urethra and into the urinary bladder to drain urine). The MDS indicated Resident 1 had obstructive uropathy. During a review of Resident 1 ' s Order Summary Report dated 4/24/2025, the Order Summary Report indicated indwelling catheter (thin, flexible tube inserted into the bladder through the urethra to drain urine) 16 French ([f] unit of measurement) Change for blockage, leaking, pulled out, excessive sedimentation and to change catheter drainage bag as needed and with every change of indwelling catheter (for obstructive and reflux uropathy). During a review of Resident 1 ' s care plan titled, Acute pain related to complain of penile discomfort, dated 5/2/2025, the interventions indicated to observe meatus (opening of the penis or vulva where urine exits the urethra [tube-like structure that carries urine from the bladder to the outside of the body] during urination) for signs of infection and pain relivers. During an interview on 5/2/2025 at 8:43 a.m. with Family Member (FM 1) and Family Member 2 (FM 2), FM 1 stated Resident 1 called him on 4/26/2025 and was complaining of pain. FM 1 stated Resident 1 told Certified Nurse Assistants (CNAs [unidentified]) and the Licensed Vocational Nurses (LVNs) that he was in so much pain all day, but no one did anything. FM1 stated he did not know the names of the nurses Resident 1 had spoken to about the pain. FM 2 stated, when he went to visit Resident 1 on 4/29/2025, he saw the resident ' s catheter was pulling when he moved and probably, was the reason why the resident was in pain. FM 2 stated the pain was affecting the resident to get better. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/2/2025 at 11:33 a.m. with Resident 1, CNA 1 and Registered Nurse (RN 1), Resident 1 stated the tip of where the catheter was inserted was hurting since 4/26/2025. Resident 1 stated he had reported it to the CNAs and LVNs, but no one did anything. Resident 1 stated the FC kept pulling and caused the pain every time the staff touched it or whenever he moved. CNA 1 stated she did not know why the FC was not secured with the FC securing device. CNA 1 removed the resident ' s diaper and Resident 1 started screaming and moaning of pain. CNA 1 stated Resident 1 had complained of pain whenever his FC was touched in the last four days and was reported to LVN 1. CNA 1 observed redness and white spots around the tip of the penis and reported to RN1. RN 1 stated the reason Resident 1 complained of pain was because the FC was pulling on his penis. RN 1 started to secure Resident 1 ' s FC with the securing device for 5 minutes and was unable to. RN 1 admitted she did not know how to secure the FC with the device. During an interview on 5/2/2025 at 3:26 p.m. with Director of Nursing (DON), the DON stated the facility did not use the FC securing device Resident 1 had on and the reason why RN 1 did not know how to secure the FC with the device. The DON stated the staff should have removed the securing device and placed the device the staff was in-serviced on. The DON stated having the catheter secured could have prevented the irritation on Resident 1 ' s penis. During a review of the facility ' s Policy and Procedure (P&P) titled Registered Nurse, dated 8/25/2025, the P&P indicated the primary purpose of this position was to provide skilled nursing care to residents under the medical direction of the residents' attending physician and within the scope of nursing practice for the state.