STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555019	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple Park Convalescent Hospital	2411 W. Temple Street Los Angeles, CA 90026

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced residents dignity and respect in full recognition of their individualities for two of ten sampled residents (Resident 85 and Resident 92). For Resident 85, the facility failed to cover the urinary collection bag (designed to collect urine drained from the bladder via a catheter) with a privacy bag. For Resident 92, the facility failed to provide dignity by standing over the resident while assisting her during a meal. These deficient practices had the potential to negatively affect the residents psychosocial wellbeing and loss of dignity. Findings: a. A review of Resident 85's Admission Record indicated the facility admitted the resident on 12/6/2023, with diagnoses including muscle weakness, and paraplegia (loss of ability to move that affects your legs, but not your arms). A review of Resident 85's Minimum Date Set (MDS) dated [DATE], indicated the resident had intact cognition (decisions consistent/reasonable) and was dependent for toileting hygiene, showering/bathing, and lower body dressing. The MDS further indicated that the resident required maximum assistance with upper body dressing and required partial/moderate assistance with personal hygiene, and oral hygiene. The MDS further indicated that Resident 85 had indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag). A review of Resident 85's History and Physical dated 12/8/2023, indicated the resident had the capacity to consent. A review of Resident 85's Physician's Orders dated 12/8/2023, indicated to monitor the placement of indwelling catheter to drainage bag during every shift. The order further indicated to provide care for the indwelling catheter during every shift. During an observation on 4/1/2024 at 8:52 AM, inside Resident 85's room, Resident 85's urinary collection bag was not covered with a privacy bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 4/1/2024 at 8:54 AM inside Resident 85's room, with the MDS Coordinator Assistant (MDSA), MDSA stated Resident 85's urinary collection bag was not covered with a privacy bag. The MDSA further stated the urinary collection bags were required to be covered with a privacy bag to promote dignity. During an interview on 4/4/2024 at 12:40 PM, the Director of Nursing (DON) stated urinary collection bags were not required to be covered with a privacy bag inside residents' rooms. 43851 b. A review of Resident 92's Admission Record indicated the facility admitted the resident on 1/27/2024, with diagnoses including muscle weakness, dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), type 2 diabetes (a long-term medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels), and transient ischemic attack (TIA, a temporary blockage of blood flow to the brain). A review of Resident 92's MDS dated [DATE], indicated the resident was cognitively intact and was dependent on help for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. A review of Resident 92's Care Plan revised on 2/9/2024, indicates the resident was at risk for a decline in Activities of Daily Living (ADLs, a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) related to the aging process, generalized weakness, and sensory impairment. The care plan indicated goals for Resident 92 to be kept clean, dry, and appropriately dressed for 90 days and for the resident to maintain their current level of ADL participation for 90 days. The care plan further indicated interventions that included to assist Resident 92 with ADL care. During a concurrent observation and interview on 4/01/2024 at 12:38 PM, Resident 92 was observed being fed by Certified Nursing Assistant (CNA) 4. CNA 4 was observed standing up on the right side of Resident 92's bed. Resident 92 was observed looking up at CNA 4, and CNA 4 was observed looking down on the resident. A folding chair was observed at bedside not being used. CNA 4 stated she should be sitting down in a chair when feeding Resident 92. CNA 4 stated she did not use a chair because it took too long. During an interview on 4/4/2024 at 1:06 PM, the Director of Nursing (DON) stated staff should be sitting in a chair and making sure they were at the same level as the resident when feeding. The DON stated the purpose of this was to ensure the staff had adequate control and can see the resident in the same line of eye. The DON stated there could potentially be dignity concerns for the resident if staff feed them standing and not at eye level. A review of the facility's undated policy and procedure titled, Assistance with Meals, indicated residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals; keeping interactions with other staff to a minimum while assisting residents with meals; avoiding the use of labels when referring to residents (e.g., feeders); and avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Resident Dignity and Personal Privacy, reviewed April 2023, indicated the facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47883 Based on observation, interview, and record review, the facility failed to ensure that a call light was within reach for one of four sampled residents (Resident 90) investigated for the call lights care area. This deficient practice had the potential to result in the residents not being able to call for facility staff assistance. Findings: A review of Resident 90's Admission Record indicated the facility admitted the resident on 12/19/2023 with diagnoses including Huntington disease (an inherited disease that causes the progressive breakdown [degeneration of the tissue to a less functional active form] of nerve cells in the brain), hypertension (a condition in which blood pressure is higher than normal), and abnormalities in gait and mobility. A review of Resident 90's History and Physical, dated 12/22/2023, indicated the resident had limited capacity to consent. A review of Resident 90's Minimum Data Set (MDS - an assessment and care screening tool), dated 12/26/2023, indicated the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks) and required moderate assistance with oral and toileting hygiene, toilet transfer, upper and lower body dressing, eating and walking 100 feet. A review of Resident 90's care plan, initiated 12/26/2024, indicated the resident had a communication deficit related to Huntington Disease. The care plan intervention indicated that a call light needs to be within reach of the resident and had to be answered promptly so that the resident could communicate his Activities of Daily Living (ADLs- activities related to personal care) needs daily. During a concurrent observation and interview on 4/1/2024 at 10:35 AM, Certified Nurse Assistant 3 (CNA 3) verified that Resident 90's call light was on the floor and not within the resident's easy reach. CNA 3 stated the call light should be within reach at all the times so the resident would be able to call for assistance if needed. During an interview on 4/4/2024 at 1:30 PM, the Director of Nursing (DON) stated call lights should always be within a resident's easy reach for staff to be able to responds to residents' needs and requests. A review of the facility's policy and procedure titled, Call Light, reviewed 5/2023, indicated when the resident was in bed and confined to a chair, the call light will be placed within easy reach of the residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to ensure the Advance Directive Acknowledgement forms (document provided by the facility that indicates whether a resident has an Advance Directive [AD- a written instruction, recognized under State law, relating to the provision of health care when the individual is unable to make decisions for themselves], would like information regarding creation of an advance directive, or refusal to create an advance directive) were completed thoroughly for two of seven sampled residents (Residents 36 and Resident 85). These deficient practices had the potential for the facility to not honor the residents' medical decisions regarding end-of-life treatment. Findings: a. A review of Resident 36's Admission Record (Face Sheet) indicated that the facility admitted the resident on 6/8/2023, and readmitted on [DATE], with diagnoses including polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), dementia (decline in mental ability severe enough to interfere with daily functioning/life), and hypertension (a condition in which blood pressure is higher than normal). A review of Resident 36's History and Physical, dated 12/20/2023, indicated the resident did not have the capacity to consent due to dementia. A review of Resident 36's Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 3/14/2024, indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that the resident was independent in eating, oral and toileting hygiene, dressing and walking. During a concurrent interview and record review on 4/2/2024 at 10 AM, with the Social Services Director (SSD), Resident 36's medical chart was reviewed. The SSD stated that the Advance Directive Acknowledgment form for Resident 36 was not completed. The SSD stated that the Advance Directive Acknowledgment form, dated 8/15/2023, was not signed by Resident 36 or her legal representative and did not indicate if the resident had or had not executed an Advanced Directive. b. A review of Resident 85's Admission Record indicated the facility admitted the resident on 12/6/2023, with diagnoses including muscle weakness, and paraplegia (loss of ability to move that affects your legs, but not your arms). A review of Resident 85's History and Physical, dated 12/8/2023, indicated that the resident had the capacity to consent. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 85's MDS dated [DATE], indicated the resident had intact cognition (decisions consistent/reasonable). The MDS indicated the resident is dependent for toileting hygiene, showering/bathing, and lower body dressing. The MDS further indicated that the resident required maximum assistance with upper body dressing. The MDS indicated that Resident 85 required partial/moderate assistance with personal hygiene, and oral hygiene. During a concurrent interview and record review on 4/2/2024 at 1:50 PM, with the Social Service Assistant (SSA), Resident 85's Advanced Directive Acknowledgment form was reviewed. The SSA stated, It seems like the form was signed by the resident, but it was not completed, and it does not indicate if the resident executed an advanced directive or not. The SSA stated staff were required to complete the AD acknowledgment form completely so it can reflect the correct information. The SSA stated the potential outcome was inability to know whether or not staff provided education and informed the resident about their right to accept or refuse medical treatments. During an interview on 4/4/2024 at 1:30 PM, the Director of Nursing (DON) stated that the Advance Directive Acknowledgment Form was required to be completed upon admission. The DON stated that staff were required to complete all sections of the form and make sure the form was signed by the resident or resident's responsible party. The DON stated Advance Directive Acknowledgment Forms for Residents 36 and 85 were not completed thoroughly and the potential outcome was that the residents' wishes may not be honored. A review of the facility's undated policy titled, Advance Directives, undated, indicated that upon admission the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatments and to formulate an advanced directive if he or she chooses to do so. Information about whether or not the resident has executed advanced directive shall be placed in the medical record. If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure that a resident was provided a communication device or board with the language that the resident was able to understand for one of one sampled resident (Resident 25). This deficient practice had the potential to delay the delivery of necessary care to the resident. Findings: A review of Resident 25's Admission Record indicated that the facility admitted Resident 25 on 10/17/2022 readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hypertension (a condition in which blood pressure is higher than normal) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 25's History and Physical, dated 9/18/2023, indicated the resident had fluctuating capacity to understand and make decisions. A review of Resident 25's Minimum Data Set (MDS- standardized assessment and care planning tool), dated 3/21/2024, indicated that the resident was severely cognitively impaired (never/rarely made decisions), can sometimes make himself understood and understand others. The MDS further indicated the resident required moderate assistance for oral hygiene, upper body dressing, personal hygiene and supervision or touching assistance with eating. A review of Resident 25's care plan initiated 3/21/2024, indicated Resident 25 had a psychosocial wellbeing problem related to a language barrier. During concurrent observation and interview on 4/2/2024 at 7:55 AM, the resident answered in Chinese. As a result, interpreter services were used to conduct the interview with Resident 25. During a concurrent observation and interview on 4/2/2024 at 8:05 AM in Resident 25's room, Certified Nurse Assistant 3 (CNA 3) stated that Resident 25 knew a few simple English words. CNA 3 stated she was using body and sign language to communicate with Resident 25. CNA 3 further stated that there was no communication device or board in Resident 25's room. During a concurrent observation and interview on 4/2/2024 at 8:05 AM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 25 speaks Chinese and that a communication device would make it clearer what the resident wanted. LVN 2 stated that he was not aware if there was any type of communication device for the resident to use to communicate. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/2024 at 4:05 PM, the Minimum Data Set Coordinator (MDSC) stated she initiated the care plan for Resident 25 and that the resident speaks Chinese, but she did not include an intervention like a communication board in his care plan. The MDSC stated the communication board was for residents who have difficulty communicating to help residents communicate better with staff. During an interview on 4/4/2024 at 1:30 PM, the Director of Nursing (DON) stated that if Resident 25 was not provided a communication device or board, there was the potential that the resident would have difficulty communicating accurately with staff. A review of the facility's undated policy and procedure titled, Communication Policy and Procedure, indicated it was the facility policy to recognize the resident's needs in communicating their needs for resident [who] uses a language other than the dominant language of the facility. It also indicated staff will assess using the resident's preferred language and the resident will be provided with communication board.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADL- refer to an individual's daily self-care activities such as eating, dressing/grooming, bathing/personal hygiene, mobility and toileting) for one of three sampled residents (Resident 29) who had severely impaired vision. This deficient practice had the potential for the resident to experience poor oral intake and be at risk for weight loss. Findings: A review of Resident 29's Admission Record indicated the facility admitted the resident on 3/18/2021, and with diagnoses including glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), need for assistance with personal care, type two diabetes (high blood sugar), and depression (a mood disorder that causes feeling of sadness and loss of interest). A review of Resident 29's Minimum Data Set (MDS - an assessment and care screening tool) dated 2/4/2024, indicated the resident had intact cognition (decisions consistent/reasonable) and required staff supervision for toileting hygiene, showering/bathing, and upper and lower body dressing. The MDS further indicated the resident required set up or clean up assistant for eating, and personal hygiene and Resident 29 had severely impaired vision. A review of Resident 29's History and Physical, dated 3/26/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 29's Physician's Orders, dated 8/13/2023, indicated the resident's diet was No Added Salt (NAS), CCHO, regular texture regular consistency (Normal, everyday foods), and double position at breakfast, lunch, and dinner. The Physician's Order dated 7/10/2023 indicated to provide diabetic snacks to the resident three times a day. A review of Resident 29's Nutritional assessment dated [DATE], indicated the resident did not have significant weight change in the last 30 days, his weight was stable, and the goal was weight maintenance. The Nutritional Assessment further indicated that Resident 29 was able to feed himself independently. A review of Resident 29's Nutrition Evaluation form, dated 2/10/2024, indicated the resident was able to see enough to determine food items. The Nutrition Evaluation form further indicated the resident had a regular portion size order. A review of Resident 29's ADL Care Plan initiated on 2/7/2024, indicated that the resident had an ADL self-care performance deficit related to muscle weakness, need for assistance with personal care and glaucoma. The care plan goal for the resident was to maintain and improve his current level of function through the review date. The care plan interventions were to encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction and encourage the resident to use the bell to call for assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 29's Glaucoma Care Plan initiated on 2/7/2024, indicated that the resident had impaired visual function related to glaucoma. The care plan goal for the resident was to show no decline in visual function through the review date. The care plan interventions were to arrange consultation with eye care practitioner as required, tell the resident where you placed their items, be consistent, and to monitor/document/report any signs and symptoms of acute (new) eye problems. A review of Resident 29's Altered Nutritional Need Care Plan initiated on 2/7/2024, indicated that the resident had NAS (no added salt), CCHO (carbohydrate controlled - used to control high blood sugar) diet with regular texture and consistency. The care plan did not indicate double portions for breakfast, lunch, and dinner. The care plan goal for the resident was to have improved labs at next reading. The care plan interventions were to provide diet as ordered by the physician, monitor weight and report significant changes to the physician and to provide snacks, mineral (a nutrient that is needed in small amounts to keep the body healthy) and vitamins as ordered. During an observation on 4/1/2024 at 12:30 PM, inside Resident 29's room, the resident was sitting on his bed and eating his lunch. Resident 29 was holding a hamburger in his left hand and using his right-hand fingers to find food items on his tray for a minute. Resident 29 was not able to find the bowl of pudding and could not locate his utensils. There was a cup of coffee on Resident 29's lunch tray with unopened sugar packages. At 12:38 PM, Certified Nursing Assistant 5 (CNA 5) entered Resident 29's room and placed a spoon in the resident's hand. CNA 5 placed the pudding bowl in front of the resident and explained to him where she was placing the pudding. CNA 5 opened sugar packages, added the sugar to his coffee and placed the cup in the resident's hand. CNA 5 stated that Resident 29 was blind and required assistance with meal set up. CNA 5 stated that Resident 29 also required receiving directions about where the food items were in his tray so he can consume them. CNA 5 stated, seems like staff did not set up Resident 29's lunch tray properly. CNA 5 stated Resident 29 likes to drink his coffee black with sugar. If we do not add sugar in his coffee, he is not going to be able to add them and he is not going to consume the coffee. During a concurrent observation and interview on 4/2/2024 at 10:45 AM, the surveyor observed Resident 29 lying on his bed. On the resident's side table there was a still wrapped, unopened sandwich that had not yet been consumed. Certified Nursing Assistant 4 (CNA 4) was present inside Resident 29's room asked the resident if he was aware that there was a sandwich on his side table. Resident 29 replied no. Resident 29 stated, Someone put something on here, but they did not tell me what it was. CNA 4 stated that the staff members were required to inform Resident 29 when they serve snacks. CNA 4 further stated that staff were required to state the location of where they placed the item on the table because Resident 29 was not able to see. CNA 4 stated Resident 29 would not be able to eat the sandwich if he does not know there is a sandwich on his bedside. During an interview on 4/4/2024 at 12:34 PM, the Director of Nursing (DON) stated Resident 29 is blind, but he needs meals set up. He eats by himself. Staff do not feed him. Staff are required to inform him the location of food items so he can consume them. The DON stated Resident 29's nutrition evaluation, dated 2/10/2024, was not completed correctly and staff were required to complete residents' assessments correctly and thoroughly. The DON stated potential outcome was insufficient care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Activities of Daily Living, Supporting, reviewed 4/2023, indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living, Residents who are unable to carry out ADLs independently, will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with dining (meals and snacks). A resident's ability to perform ADLs will be measured using clinical tools, including MDS.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure that one of the six sampled staff Certified Nursing Assistant (CNA 2) had a Basic Life Support (BLS - an emergency lifesaving procedure that includes recognition of the signs of sudden cardiac arrest, heart attack, and stroke, as well as the performance of cardiopulmonary resuscitation [CPR] when the heart stops beating) certificate was up to date. This deficient practice had the potential to result in facility residents receiving emergency care that was not up to date, which could lead to resident harm and/or death. Findings: A review of CNA 2's employee file indicated the CNA 2 had a BLS certificate that expired on ,d+[DATE]. A review of the Nursing Staffing Assignment and sign-in sheet dated [DATE] indicated that CNA 2 was working in the facility on [DATE]. During a concurrent interview and record review on [DATE] at 9:50 AM, CNA 2's employee file was reviewed with the Director of Staff Development (DSD). The DSD verified that CNA 2's BLS certificate expired on , d+[DATE] and she was not aware that CNA 2's BLS certificate had expired. The DSD indicated that CNA 2 was working on [DATE] and had not yet renewed or obtained a new BLS certificate. During a concurrent interview and record review on [DATE] at 1:30 PM, CNA 2's employee file was reviewed with the Director of Nursing (DON). The DON verified that CNA 2's BLS certificate expired on ,d+[DATE]. The DON stated that staff CPR certificates were to be renewed every 2 years. The DON stated that staff not having a valid BLS certificate had the potential to result in residents receiving medical care that was not up to date, which could potentially cause the residents harm. A review of the facility's undated policy, Emergency Procedure- Cardiopulmonary Recitation, undated, indicated personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS). It also indicated clinical staff members who will direct resuscitative efforts, including non-licensed personnel will obtain and/or maintain American red Cross or American Heart Association certification in BLS/CPR.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 43851 Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 42), who was identified with visual impairment and functional limitation, was provided with activities that stimulate the resident's senses as evidenced by -Failing to provide Resident 42 with a radio and television. -Failing to formulate a care plan for activities for Resident 42. -Failing to perform an activity participation review quarterly for Resident 42. This deficient practice resulted in Resident 42 experiencing emotional distress verbalizing she felt her days were empty; and indicating she was frustrated and uncomfortable because she was bored. Findings: A review of Resident 42's Admission Record indicated the facility originally admitted the resident on 11/6/2020 and readmitted the resident on 10/27/2021 with diagnoses including adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), cachexia (a general state of ill health involving great weight loss and muscle loss), muscle weakness, dysphagia (difficulty swallowing), difficulty in walking, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 42's Physician's Order dated 10/27/2021, indicated the resident was to receive activity as tolerated and not in conflict with their treatment plan. A review of Resident 42's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 12/26/2023, indicated the resident had severely impaired cognition (ability to make decisions, understand, learn). The MDS further indicated the Resident 42 was dependent on assistance for oral hygiene, toileting hygiene, showering/bathing self, upper/lower body dressing, and personal hygiene. A review of Resident 42's Activities Participation Review dated 12/26/2023 at 1:43 PM, indicated the resident was one on one (1:1) with activity staff. The review indicated Resident 42 enjoyed sensory stimulation, nail care, listening to music and watching television (TV). The review further indicated Resident 42 needed assistance to and from the activity room. There was no indication an Activities Participation Review was conducted after 12/26/2023. A review of Resident 42's Resident Care Conference Review dated 12/28/2023 at 11:06 PM, indicated the resident was alert with periods of forgetfulness, verbally responsive, and able to make their needs known. The review further indicated the resident enjoyed nail care, hand massage, and relaxing in their room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 42's Care Plan revised on 1/2/2024, indicated the resident had impaired visual function related to cataracts (clouding of the normally clear lens of the eye, causing blurred vision). The care plan indicated goals for Resident 42 that included maintaining optimal quality of life within limitation imposed by visual function and using the appropriate visual devices to promote participation in Activities of Daily Living (ADLs, activities related to personal care that include bathing or showering, dressing, getting in and out of bed, walking, using the toilet, and eating) through the review date. The care plan indicated interventions that included arranging a consultation with an eye care practitioner, identifying, and recording factors affecting visual function, and telling the resident where items are placed. Further review of Resident 42's care plan did not indicate there was a care plan that addressed activities. A review of Resident 42's Activity Attendance Record indicated the resident did not receive a room visit from activities on 1/3/2024 and 1/12/2024. The Activity Attendance Record did not indicate Resident 42 participated in an independent activity on 1/1 and 1/2/2024. The Activity Attendance Record further indicated on 1/4, 1/6 - 1/11, 1/13 - 1/17, 1/20 - 1/22, 1/24 and 1/27 - 1/31/2024 Resident 42 was in bed relaxing. A review of Resident 42's Activity Attendance Record indicated the resident did not receive a room visit from activities on 2/1, 2/2, 2/7, 2/8, 2/14, 2/16, 2/23 and 2/29/2024. The Activity Attendance Record indicated Resident 42 listened to music on 2/9, 2/15, 2/17, and 2/20/2024. The Activity Attendance Record indicated Resident 42 performed other independent activity on 2/3 - 2/6, 2/10 - 2/13, 2/18, 2/19, 2/21, 2/22, and 2/24 - 2/28/2024. The Activity Attendance Record did not specify what other independent activity represented. A review of Resident 42's Activity Attendance Record indicated the resident did not receive a room visit from activities on 3/31/2024 and the resident performed other independent activity on 3/5, 3/6, 3/9 - 3/14, 3/18 - 3/20, 3/22 - 3/27, 3/29 and 3/30/2024. The Activity Attendance Record did not specify what other independent activity represented. A review of Resident 42's Activity Attendance Record indicated the resident performed other independent activity on 4/1 - 4/3/2024. The Activity Attendance Record did not specify what other independent activity represented. During a concurrent observation and interview on 4/1/2024 at 8:34 AM, Resident 42 was observed lying in bed with a blank stare. Resident stated she could not see well, and indicated she only saw shadows. Resident 42 stated she spends her days in her room, because she could not get up to go to activities. Resident 42 stated she would rather stay in her room than go to the activities room. Resident 42 stated she had asked for a radio a few weeks ago because she thought it would be a great way to pass the time. Resident 42 stated she could not remember who she told, but indicated she was informed the staff were working on it. Resident 42 was observed without a radio or television in her room. Resident 42 stated she felt uncomfortable and frustrated because she was bored and did not have anything to listen to. Resident 42 stated she would also like to listen to the TV sometimes. Resident 42 stated she felt her days were empty. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/2/2024 at 1:55 PM, Resident 42's Activity Participation Review, Care Plan, and Activity Attendance Records were reviewed with the Activities Director (AD). The AD stated Resident 42 was bed bound and visually impaired. The AD stated Resident 42 had 1:1 visits with activities in her room. The AD stated Resident 42 enjoyed listening to music, having someone read to her, and hand massage. The AD stated activities did room rounds around 1 PM to 2 PM and indicated they try to visit Resident 42 every day. The AD stated activities only visits Resident 42 once a day. The AD stated they try not to do more than 10 minutes with Resident 42 because of all the other residents activities had to see. The AD verified Resident 42's last Activity Participation Review was on 12/26/2023. The AD stated the Activity Participation Review should have been done in 3/2024 and indicated it should be done quarterly. The AD stated the purpose of the Activity Participation Review was to evaluate a resident's preferences for the types of activity and participation they prefer. The AD further verified Resident 42 did not have a care plan for activities. The AD stated every resident should have a care plan for their activity preferences, so staff know what activities to provide the resident with. The AD stated the activities department wass responsible for developing a care plan for activities. The AD verified Resident 42 did not have a TV in their room, and stated she was not aware Resident 42 had asked for a radio. During a concurrent observation and interview on 4/2/2024 at 2:20 PM, Certified Nursing Assistant (CNA) 4 stated Resident 42 had a difficult time seeing. CNA 4 verified Resident 4 did not have a radio or TV in their room. CNA 4 did not know how long Resident 4 did not have a TV or radio. CNA 4 stated she was not aware Resident 42 had asked for a radio. During an interview on 4/2/2024 at 2:30 PM, Licensed Vocational Nurse (LVN) 4 stated Resident 42 was visually impaired. LVN 4 stated he was not sure how often activities come to Resident 42's room. LVN 4 stated Resident 42 did not have a TV or radio. LVN 4 stated he was not aware Resident 42 had asked for a radio, and stated he didn't realize the resident hand no TV in their room. During a concurrent interview and record review on 4/3/2024 at 3:36 PM, Resident 42's Activity Attendance Records were reviewed with the Activities Assistant (AA). The AA stated the other independent activity on the attendance records indicated Resident 42 was either asleep or getting changed/cleaned up when the room visit was attempted. The AA stated Resident 42 had difficulty seeing and did not like to go to the activities room. The AA stated Resident 42 liked to have activities in her room. The AA stated Resident 42 liked to listen to music or have a hand massage. The AA stated she was not aware Resident 42 asked for a radio, and indicated she was not aware Resident 42 did not have a TV. The AA stated when doing room visits, she spends about 10 minutes with each resident. The AA stated if Resident 42 was sleeping or getting changed when she first attempted the visit, she did nott come back to the room at a later time because she had to see the other residents and had other activities scheduled for the day in the activity room. The AA stated activities would try to see the residents that required 1:1 activity every day but indicated there may be sometimes when it would not happen. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/4/2024 at 1:16 PM, Resident 42's Activity Participation Review, Care Plan, and Activity Attendance Records were reviewed with the Director of Nursing (DON). The DON stated Resident 42 had visual impairment and liked to be in their room. The DON stated Resident 42 needed sensory activities because of their visual impairment. The DON stated if the resident would like a radio, one should be provided to them. The DON verified the last Activity Participation Review for Resident 42 was conducted on 12/26/2023, and stated it was due to be completed. The DON stated the Activity Participation Review should be done on admission, quarterly, annually, and with a change of condition. The DON further verified Resident 42 did not have an activity care plan. The DON stated the Activity Participation Review was conducted to determine activity preferences. The DON stated the care plan was used to guide care and provide the resident with what they would want for activities. The DON stated if a resident was not evaluated for their activity preferences and do not have a care plan for activity, the resident may not receive the activities they want. The DON stated this could lead to a decline to the resident's quality of life. A review of the facility's undated policy and procedure titled, Activity Evaluation, indicated in order to promote the physical, mental, and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. An activity evaluation is conducted as part of the comprehensive assessment to help develop an activity plan that reflects the choices and interests of the resident. The resident's activity evaluation is conducted by activity department personnel, in conjunction with other staff who evaluate related factors such as functional level, cognition, and medical conditions that may affect activities participation. The activity evaluation is used to develop individual activities care plan (separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest. Each resident's activities care plan related to his/her comprehensive assessment and reflects his/her individual needs. The completed activity evaluation is part of the resident's medical record and is updated as necessary, but at least quarterly.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43851 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 98) received pressure ulcer (localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) care as indicated in their policy and procedure as evidenced by: -Failing to ensure Resident 98's wound vac (negative pressure wound therapy, a therapeutic technique using a suction pump, tubing, and a dressing to remove excess drainage and promote wound healing) was on and functioning. -Failing to revise Resident 98's Stage 4 pressure ulcer (pressure injuries that extend to muscle, tendon, or bone) care plan. These deficient practices had the potential to cause the development and worsening of Resident 98's pressure ulcer that could lead to severe illness, hospitalization , and death. Findings: A review of Resident 98's Admission Record indicated the facility admitted the resident on 3/14/2024 with diagnoses that included metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), osteomyelitis (infection in the bone), muscle weakness, sepsis (a severe body response to infection, which causes the immune system to attack tissues and leads to inflammation and potential organ damage), adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), stage 4 pressure ulcer of the sacral (tailbone) region, and stage 3 pressure ulcer (pressure ulcers that affect the top two layers of skin, as well as fatty tissue) of the right buttock. A review of Resident 98's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/18/2024, indicated the resident had severely impaired cognition (never/rarely made decisions) and required supervision or touching assistance for eating. The MDS indicated Resident 98 required substantial/maximal assistance for oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 98 was dependent on help for toileting hygiene, showering/bathing self, and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 98 was at risk for developing pressure ulcers and had one Stage 3 pressure ulcer and one Stage 4 pressure ulcer present on admission to the facility. The MDS indicated Resident 98 was receiving pressure ulcer care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 98's care plan revised on 3/19/2024, indicated the resident had a Stage 4 pressure injury of the sacrococcyx (tailbone) area. The care plan indicated goals for Resident 98 to show no signs or development of infection, show no signs or development of new pressure injury, and to have no complications related to pressure injury through the review date. The care plan indicated interventions that included administering treatment as ordered by the physician and a treatment order to cleanse the pressure ulcer with Dakin's solution (a solution used to cleanse wounds and prevent infection), pat dry, apply collagen (wound dressings can stimulate the growth of new tissue), cover with a dry clean dressing daily, and a low air loss mattress (a mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) on the bed for skin integrity management. The care plan did not indicate it was revised to include Resident 98's wound vac treatment that was initiated on 3/28/2024. A review of Resident 98's Physician's Order dated 3/28/2024, indicated to cleanse the resident's Stage 4 pressure ulcer with normal saline, pat dry, apply negative pressure wound therapy (wound vac) with settings running at 125 mm hg continuously. The Physician's Order indicated to change the wound vac dressing every Tuesday, Thursday, and Saturday. A review of Resident 98's Wound Consultation Notes dated 3/28/2024, indicated the resident's Stage 3 right buttock pressure ulcer closed on 3/28/2024. During an observation on 4/1/2024 at 8:55 AM, Resident 98 was observed lying in bed. During a concurrent interview, Resident 98 stated she had wounds but was not able to specify where. Resident 98 was observed with a wound vac placed in bed on the resident's left side. The wound vac was observed off and unplugged. During a concurrent observation and interview on 4/1/2024 at 8:59 AM, the Infection Preventionist (IP) verified Resident 98's wound vac was off and unplugged. The IP stated Resident 98's wound vac should be on continuously and they were not sure for how long Resident 98's wound vac was off. The IP stated it should be on continuously to drain the resident's wound and it was possible for Resident 98's wound to get bigger if the wound vac was not on. During a concurrent interview and record review, on 4/4/2024 at 10:19 AM, Resident 98's Stage 4 sacrococcyx pressure ulcer care plan was reviewed with the IP. The IP stated Resident 98's care plan was not revised to reflect Resident 98's current wound treatment with the wound vac. The IP indicated the care plan should be revised. The IP stated the purpose of the care plan was to develop Resident 98's plan of care and for staff to know the resident's needs. The IP stated if the care plan was not updated and revised there could be a potential for Resident 98 to not receive the care they need. During a concurrent interview and record review on 4/4/2024 at 1:12 PM, the Director of Nursing (DON) verified Resident 98 had Physician's Orders for a wound vac continuously to the resident's Stage 4 sacrococcyx pressure ulcer. The DON reviewed Resident 98's care plan for the Stage 4 pressure ulcer and indicated the care plan was not revised to reflect the resident's current treatment plan. The DON stated the care plan should have been updated to reflect Resident 98's current treatment. The DON indicated having a care plan that is not updated and a wound vac that is not on continuously could contribute to infection and worsening of Resident 98's pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the wound vac reference and troubleshooting guide titled, KMS Negative Pressure Wound Therapy System, dated 2023, indicated the KMS Negative Pressure Wound Therapy (NPWT) pump helps to promote wound healing with the power of gentle suction. The suction aids in removing excess exudates, tissue debris, and infectious material. Power the NPWT system by pressing the power button on the keypad. Turn on the NPWT system. Make sure that the pressure is set at proper mmHg or per doctor's order. Therapy is 24 hours a day/7 days a week until the wound is sufficiently healed. A review of the facility's policy and procedure titled, Care Plan - Comprehensive Person-Centered, dated 10/2023, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed as least quarterly.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview and record review, the facility failed to ensure one of three sampled resident's (Resident 84) urinary indwelling urinary catheter (Foley catheter [brand name] a flexible tube (a catheter) inserted into the bladder that remains (dwells) there to provide continuous urinary drainage) was securely anchored (secured to the resident). This deficient practice had the potential for the resident to endure pain from potential pulling tractions and dislodgement of the catheter that may result in urethral (a muscular structure that helps keep urine in the bladder until voiding can occur) trauma. Findings: According to the admission record, the facility admitted Resident 84 on 2/11/2024, and readmitted on [DATE], with diagnoses that included urinary tract infection, diabetes and chronic kidney disease. The Minimum Data Set (MDS, assessment and care-screening tool), dated 3/4/2024, indicated the resident had severe cognitive (ability to acquire and understand knowledge) impairment. The MDS also indicated the resident had an indwelling urinary catheter and was not part of a toileting program and required total assistance with toileting hygiene, dressing and personal hygiene. A review of the Physician's Orders, dated 2/12/2024, indicated Resident 1 was to receive the following care: - Foley Catheter to drainage bag. Monitor placement every shift - Change Foley catheter with 16 French (Fr)/10 cubic centimeter (cc) and drainage bag as needed for dislodgement, malfunctioning or blockage/soiled or leaking - Monitor placement of privacy bag to foley catheter drainage bag and catheter stabilizer every shift - Monitor for drainage, redness, bleeding, irritation, crusting or pain at the catheter urethral junction during catheter care. A review of Resident 84's Needs Foley Catheter care plan, initiated 3/1/2024, indicated Resident 84 had a urinary catheter to prevent irritation and contamination of pressure sore. The care plan indicated the goal was for the resident's bladder to adequately empty without complication as evidenced by no bladder distention, pain/discomfort and no signs and symptoms of bladder infection. The interventions included to maintain unobstructed urine flow by maintaining patency tubing and drainage by gravity, and to used bed sheet foley clamp to secure foley catheter tubing. During an observation on 4/2/2024 at 10:40 AM, Resident 84's wound care and catheter was observed. Resident 84's catheter was not anchored to prevent the potential catheter or excessive tension to the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2024 at 9:28 AM with Infection Preventionist (IP), inside Resident 84's room, Resident 84's urinary catheter was observed. The IP stated Resident 84's catheter was not anchored to the resident's leg or to the bed and the catheter should have an anchor in place to prevent dislodgement. During an interview on 4/4/2024 at 11:11 AM, the Director of Nursing (DON) stated staff were to secure resident's catheter with either a statlock (a stabilization device) or a bedside Foley clamp. The DON stated the catheter tubing was secured so that the foley catheter would not be dislodged. A review of the facility's policy and procedure titled, Foley Catheter Care, revised 4/2023, indicated the catheter remains secured to reduce friction and movement at the insertion site.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview and record review, the facility failed to provide respiratory care and services according to professional standards of practice for one of three sampled residents (Resident 39). The facility implemented the following deficient practices: - the facility administered oxygen via a non-rebreather mask without a physician order and without administering 10 -15 LPM oxygen as required for correct functioning of mask. - failed to monitor oxygen saturation level in accordance with the physician's order - develop/revise a plan of care for Resident 39 who was using oxygen and had had shortness of breath Findings: A review of Resident 39's admission record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included myocardial infarction (heart attack), type 2 diabetes (high blood sugar) and high blood pressure. A review of the History and Physical, dated 8/4/2023, indicated the resident's lung sounds were diminished bilaterally. A review of the shortness of breath (SOB) care plan, developed 12/2/2023, indicated the goal was for the resident to not have complications related to SOB and the resident's Pulse Oximetry would remain above (SPECIFY). The care plan indicated the pulse oximetry level was not specified. The interventions included to position resident with proper body alignment for optimal breathing pattern, monitor/document breathing patterns, report abnormalities such as nasal flaring, respiratory depth changes, altered chest excursion, use of accessory muscles, pursed-lip breathing or prolonged expiratory phase, Increased anteposterior chest diameter to the physician. A review of the care plan also indicated the resident's oxygen use was not part of the plan of care. A review of Resident 39's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 2/6/2024, indicated Resident 39's cognition was severely impaired (never/rarely made decisions) and was totally dependent on staff in, bed mobility, and dressing and toileting hygiene and personal hygiene. A review of Resident 39's Physician's Order dated 4/19/2023, indicated to administer oxygen two to four liters per minute (lpm) via nasal cannula to five to ten lpm via oxygen mask to reach oxygen saturations equal or more than 92% as needed for shortness of breath and to record oxygen saturations before oxygen administration. A review of Resident 39's March and April 2024 Medication Administration Records (MAR) indicated there were no oxygen saturation levels documented for the entire month of March. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 39's April 2024 Medication Administration Record (MAR) for 4/1/2024 indicated the resident's oxygen saturation was not documented. During an observation on 4/1/2024 at 9:03 AM, at Resident 39's bedside, Resident 39 was wearing a non-rebreather mask and the reservoir was not fully inflated. Resident 39 was non-interviewable. During an observation and concurrent interview on 4/1/2024 at 12:45 PM, in Resident 39's room, Licensed Vocational Nurse 1, (LVN 1) stated that Resident 39 was receiving oxygen at 8 lpm through a non-rebreather mask. LVN 1 stated there should be Physician's Order to use a non-rebreather mask. LVN 1 stated Resident 39 was admitted wearing the non-rebreather. During a concurrent record review of the Nursing Progress notes and MAR, LVN 1 stated there was no documentation indicating oxygen was being administered to Resident 39. LVN 1 also stated there were no oxygen saturation levels documented per the physician's order. During an interview on 4/3/2024 10:57 AM Licensed Vocational Nurse 3 (LVN 3) stated Resident 39 had a shortness of breath care plan initiated on 12/2/2023, but the resident's oxygen use was not care planned on the shortness of breath care plan or on any other care plan. LVN 3 stated Resident 39's oxygen use should be care planned in order to ensure the resident's needs were met and that the facility was able to address any needs that may arise. During an interview on 4/4/2024 at 11:12 AM, the Director of Nursing (DON) stated she did not know if a non-rebreather mask required a physician's order. The DON stated to properly use a nonrebreather mask the lpm should be set above 9 and that Resident 39's oxygen use should have been care planned. The DON stated oxygen was care planned in order to ensure the correct interventions were implemented and a possible outcome was one might miss something in the resident's care. According to the Open RN Nursing Skills Handbook, 2021, a non-rebreather mask consisted of a mask attached to a reservoir bag that was attached with tubing to a flow meter. The reservoir bag should never totally deflate; if the bag deflates, there was a problem and immediate intervention was required. The the Open RN Nursing Skills Handbook indicated the flow rate for a non-rebreather mask should be set to deliver a minimum of 10 to 15 lpm and the reservoir bag should be inflated prior to placing the mask on the patient. A review of the facility's policies and procedures titled, Care Plan - Comprehensive Person-Centered, dated 10/2023, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. It also indicated Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly. A review of the facility's policy and procedure titled, Oxygen Administration, dated 4/2023, indicated the purpose of this procedure was to provide guidelines for safe oxygen administration. It also indicated to: - Turn on the oxygen. Start the flow of oxygen as per physician's order. - Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter) and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview and record review, the facility failed to ensure one of 18 sampled residents (Resident 32) who was dependent upon hemodialysis (a medical procedure to remove fluid and waste products from the body) had an emergency kit at resident's bedside. This deficient practice had the potential for resident to receive delay intervention during accidental bleeding. Findings: A review of the admission record, indicated the facility admitted Resident 32 on and readmitted on [DATE] and readmitted the resident on 3/25/2024 with diagnoses that included end stage renal disease (ESRD, when kidneys are no longer able to work as they should to meet the needs of the body) requiring hemodialysis, type 2 diabetes mellitus (adult onset diabetes - a chronic condition that affects the way the body processes blood sugar), legal blindness, right foot amputation. A review of the Physician's Orders, dated 3/25/2024, indicated Resident 32 required hemodialysis every Monday, Wednesday and Friday at 11:30 AM. A review of the Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 3/6/2024, indicated Resident 32's cognition was intact and required partial/moderate assistance with toileting hygiene, lower body dressing and putting on/taking off footwear. It also indicated the resident received hemodialysis. A review of Need for Dialysis care plan, initiated 11/30/2023, indicated the Resident 32 was at risk for bleeding due to heparin (used to prevent blood from clotting in the heart or blood vessels) administration during dialysis and the goal was for the resident to have no complications related to hemodialysis. The care plan interventions included to assess the resident for signs and symptoms of bleeding and to communicate with dialysis center for progress or any problems and for nutritional concerns. During an observation on 4/1/2024 at 8:47 AM, at Resident 32's bedside, Resident 32's bed area was observed. No dialysis emergency kit was observed. After gaining permission from Resident 32, checked inside the resident' bedside drawer and no emergency kit was seen. During an interview on 4/3/2024 at 8:40 AM, Resident 32 stated she was ready to go to dialysis today. Resident 32 also stated she did not have an emergency kit at the bedside. Resident 32 further stated she did not know what a dialysis emergency kit was. During a concurrent observation and interview on 4/3/20 24 at 9:20 AM, the Infection Preventionist stated she was not able to find a dialysis kit at Resident 32's bedside. The IP stated the resident should have one at bedside in case of bleeding. During an interview on 4/4/2024 at 11:20 AM , the Director of Nursing (DON) stated dialysis residents were to have an emergency kit at beside to stop bleeding and for emergencies. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled, End-Stage Renal Disease, Care of a Resident with, undated, indicated Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. It also indicated education of staff includes, specifically how to recognize and intervene in medical emergencies such as hemorrhages and septic infections and how to recognize and manage equipment failure or complications (according to the type of equipment used in the facility).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43851 Based on observation, interview, and record review the facility failed to post staffing information per the facility policy and procedure titled, 'Posting Direct Care Daily Staffing Numbers. This deficient practice had the potential for residents, staff, and visitors of the facility to not have knowledge of the facility's staffing information. Findings: During an observation on 4/23/2024 at 4:15 PM, the facility's staff posting was observed displayed at the nursing station. The staff posting did not indicate the facility's name. During a concurrent interview and record review on 4/4/2024 at 10:51 AM, the facility's staff posting was reviewed with the Director of Staff Development (DSD). The DSD stated the staff posting did not include the facility's name and that it was important for the facility's name to be included in the staff posting so residents, visitors, and staff know the information is for the facility. During a concurrent interview and record review on 4/4/2023 at 1:14 PM, the facility's staff posting was reviewed with the Director of Nursing (DON). The DON verified the staff posting did not include the facility's name and stated the facility would edit the posting. The DON stated there was a potential for residents, visitors, and staff to not have knowledge of the facility's staffing information if the staff posting did not include the facility's name. A review of the facility's undated policy and procedure titled, Posting Direct Care Daily Staffing Numbers, indicated shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: The name of the facility; the current date (the date for which the information is posted); the resident census at the beginning of the shift for which the information is posted; twenty-four (24)-hour shift schedule operated by the facility; the shift for which the information is posted; type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); the actual time worked during that shift for each category and type of nursing staff; and total number of licensed and non-licensed nursing staff working for the posted shift.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to meet the nutritional needs for two out of six sampled residents (Resident 14 and Resident 29) by failing to provide double portion meals as ordered by the physician. These deficient practices had the potential to result in decreased nutritional intake and weight loss. Findings: a. A review of Resident 14's Admission Record indicated that the facility admitted the resident on 8/16/2019, and readmitted him on 3/26/2024, with diagnoses including polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), dysphasia (swallowing difficulties), fibromyalgia (chronic, widespread pain throughout the body or at multiple sites), and urinary tract infection (an infection in any part of the urinary system). A review of Resident 14's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 3/21/2024, indicated the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning), and required moderate assistance with bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of Resident 14's Physician's Order, dated 3/26/2024, indicated the resident had to have a controlled carbohydrate diet (CCHO- eating the same amount of carbohydrates every day) with pureed texture (a smooth texture with no lumps), regular consistency, and a double entree. A review of Resident 14's Care Plan initiated on 1/24/2024, indicated the resident had unplanned weight loss. During a concurrent interview and record review on 4/2/2024 at 2:46 PM, the Registered Dietitian (RD - a medical professional who works with patients and families to create specific diets and teach about nutrition) stated Resident 14 was underweight and was trying to gain weight. The RD stated Resident 14's weight was stable at 140 pounds (lb - unit of weight measurement) at this time, but he did have a history of unexpected weight loss to 134 lb, and it was important that Resident 14 received a double entree to maintain his weight. The RD reviewed Resident 14's nutritional assessment, dated 1/3/2024, and stated Resident 14's diet intervention was to change his diet to CCHO and a double entree. According to the facility's lunch menu on 4/3/2024, the following items were served for CCHO diet: four ounces (oz) roast turkey with sauce, half a cup of herb roasted potatoes, half a cup of rosemary cauliflower and peas, half a cup of fresh green salad with dressing, and four oz of milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2024 at 12:25 PM, with the Dietary Supervisor (DS) during dining observation, the DS stated Resident 14's lunch tray contained puree, CCHO (controlled carbohydrate - diet to control high blood sugar), regular/thin liquid diet: four ounces of roast turkey with sauce, half a cup of herb roasted potatoes, half a cup of rosemary cauliflower and peas, half a cup of fresh green salad , eight oz of milk and one package of pepper. The DS confirmed that Resident 14's meal ticket indicated double entree, and two packages of eight oz nonfat milk. The DS stated that this was not a double entree, and one nonfat milk was served. The DS stated that he would change the entree right away to meet the nutritional needs and preferences of the resident. b. A review of Resident 29's Admission Record indicated the facility admitted the resident on 3/18/2021 with diagnoses including glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), need for assistance with personal care and depression (a mood disorder that causes feeling of sadness and loss of interest). A review of Resident 29's MDS dated [DATE], indicated the resident had intact cognition (decisions consistent/reasonable) and required staff supervision for toileting hygiene, showering/bathing, and upper and lower body dressing. The MDS further indicated the resident required set up or clean up assistant for eating, and personal hygiene. The MDS further indicated Resident 29 had severely impaired vision. A review of Resident 29's History and Physical dated 3/26/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 29's Physician's Orders dated 8/13/2023, indicated the resident's diet was No Added Salt (NAS), CCHO, regular texture regular consistency (Normal, everyday foods), and double position at breakfast, lunch, and dinner. A review of Resident 29's Nutritional assessment dated [DATE], indicated the resident did not have significant weight change in the last 30 days, his weight was stable, and the goal was weight maintenance. The Assessment further indicated Resident 29's diet was NAS, CCHO, double portions. A review of Resident 29's Altered Nutritional Need Care Plan initiated on 2/7/2024, indicated the resident had NAS, CCHO diet with regular texture and consistency. The care plan did not indicate double positions for breakfast, lunch, and dinner. The care plan goal for the resident was to have improved labs at next reading. The care plan interventions were to provide diet as ordered by the physician, monitor weight and report significant changes to the physician and to provide snacks, mineral (a nutrient that is needed in small amounts to keep the body healthy) and vitamins as ordered. During an observation on 4/2/2024 at 12:45 PM, inside Resident 29's room, Resident 29 was sitting on his bed and eating his lunch. Resident 29 held a slice of quesadilla in his hand and two more slices on his plate. The meal ticket on Resident 29's tray indicated regular CCHO, no added salt with regular thin liquid diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/2/2024 at 12:50 AM, inside Resident 29's room with the RD, Resident 29's lunch tray and meal ticket were observed. The RD stated Resident 29 did not receive double portion for lunch. The RD stated, For some reason some of the double portion orders which are placed by the physicians in the comment section of the orders, are not showing in residents' meal tickets. I manually fixed this issue for some residents. However, for Resident 29, it was missed. The RD stated the potential outcome of not providing double portion meals to a resident was not following the physician's order and possible weight loss. During an interview on 4/4/2024 at 1:30 PM, the Director of Nursing (DON) stated the facility was required to serve meals based on the residents' physician's orders. The DON stated the potential outcome of not serving double portion meal to residents was inability to meet residents' nutritional needs which could lead to weight loss. A review of the facility's policy and procedure (P&P) titled, Food Preferences, dated 6/2023, indicated resident's food preferences will be adhered to within reason. Food preferences will be obtained as soon as possible through the initial resident screen. Updating of food preferences will be done as resident's needs changes and /or during the quarterly review. A review of the facility's policy and procedure titled, Food and Nutrition Services, dated 6/4/2023, indicated the purpose of this policy is to provide diets as ordered by the physician. Large or small portion modifications are made for residents who desire a change or as a part of their care plan interventions.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 43851 Based on observation, interview, and record review, the facility failed to evaluate the food preferences for one of six sampled residents (Resident 1), as evidenced by failing to perform a Nutrition Evaluation for the resident quarterly. This deficient practice had the potential for Resident 1 to feel their needs were not being met and experience emotional distress. Findings: A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 11/13/2003 and readmitted the resident on 5/30/2019 with diagnoses that included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), hypertension (high blood pressure), depressive episodes (a person experiences a depressed mood (feeling sad, irritable, empty), type 2 diabetes (a long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), and hyperlipidemia (high cholesterol levels in the blood). A review of Resident 1's History and Physical dated 7/27/2022, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Physician's Order dated 8/13/2023 indicated the resident was on a no salt added, controlled carbohydrate (eating the same amount of carbohydrates in a day), regular texture and regular consistency diet. A review of Resident 1's Nutrition Evaluation dated 11/8/2023, indicated the resident liked mostly everything to eat, and disliked gravy. There were no Nutrition Evaluations for review after 11/8/2023. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 2/6/2024, indicated the resident was cognitively intact (had the ability to think, understand, and reason) and independent when eating, with oral hygiene, toileting, showering/bathing self, upper body/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS further indicated Resident 1 felt it was very important to have snacks available between meals. A review of Resident 1's Resident Care Conference Review dated 2/7/2024 at 11:29 AM, indicated resident's food preferences were reviewed, but did not specify which foods the resident preferred. The Resident Care Conference Review indicated Resident 1 would continue with the current diet prescribed by the physician. During a concurrent observation and interview, on 4/1/2024 at 8:42 AM, Resident 1 was observed sitting in a wheelchair at bedside. Resident 1 was observed with a breakfast tray on their bedside table. Resident 1's breakfast tray was observed untouched. Resident 1 stated she did not want breakfast because she did not like the food. Resident 1 stated staff never asked her about her food preferences, and stated she doesn't really get any food that is appetizing to her. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/2024 at 1:12 PM, the Dietary Supervisor (DS) stated residents were asked about their preferences on admission, during care conferences, and during nutrition evaluations. The DS stated they were responsible for doing nutrition evaluations. The DS reviewed Resident 1's Nutrition Evaluations and verified the last one done was on 11/8/2023. The DS stated Nutrition Evaluations were done on admission and quarterly. The DS stated Resident 1 was due to have a Nutritional Evaluation done in 3/2024 and it was past due. The DS stated he would complete a Nutrition Evaluation for Resident 1. The DS stated the Nutritional Evaluations were important to do, so the kitchen would know what the residents like and did not like to eat. During a concurrent interview and record review, on 4/4/2024 at 1:10 PM, the Director of Nursing (DON) verified Resident 1's last Nutrition Evaluation was dated 11/8/2023. The DON stated Nutrition Evaluations should be done quarterly, annually, and as needed. The DON stated there was a potential for the resident to not have their needs met and not be happy because they were not receiving the food they like if their nutritional preferences were evaluated. A review of the facility's policy and procedure titled, Food Preferences dated 6/2023, indicated food preferences will be obtained as soon as possible through the initial resident screen. Assessment must be completed within 7 days of admission by the FNS Director. Food preferences can be obtained from the resident, family, or staff members. Updating of food preferences will be done as resident's needs change and/or during the quarterly review.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety by not labeling: A.Sliced ham with the use by date. B. Ground chicken with the use by date. C. Chicken meat with the use by date D. Sliced Bacon with the use by date. E. Creamy Italian Dressing with the use by date. F. Sausage with the use by date The facility failed to discard ground beef that was still being stored in the refrigerator after its use by date of [DATE] and failed to maintain the refrigerator and freezer temperature log on [DATE] and [DATE]. These deficient practices had the potential to cause food-borne illnesses. Findings: During a concurrent observation and interview on [DATE] at 7:52 A.M., the following was in the refrigerator: - Sliced ham in a transparent plastic container with a blue lid with an open date of [DATE] and no use by date label. - Ground chicken inside a white plastic bag with an open date of [DATE] and no use by date label. - Chicken meat inside a transparent plastic bag with an open date of [DATE] and no use by date label. - Sliced bacon inside a transparent plastic container with a blue lid with an open date of [DATE] and no use by date label. - Creamy Italian Dressing in white container with an open date of [DATE] and no use by date label. - Sausage inside a transparent plastic bag inside a box with an open date of [DATE] and no use by date label. - Ground beef inside a transparent plastic bag with an open date of [DATE] and a use by date of [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555019	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple Park Convalescent Hospital	2411 W. Temple Street Los Angeles, CA 90026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Supervisor Assistant 1 (DSA 1) stated the ground beef should have been discarded immediately after the expiration date on [DATE], and that all of the food items in the refrigerator should be labeled with an open date and a use by date. DSA 1 reviewed the temperature logs for refrigerators 1 and 2, as well as freezer 1 and 2, and stated that the temperature log was not maintained on [DATE] and [DATE]. During an interview on [DATE] at 12:06 PM, the Dietary Supervisor (DS) stated the staff should place an open date label and a use by date label on all food products transferred to other containers to know when to discard them. The DS stated the temperature should be monitored three times during the day and recorded in the temperature logs to ensure a safe temperature regiment. The DS stated not monitoring the temperature in refrigerators and freezers may cause food borne illnesses in the residents. The DS stated that according to facility policy, the ground beef should have been discarded on [DATE]. During an interview on [DATE] at 1:30 PM, the Director of Nursing (DON) stated the staff should be checking the food items for expiration dates, open dates, and best by dates so as to not harm the patients with expired food products. The DON stated the kitchen staff should have removed items that were not properly dated and labeled. A review of the facility's undated policy, Labeling and Dating of Food, indicated newly opened food items will need to be closed and labeled with open date and use by date that follows guidelines on pages 6.6, 6.7, 6.8, 6.13, 6.15, and 6.17. Correct temperatures for storing and handling of food are used. Thermometers will be used to check temperatures of refrigerators, freezers, and food [NAME].

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the licensed nursing staff failed to maintain accurate medical records in accordance with accepted professional standards for one sampled resident (Resident 16). The facility failed to ensure the licensed nursing staff maintained accurate information regarding the Physician's Order for Life-Sustained Treatment (POLST) for Resident 16. This deficient practice had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment. Findings: A review of Resident 16's Admission Record indicated the facility admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (brain disease, damage, or malfunction of brain), acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the air sacs of the lungs cannot release enough oxygen into the blood), dysphasia (a swallowing difficulties), encounter for attention for gastrostomy (a surgical procedure to insert a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube), and sepsis (the body's extreme response to an infection). A review of Resident 16's History and Physical, dated [DATE], indicated the resident did not have capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS- standardized assessment and care planning tool), dated [DATE], indicated the resident was severely cognitively impaired (never/rarely made decisions) and was totally dependent on two or more helpers with bed mobility, transfer, dressing, eating, toilet use and personal hygiene. A review of Resident 16's Physician's Order, dated [DATE], indicated the code status was Do not Resuscitate with limited interventions. A review of Resident 16's Care Conference Review, dated [DATE], indicated the interdisciplinary team (IDT) conducted a readmission care plan meeting with Resident 16's FM 4 via phone call. The Resident Care Conference Review indicated the POLST was explained to FM 4 and FM 4 wanted to keep the same full code (Attempt Resuscitation) despite the explaining that the Resident 16 was at risk for decline. A review of Resident 16's Latest POLST, dated both [DATE] and [DATE] indicated both choices were marked: Attempt Resuscitation and Do not Resuscitate. During an observation on [DATE] at 9:34 AM, the surveyor noted that Assistant Director of Nursing (ADON) ran to the Resident 16's room, called a code blue and started Cardiovascular Resuscitation (CPR) on the Resident 16. Further the Director of Staff Development (DSD) and the Infection Prevention (IP) with crash cart ran to Resident 16's room and continued CPR. The paramedics arrived at 9:50 AM. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 1:58 PM, the Minimum Data Set Coordinator (MDSC) reviewed Resident 16's POLST and stated that the document was not clear because two options were marked on it, one to Attempt Resuscitation and another to Do Not Resuscitate, and it had two dates, [DATE] and [DATE]. The MDSC stated when changes needed to be made to the POST, the staff had to fill out a new document with a new selection and date to be accurate and clear. During a concurrent interview and record review on [DATE] at 1:05 PM, the Licensed Vocational Nurse 2 (LVN 2) reviewed Resident 16's POLST and stated the document was confusing and did not provide accurate information on what to do if CPR was needed for Resident 16. LVN 2 stated that if it was unclear whether or not to perform CPR, he would perform CPR according, per facility policy. During an interview on [DATE] at 2:10 PM, the Director of Staff Development (DSD) stated that she reviewed Resident 16's POLTS on [DATE] before she ran to the Resident 16's room and noticed an indication on his POLST that indicated Attempt Resuscitation. The DSD stated that she had not noticed that both of the POLST options had been checked. During a concurrent interview and record review on [DATE] at 1:30 PM, the Director of Nursing (DON) reviewed Resident 16's POLST and stated that according to POLST we have to do CPR because Attempt Resuscitation /CPR was marked. She stated that she had not noticed that both the Attempt Resuscitation/CPR and to Do not Attempt Resuscitation /CPR options were checked on this form. A review of the facility's undated policy and procedure titled, Advanced Directives, indicated the plan of care for each resident will be consistent with his or her documented treatment preferences and /or advance directive.