STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555045	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Healthcare Center	10158 Sunland Blvd Sunland, CA 91040

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview and record review, the facility failed to provide dignity and respect for two out of two sampled residents (Resident 18 and 49) when: 1. Restorative Nursing Assistant 1 (RNA 1, a staff who is trained in activities to help residents with limited mobility and abilities) was observed standing over Resident 49 while assisting Resident 49 with eating. 2. Certified Nursing Assistant 3 (CNA 3, a staff who is trained in providing basic, hands-on patient care) was observed standing over Resident 18 while assisting Resident 18 with eating. These failures had the potential to negatively affect Resident 49's and Resident 18's self-esteem and self-worth during mealtimes in the facility. Findings: 1. During a review of Resident 49's Admission record indicated the facility admitted the resident on 2/28/2024, including a readmission on 4/15/2024, with diagnoses that included dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 49's Minimum Data (MDS - a federally mandated resident assessment tool), dated 10/06/2024, the document indicated, Resident 49 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 49 required supervision (helper provides verbal cues, and/or touching assistance as resident completes activity; assistance may be provided throughout the activity or intermittently [irregular intervals, not continuously]). During a review of Resident 49's Care Plan for Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), initiated 2/28/2024, the document indicated a goal for the resident that included, the resident will be well groomed and dressed appropriately daily. The care plan further indicated, Resident 49 required limited assistance with eating, and included an intervention to encourage participation with activities. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/22/2024 at 7:31 a.m., observed Resident 49 sitting in a wheelchair with a breakfast tray on a bedside table with Restorative Nursing Assistant 1 (RNA 1) standing over the resident while feeding her. There was no chair located in the hallway, and there were approximately six other residents also in the hallway eating breakfast. RNA 1 stated, she knew she should have been sitting while assisting Resident 49 with eating but was unable to because a chair in the hallway would block the hallway. RNA 1 further stated, she needed to watch the other residents in the hallway while they were eating. During an interview on 10/22/2024 at 7:39 a.m. with RNA 1, RNA 1 stated she could have used help, but the residents' trays came, and she was unable to leave to go to Nurse Station One to seek assistance. During an interview on 10/22/2024 at 7:45 a.m. with Treatment Nurse 1 (TN 1), TN 1 stated staff should be seated while assisting a resident with eating. During a review of the facility's policies and procedures (P&P) titled, Assistance with Meals, reviewed on 10/16/2024, the P&P 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. 2. During a review of Resident 18's Admission Record indicated the facility admitted Resident 18 on 5/12/2019, including a readmission on 06/24/2023, with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), urinary tract infection (UTI - an infection in the bladder/urinary tract), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 18's History and Physical (H&P), dated 8/26/2024, the H&P indicated, Resident 18 did not have the mental capacity to understand and make decisions. During a review of Resident 18's MDS dated [DATE], the MDS indicated, Resident 18 had moderately impaired cognition (decreased mental abilities, including remembering things, making decisions, concentrating, or learning) and required moderate to maximal assistance with toileting and personal hygiene, dressing, and showering. The MDS further indicated, Resident 18 required supervision or touching assistance with eating. During a review of Resident 18's Care Plan for Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), initiated 6/24/2024, the document indicated a goal that Resident 18 will be well groomed and dressed appropriately daily. The care plan further indicated Resident 18 required limited assistance with meals as needed. During a concurrent observation and interview on 10/22/2024 at 12:55 p.m. with Certified Nursing Assistant 3 (CNA 3) in Resident 18's room, Resident 18 was observed to be seated in High Fowler's position (a patient positioning where resident is seated up-right on their back with their upper body at 60 -90-degree angle to their lower body) in the bed. CNA 3 was observed to be standing while feeding lunch to Resident 18, and Resident 18 was observed to be extending her neck to look up at CNA 3 during the feeding. CNA 3 stated, she should be seated during the feeding of residents, but she did not seat herself because she was trying to feed Resident 18 fast. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/2024 at 12:56 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, CNAs should feed the residents while in a sitting position. During an interview on 10/22/2024 at 2:11 p.m. with the Director of Nurses (DON), the DON stated, staff should be seated at eye level when assisting residents with eating. The DON further stated, this was important to ensure residents were chewing well, not experiencing aspiration (inhaling food into the lungs), and to ensure residents did not feel rushed while eating. During a review of the facility's policies and procedures (P&P) titled, Assistance with Meals, reviewed on 10/16/2024, the P&P 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. 47883

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure the resident call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within accessible reach of the resident from for two of two sampled residents (Resident 23 and Resident 59) in the facility. This failure had the potential for residents in the facility to be unable to summon facility staff for help, as needed, which could have resulted in resident discomfort and/or harm due to the residents' inability to reliably call facility staff for help. Findings: 1. During a review of Resident 23's Admission Record, the document indicated the facility admitted Resident 23 on 5/24/2022, including a readmission on 7/28/2024, with diagnoses that included spinal stenosis (a narrowing of one or more spaces within your spinal canal), displaced fracture of left femur (fracture requiring realignment [putting back into its normal position] of the bone), and aphasia (a condition that makes it hard for a person to speak, understand, read, or write language). During a review of Resident 23's History and Physical (H&P), dated 9/2/2024, the H&P indicated, Resident 23 did not have the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/22/2023, the document indicated, Resident 23's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (including decreased ability to remember things, make decisions, concentrate, or learn). The MDS further indicated, Resident 23 required moderate assistance on bed mobility, dressing, toilet hygiene, shower and dressing and supervision on personal and oral hygiene. During a concurrent observation and interview on 10/21/2023 at 9:28 AM with Restorative Nursing Assistant 2 (RNA 2) in Resident 23's room, the call light button of Resident 23 was observed looped over the upper side of the wall light. RNA 2 stated, the call light for Resident 23 should not have been placed over the wall light, and it should have been clipped to the pillow instead, to facilitate ease in the use of the call light for Resident 23. RNA 2 further stated, the call light being out of reach for Resident 23 had the potential for the resident to be unable to ask for help when needed and Resident 23 could fall. 2. During a review of Resident 59's Admission Record, the document indicated the facility admitted Resident 59 to the facility on [DATE], including a readmission of the resident on 10/13/2023, with diagnoses that included senile degeneration of the brain (a process of gradual decline of brain cells that is associated with memory loss and difficulty thinking clearly), aphasia (a condition that makes it hard for a person to speak, understand, read or write language), and personal history of transient ischemic attack (a stroke that last only a few minutes). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/7/2024, the document indicated, the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (including decreased ability to remember things, make decisions, concentrate, or learn), and Resident 59 was dependent on assistance of two or more helpers for eating, personal and toileting hygiene, and showering and dressing. During a concurrent observation and interview on 10/21/2023 at 9:40 AM with Restorative Nurse Assistant 2 (RNA 2) in Resident 59's room, the adaptive call light button of Resident 59 was noticed to be located behind the resident's head of the bed, in the upper-right side railing. RNA 2 stated, the call light of Resident 59 should not have been curled on the upper-right side railing of the resident's bed, and it should have been clipped to the resident's pillow instead, to facilitate ease in the use of the call light for Resident 59. RNA 2 further stated, the call light being out of reach for Resident 59 had the potential for the resident to be unable to ask for help when needed and Resident 59 could fall. During an interview on 10/24/2023 at 1:30 PM with the Director of Nursing (DON), the DON stated the call light should always be within reach for the resident when making rounds, untangled when needed, and clipped to the pillow to make sure it was available for the resident. The DON stated, if the resident needed something, the resident could not get help without the call light within reach. The DON further stated, the resident could also fall if the resident tried to reach the call light out of their reach. During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, last reviewed on 10/16/2024, the P&P indicated, residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.

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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 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** 47883 Based on interview and record review, the facility failed to ensure the residents' clinical records were updated regarding advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for one of three sampled residents (Resident 59), by failing to maintain a current copy of the resident's advance directives in Resident 59's active clinical record. This failure had the potential to cause conflict with Resident 59's wishes regarding health care services received. Findings: During a review of Resident 59's Admission Record, the document indicated Resident 59 was admitted to the facility on [DATE], with a readmission on 10/13/2023, with diagnoses that included senile degeneration of the brain (a process of gradual decline of brain cells that is associated with memory loss and difficulty thinking clearly), aphasia (a condition that makes it hard for a person to speak, understand, read or write language), and personal history of transient ischemic attack (a stroke that last only a few minutes). During a review of Resident 59's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/7/2024, the MDS indicated, Resident 59's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (including decreased ability to remember things, make decisions, concentrate, or learn), and the resident was dependent on assistance of two or more helpers for eating, personal and toileting hygiene, and showering and dressing. During a concurrent interview and record review on 10/21/2024 at 2:15 PM with the Director of Social Services (SSD), Resident 59's clinical record was reviewed. The SSD stated, Resident 59's Advance Directive acknowledgement form indicated Resident 59 had an advance directive, but it was not found in Resident 59's clinical record. The SSD further stated, Resident 59's advance directive was not in their chart, and she would check the resident's medical record. During an interview on 10/22/2024 at 3:39 PM with the SSD, the SSD stated she had located Resident 59's advance directive in the overflow chart of the medical record. The SSD stated, a copy of Resident 59's advance directive should have been kept in the resident's active chart, to provide guidance to the facility staff about Resident 59's wishes. During an interview on 10/24/2024 at 1:30 PM with the Director of Nursing (DON), the DON stated a copy of Resident 59's advance directive should have been kept in the resident's active chart, to ensure Resident 59's wishes would be carried out, and to provide guidance to the facility staff about Resident 59's wishes. (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 the facility's policies and procedures (P&P) titled, Advance Directives, reviewed 10/16/2024, the P&P indicated, if the resident or resident's representative had executed an advanced directive, a copy of the document was to be obtained and maintained in the same section of the resident medical record and was readily retrievable by any facility staff.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure the activation of the correct setting of a Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries) for one of one sampled residents (Resident 59) requiring a LALM, when Resident 59 was investigated for pressure injury (PI - localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) care. This failure had the potential to place Resident 59 at risk for discomfort and development of avoidable pressure ulcers/injuries. Findings: During a review of Resident 59's Admission Record, the document indicated Resident 59 was admitted to the facility on [DATE], with a readmission on 10/13/2023, with diagnoses that included senile degeneration of the brain (a process of gradual decline of brain cells that is associated with memory loss and difficulty thinking clearly), aphasia (a condition that makes it hard for a person to speak, understand, read or write language), and personal history of transient ischemic attack (a stroke that last only a few minutes). During a review of Resident 59's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/7/2024, the MDS indicated, Resident 59's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (including decreased ability to remember things, make decisions, concentrate, or learn), and the resident was dependent on assistance of two or more helpers for eating, personal and toileting hygiene, and showering and dressing. During a review of Resident 59's care plan, dated 7/21/2024, the care plan indicated, Resident 59 was at risk for the development and worsening of unavoidable pressure injuries related to impaired mobilities. The care plan interventions indicated to use a low air loss mattress (LALM) as a pressure relieving device for Resident 59. During a review of Resident 59's Order Summary Review, the document indicated, a physician order to apply an LAL mattress for pressure injury management and prevention. The order indicated to the Charge Nurse, to check proper placement and function of the LAL mattress for Resident 59. During a concurrent observation and interview on 10/23/2024 at 9:23 AM with Treatment Nurse 1 (TN 1) in Resident 59's room, Resident 59's pressure reduction mattress was observed to be set between 150 to 180 pounds (lbs. - unit of measurement for weight). TN 1 stated, the LALM for Resident 59 was supposed to be set at the resident's weight of around 106 lbs. TN 1 stated, the use of the LALM is an intervention to promote wound healing and prevent further pressure injuries from developing. TN 1 stated, if the LALM is not set at the correct setting, then it wouldn't be effective and there was a potential for the resident to develop further pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 1:30 PM with the Director of Nursing (DON), the DON stated, it was important to follow the physician's order for the correct setting of the LALM for each resident. The DON stated, if the LALM was not set at the correct setting, then it wouldn't be effective and there was a potential the resident may develop further skin injuries. During a review of the manual for the air mattress with pump, the manual indicated, the LAL mattress was designed for wound care therapy treatment and prevention. The manual further indicated to turn the pressure adjustment knob to set a comfortable pressure level by using the weight as a guide.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure licensed nurses provided non-pharmacological interventions prior to administering an as needed (prn) opioid medication on multiple days for two of two sampled residents (Resident 36 and Resident 61). These failures had the potential to result in Resident 36 and Resident 61 receiving unnecessary pain medications. Findings: 1. During a review of Resident 36's Face Sheet (admission record), the document indicated Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pelvic fracture. During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/26/2024, the MDS indicated Resident 36 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 36 required moderate assistance (helper does less than half the effort) with eating, dressing, and personal hygiene. During a review of Resident 36's Physician's Orders, printed on 10/23/2024, the document indicated an order for tramadol (pain medication) 50 milligrams (mg, a unit of measure), give one tablet by mouth every 12 hours as needed for moderate pain (4 - 6 level pain on a pain scale [0 - 10] with zero being no pain and 10 being the most excruciating pain), dated 8/21/2024. The physician's orders did not indicate an order for non-pharmacological interventions prior to giving pain medication. During a review of Resident 36's Pain Care Plan, initiated 1/12/2024, the document indicated Resident 36 suffered a pelvic fracture. The care plan indicated a goal that Resident 36 will remain comfortable daily for three months. The care plan indicated an intervention to medicate with pain medication as ordered. The care plan did not indicate non-pharmacological interventions. A review of the facility's policy and procedure (P&P) titled, Pain Management, last reviewed on 10/16/2024, the P&P indicated the resident should be assessed for pain and non-pharmacological interventions should be attempted prior to giving pain medications. 2. During a review of Resident 61's Face Sheet, the document indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified fall and dementia (a progressive state of decline in mental abilities). During a review of Resident 61' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated Resident 61 was moderately impaired in cognition with skills required for daily decision making. The MDS further indicated Resident 61 required supervision with personal hygiene and dressing. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 61's Physician's Orders, printed on 10/23/2024, the document indicated an order for tramadol 50 mg, give one tablet by mouth every eight hours as needed for moderate to severe pain (4-10/10), dated 8/30/2024. The physician's orders did not indicate an order for non-pharmacological interventions prior to giving pain medication. During a review of Resident 61's Pain Care Plan, initiated 6/16/2024, the document indicated a goal that the resident will not have an interruption in normal activities due to pain through the review date. The care plan indicated an intervention to anticipate Resident 61's need for pain relief and respond immediately to any complaint of pain. The care plan did not indicate non-pharmacological interventions. During a concurrent interview and record review on 10/23/2024 with the Director of Nurses (DON), reviewed Resident 36's and Resident 61's October 2024 Medication Administration Record (MAR), physician's orders and care plans. The DON verified that there were not any non-pharmacological interventions prior to giving pain medication for the residents. The DON stated, there should always be a non-pharmacological intervention attempted prior to giving pain medication. The DON stated it was important to do this to decrease the chance of giving an unnecessary medication. A review of the facility's policy and procedure (P&P) titled, Pain Management, last reviewed on 10/16/2024, the P&P indicated the resident should be assessed for pain and non-pharmacological interventions should be attempted prior to giving pain medications.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure two of eight sampled residents were free from medication error by failing to ensure the Controlled Drug Record (CDR - accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR - a report detailing the drugs administered to a patient by the licensed nurses) for two (Resident 36 & Resident 61) of four residents sampled during the medication storage observation. These failures had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug) in the facility. Findings: 1. During a review of Resident 36's Face Sheet (admission record), the document indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pelvic fracture. During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/26/2024, the document indicated Resident 36 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS further indicated Resident 36 required moderate assistance (helper does less than half the effort) with eating, dressing, and personal hygiene. During a review of Resident 36's Physician's Orders, the document indicated an order for tramadol (pain medication) 50 milligrams (mg, a unit of measure), give one tablet by mouth every 12 hours as needed for moderate pain (4 - 6 level pain on a pain scale [0 - 10] with zero being no pain and 10 being the most excruciating pain), dated 8/21/2024. During a review of Resident 36's Pain Care Plan, initiated 1/12/2024, the document indicated Resident 36 suffered a pelvic fracture. The care plan indicated a goal that Resident 36 would remain comfortable daily for three months. The care plan indicated an intervention to medicate with pain medication as ordered. A review of Resident 36's Controlled Drug Record indicated the medication Tramadol was removed from the bubble pack on 10/7/2024, 10/15/2024, and 10/20/2024, but there was no corresponding entry in Resident 36's October 2024 MAR. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, last reviewed 10/16/2024, the P&P indicated controlled substances were reconciled not only upon receipt, disposition, and at the end of each shift, but also upon administration. During a review of the facility's P&P titled, Administering Medications, last reviewed 10/16/2024, the P&P indicated the individual administering the medication records the administration in the resident's medical record, with the date and time the medication was administered. (continued on next page)

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	555045	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Healthcare Center	10158 Sunland Blvd Sunland, CA 91040

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 61's Face Sheet, the document indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified fall and dementia (a progressive state of decline in mental abilities). During a review of Resident 61' s (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the document indicated Resident 61 was moderately impaired in cognition with skills required for daily decision making. The MDS further indicated Resident 61 required supervision with personal hygiene and dressing. During a review of Resident 61's Physician's Orders, the document indicated an order for tramadol 50 mg, give one tablet by mouth every eight hours as needed for moderate to severe pain (4-10/10), dated 8/30/2024. During a review of Resident 61's Pain Care Plan, initiated 6/16/2024, the document indicated a goal that the resident would not have an interruption in normal activities due to pain through the review date. The care plan indicated an intervention to anticipate Resident 61's need for pain relief and respond immediately to any complaint of pain. During a review of Resident 61's Controlled Drug Record, the document indicated the medication Ultram (also known as Tramadol, a pain medication) was removed from the bubble pack on 10/9/2024 and 10/15/2024, but there was no corresponding entry in Resident 61's October 2024 MAR. During a concurrent observation, interview, and record review on 10/21/2024 at 3:46 p.m. with Licensed Vocational Nurse 2 (LVN 2), the Skilled Nursing Facility Medication Cart 2 was observed. Resident 36's and Resident 61's October 2024 MARs were also reviewed with LVN 2. LVN 2 verified that there were no entries for Resident 36 and Resident 61's October 2024 MARs for the dates signed by the licensed nurse on Resident 36 and Resident 61's Controlled Drug Records. LVN 2 stated, the process when giving a controlled medication was to remove the medication from the medication cart, sign the controlled drug record, give the medication, and then sign the MAR for the respective resident. LVN 2 stated, the licensed nurse who administered the medication on the other dates and times should have signed both the MAR and the controlled drug record. LVN 2 further stated, this was important to have an accurate accounting for controlled medications in the facility. During a concurrent interview and record review on 10/22/2024 at 1:41 p.m. with the Director of Nurses (DON), reviewed Resident 36 and Resident 61's October 2024 MARs and controlled drug sheets. The DON verified that there was a discrepancy between the records for these residents. The DON stated, the process was that when a controlled drug was removed from the bubble pack, the licensed nurse was to sign the controlled drug record, give the medication to the resident, and then sign the MAR for the respective resident. The DON stated it was important to do this to decrease the chance of a medication error. The DON stated, these residents would be at risk of receiving a medication twice, since a second nurse may not have seen that it was given, since it was not signed on the MAR. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, last reviewed 10/16/2024, the P&P indicated controlled substances were reconciled not only upon receipt, disposition, and at the end of each shift, but also upon administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Administering Medications, last reviewed 10/16/2024, the P&P indicated the individual administering the medication records the administration in the resident's medical record, with the date and time the medication was administered.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to ensure the implementation of the Medication Regimen Review (MRR - a pharmacist's thorough evaluation of a resident's medication routine and recommendations) for two of three residents (Resident 49 and Resident 63). This failure could have resulted in preventable medication side effects, including up to bleeding, blood clotting, or seizures for Resident 49 and Resident 63. Findings: 1. During a review of Resident 49's Admission Record, dated 11/24/2024, the document indicated Resident 49 was admitted on [DATE] with diagnoses that included hydrocephalus (an abnormal buildup of cerebrospinal fluid [CSF- a clear, colorless, watery fluid that flows in and around your brain and spinal cord] deep within the brain), presence of cerebrospinal drainage device (shunt - a passage, such as a tube that is made to allow blood or other fluid to move from one part of the body to another), dysphagia (swallowing difficulties), history of falling, and dementia (the loss of remembering and reasoning to the extent that it effects their everyday activities). During a review of Resident 49's History and Physical (H&P), the H&P indicated Resident 49 had a history of a subdermal hematoma (a collection of blood between the covering of the brain [dura] and the surface of the brain) and did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/6/2024, the document indicated Resident 49 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 49's Order Summary Report, printed on 10/24/2024, the document indicated Resident 49's medical doctor ordered valproic acid (medication to help prevent seizures [a sudden, uncontrolled burst of electrical activity in the brain]) 250 milligrams (mg - unit if measurement) three times a day and heparin (a medication that prevents or breaks up blood clots) 5000 unit/ml - inject 1ml every eight hours to prevent deep vein thrombosis (DVT - a blood clot that forms in the deep veins) on 4/15/2024. During a review of Resident 49's Medication Regimen Review (MRR - recommendations the pharmacists make for each resident monthly that is given by staff to resident's doctors to view, deny and or makes changes to prescribed medications), dated 5/3/2024, the MRR indicated there was a recommendation for valproic acid level and partial thromboplastin time (PTT - the time it takes for a patient's blood to form a clot; measured in seconds), but did not indicate the recommendation was sent to the physician. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/2024 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed Resident 49's MRR, dated 5/3/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the orders to draw blood to check the valproic acid and heparin levels were missed and were not done since before the resident moved into the facility. The DON further explained, the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots and valproic acid to prevent seizures. The DON further stated, the resident was at risk for bleeding, blood clots, and seizures without the MRR being followed up by the physician. A review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated, a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated, it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. A review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated, the attending physician would determine the relevance of any recommended interventions from other disciplines. 2. During a review of Resident 63's Admission Record, dated 10/24/2024, the document indicated Resident 63 was admitted on [DATE] with diagnoses that included nontraumatic (not caused by trauma) subdural hematoma, history of falling, and unspecified dementia. During a review of Resident 63's History and Physical (H&P), the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/9/2024, the document indicated Resident 63 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 63's Order Summary Report, printed on 10/24/2024, the document indicated Resident 63's medical doctor ordered heparin 5000 unit/ml - inject 1ml every eight hours to prevent to prevent DVT on 7/2/2024. During a review of Resident 63's MRR, dated 7/5/2024, the MRR indicated a recommendation for PTT blood draw, but the MRR did not indicate the recommendation was sent to the physician. During a concurrent interview and record review on 10/24/2024 at 1:35 p.m. with the Director of Nursing (DON), the DON reviewed Resident 63's MRR, dated 7/5/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the order to draw blood to check the heparin level was missed and was not done since before the resident moved into the facility. The DON further explained, the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots. The DON further stated the resident was at risk for bleeding without the MRR being followed up by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated, a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated, it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. A review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated, the attending physician would determine the relevance of any recommended interventions from other disciplines.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to ensure residents' drug regimens were free from unnecessary drugs, by failing to adequately monitor valproic acid and heparin for two of three residents (Resident 49 and Resident 63). This failure could have resulted in medication side effects leading up to bleeding, blood clotting, or seizures for Resident 49 and Resident 63. Findings: 1. During a review of Resident 49's Admission Record, dated 11/24/2024, the document indicated Resident 49 was admitted on [DATE] with diagnoses that included hydrocephalus (an abnormal buildup of cerebrospinal fluid [CSF- a clear, colorless, watery fluid that flows in and around your brain and spinal cord] deep within the brain), presence of cerebrospinal drainage device (shunt - a passage, such as a tube that is made to allow blood or other fluid to move from one part of the body to another), dysphagia (swallowing difficulties), history of falling, and dementia (the loss of remembering and reasoning to the extent that it effects their everyday activities). During a review of Resident 49's History and Physical (H&P), the H&P indicated Resident 49 had a history of a subdermal hematoma (a collection of blood between the covering of the brain [dura] and the surface of the brain) and did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/6/2024, the document indicated Resident 49 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 49's Order Summary Report, printed on 10/24/2024, the document indicated Resident 49's medical doctor ordered valproic acid (medication to help prevent seizures [a sudden, uncontrolled burst of electrical activity in the brain]) 250 milligrams (mg - unit if measurement) three times a day and heparin (a medication that prevents or breaks up blood clots) 5000 unit/ml - inject 1ml every eight hours to prevent deep vein thrombosis (DVT - a blood clot that forms in the deep veins) on 4/15/2024. During a review of Resident 49's Medication Regimen Review (MRR - recommendations the pharmacists make for each resident monthly that is given by staff to resident's doctors to view, deny and or makes changes to prescribed medications), dated 5/3/2024, the MRR indicated a recommendation for valproic acid level and partial thromboplastin time (PTT - the time it takes for a patient's blood to form a clot; measured in seconds), but did not indicate the recommendation was sent to the physician. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/2024 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed Resident 49's MRR, dated 5/3/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the orders to draw blood to check the valproic acid and heparin levels were missed and not done since before the resident moved into the facility. The DON further explained the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots, and valproic acid to prevent seizures, and without the levels, her licensed nurses wouldn't know if the medication was safe to give to the resident. The DON further stated, the resident was at risk for bleeding, blood clots, and seizures without the MRR being followed up by the physician. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated, it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. During a review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated the attending physician would determine the relevance of any recommended interventions from other disciplines. During a review of the facility's P&P titled, Anticoagulation, revised 10/16/24, the P&P indicated the physician must assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to the drug through recent labs and monitoring. The P&P also indicated the physician should collaborate with the consultant pharmacist and nursing staff. During a review of the facility's P&P titled, Seizures and Epilepsy - Clinical Protocol, revised 10/16/24, the P&P indicated the physician must assess for evidence through lab work if the antiplatelet medication was subtherapeutic or greater than therapeutic drug level. 2. During a review of Resident 63's Admission Record, dated 10/24/2024, the document indicated Resident 63 was admitted on [DATE] with diagnoses that included nontraumatic (not caused by trauma) subdural hematoma, history of falling, and unspecified dementia. During a review of Resident 63's History and Physical (H&P), the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/9/2024, the document indicated Resident 63 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 63's Order Summary Report, printed on 10/24/2024, the document indicated Resident 63's medical doctor ordered heparin 5000 unit/ml - inject 1ml every eight hours to prevent to prevent DVT on 7/2/2024. During a review of Resident 63's MRR, dated 7/5/2024, the MRR indicated a recommendation for PTT blood draw, but the MRR did not indicate the recommendation was sent to the physician. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/2024 at 1:35 p.m. with the Director of Nursing (DON), the DON reviewed Resident 63's MRR, dated 7/5/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the order to draw blood to check the heparin level was missed and not done since before the resident moved into the facility. The DON further explained the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots, and without the levels, her licensed nurses wouldn't know if the medication was safe to give to the residents. The DON further stated the resident was at risk of bleeding without the MRR being followed up by the physician. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated, it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. During a review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated the attending physician would determine the relevance of any recommended interventions from other disciplines. During a review of the facility's P&P titled, Anticoagulation, revised 10/16/24, the P&P indicated the physician must assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to the drug through recent labs and monitoring. The P&P also indicated the physician should collaborate with the consultant pharmacist and nursing staff. During a review of the facility's P&P titled, Seizures and Epilepsy - Clinical Protocol, revised 10/16/24, the P&P indicated the physician must assess for evidence through lab work if the antiplatelet medication was subtherapeutic or greater than therapeutic drug level.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors, when the facility continued to give medications without checking the therapeutic levels for two of three sampled residents (Residents 49 and Resident 63). This failure had the potential to result in bleeding, blood clots, or seizures for Resident 49 and Resident 63. Findings: 1. During a review of Resident 49's Admission Record, dated 11/24/2024, the document indicated Resident 49 was admitted on [DATE] with diagnoses that included hydrocephalus (an abnormal buildup of cerebrospinal fluid [CSF- a clear, colorless, watery fluid that flows in and around your brain and spinal cord] deep within the brain), presence of cerebrospinal drainage device (shunt - a passage, such as a tube that is made to allow blood or other fluid to move from one part of the body to another), dysphagia (swallowing difficulties), history of falling, and dementia (the loss of remembering and reasoning to the extent that it effects their everyday activities). During a review of Resident 49's History and Physical (H&P), the H&P indicated Resident 49 had a history of a subdermal hematoma (a collection of blood between the covering of the brain [dura] and the surface of the brain) and did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/6/2024, the documentation indicated Resident 49 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 49's Order Summary Report, printed on 10/24/2024, the documentation indicated Resident 49's medical doctor ordered valproic acid (medication to help prevent seizures [a sudden, uncontrolled burst of electrical activity in the brain]) 250 milligrams (mg - unit of measurement) three times a day and heparin (a medication that prevents or breaks up blood clots) 5000 unit/ml - inject 1ml every eight hours to prevent deep vein thrombosis (DVT - a blood clot that forms in the deep veins) on 4/15/2024. During a review of Resident 49's Medication Regimen Review (MRR - recommendations the pharmacists make for each resident monthly that is given by staff to resident's doctors to view, deny and or makes changes to prescribed medications), dated 5/3/2024, the MRR indicated a recommendation for valproic acid level and partial thromboplastin time (PTT - the time it takes for a patient's blood to form a clot; measured in seconds), but did not indicate the recommendation was sent to the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/2024 at 1:30 p.m. with the Director of Nursing (DON), the DON reviewed Resident 49's MRR, dated 5/3/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the orders to draw blood to check the valproic acid and heparin levels were missed and not done since before the resident moved into the facility. The DON further explained the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots, and valproic acid to prevent seizures. The DON further stated, the resident was at risk for bleeding, blood clotting, and seizures without the MRR being followed up by the physician. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. During a review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated the attending physician would determine the relevance of any recommended interventions from other disciplines. During a review of the facility's P&P titled, Anticoagulation, revised 10/16/24, the P&P indicated the physician must assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to the drug through recent labs and monitoring. The P&P also indicated the physician should collaborate with the consultant pharmacist and nursing staff. During a review of the facility's P&P titled, Seizures and Epilepsy - Clinical Protocol, revised 10/16/24, the P&P indicated the physician must assess for evidence through lab work, if the antiplatelet medication was subtherapeutic or greater than therapeutic drug level. 2. During a review of Resident 63's Admission Record, dated 10/24/2024, the documentation indicated Resident 63 was admitted on [DATE] with diagnoses that included, nontraumatic (not caused by trauma) subdural hematoma, history of falling, and unspecified dementia. During a review of Resident 63's History and Physical (H&P), the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/9/2024, the document indicated Resident 63 needed assistance from facility staff for toileting, showering, hygiene, and dressing. During a review of Resident 63's Order Summary Report, printed on 10/24/2024, the documentation indicated Resident 63's medical doctor ordered heparin 5000 unit/ml - inject 1ml every eight hours to prevent to prevent DVT on 7/2/2024. During a review of Resident 63's MRR, dated 7/5/2024, the MRR indicated a recommendation for PTT blood draw, but the MRR did not indicate the recommendation was sent to the physician. (continued on next page)

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The Hills Healthcare Center	10158 Sunland Blvd Sunland, CA 91040

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/2024 at 1:35 p.m. with the Director of Nursing (DON), the DON reviewed Resident 63's MRR, dated 7/5/2024, and stated it was her responsibility to notify the physician of the MRR recommendations every month after the consulting pharmacist made their recommendations. The DON further stated, the order to draw blood to check the heparin level was missed and not done since before the resident moved into the facility. The DON further explained the heparin levels needed to be checked to ensure the resident was safe from bleeding and blood clots, and it was considered a medication error without verifying how much medication the resident needed based on the lab work. The DON further stated the resident was at risk for bleeding without the MRR being followed up by the physician. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, revised 10/16/24, the P&P indicated a consultant pharmacist was to review the drug regimen of each facility's residents monthly. The P&P further indicated it was the facility's responsibility to follow-up on each pharmacist's recommendation by providing it to the appropriate primary physician, and the DON was responsible for ensuring proper follow-through. During a review of the facility's P&P titled, Physician's Services, revised 10/16/24, the P&P indicated the attending physician would determine the relevance of any recommended interventions from other disciplines. During a review of the facility's P&P titled, Anticoagulation, revised 10/16/24, the P&P indicated the physician must assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to the drug through recent labs and monitoring. The P&P also indicated the physician should collaborate with the consultant pharmacist and nursing staff. During a review of the facility's P&P titled, Seizures and Epilepsy - Clinical Protocol, revised 10/16/24, the P&P indicated the physician must assess for evidence through lab work, if the antiplatelet medication was subtherapeutic or greater than therapeutic drug level.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34659 Based on observation, interview, and record review, the facility failed to ensure medications were stored in a locked compartment, when the Station Two Nursing Station Medication Cabinet did not have a lock, which permitted any staff or resident access. This failure had the potential for residents to take medications, which could cause harmful adverse side effects for the residents. Findings: During a concurrent observation and interview on 10/21/2024 at 4:00 p.m. with the Director of Staff Development (DSD), in the facility's medication storage area, observed Nursing Station Two right-side drug cabinet. The cabinet did not have a lock as the left-side cabinet had. The right-side cabinet contained the following: 1. Two Iron Supplement (given to one with a low level of iron in the blood) Liquid 16 fluid ounce (fl. oz., a unit of measure for liquids) bottles. 2. Two Bismuth subsalicylate (commonly known as Pepto Bismol, given for treating diarrhea and upset stomach) 16 fl. oz. bottles. 3. One Liquid Multi-Vitamin 16 fl. oz. bottle. 4. Three Liquid Acetaminophen (also known as Tylenol, given for pain relief but taken in excess can yield liver damage) 16 fl. oz. bottles. 5. Two Liquid Vitamin C Supplement 16 fl. oz. bottles. 6. Two Constulose (also known as Lactulose, a medication to treat constipation and reduce ammonia [a waste product] levels in the blood) 10 grams in 15 milliliters (gm/mL, a unit of measure for liquids) bottles. 7. One Milk of Magnesia (medication to treat constipation and upset stomach) 16 fl. oz. bottle. The DSD stated, the medication storage should not be left unlocked, because residents should be kept safe from taking the medication. During an interview on 10/22/2024 at 1:41 p.m. with the Director of Nurses (DON), the DON stated she was unaware that the Station Two medication cabinet lock was broken. The DON further stated, it was important for medications to be kept in a locked cabinet, so residents do not gain access to them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, last reviewed 10/16/2024, the P&P indicated, drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light, and humidity controls. The P&P further indicated, only persons authorized to prepare and administer medications had access to locked medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47883 Based on observation, interview, and record review, the facility failed to ensure the storage of food in accordance with professional standards by not labeling stored food with a use-by date (the indicated date that the food item should be used or consumed by). These failures had the potential for 66 of 67 facility residents who receive food from the facility kitchen to be at risk for food borne illness (illness caused by food contamination with bacteria, viruses, parasites, or toxins). Findings: During a concurrent observation and interview on 10/21/2024 at 8:00 a.m. with the Dietary Supervisor (DS), the refrigerator was observed and the following was noted: one clear zip-lock bag of garlic, one clear plastic container of ham, and one clear plastic container of apple sauce - none of these items were labeled with a use-by date. Further observation included the dry storage room and the following was noted: seven pistachio puddings and pie fillings, six vanilla pudding and pie fillings, five lime gelatine desserts, three cherry gelatine desserts, four strawberry gelatine desserts, three orange gelatine desserts, two raspberry gelatine desserts, five paper bags of scalloped potatoes, five jars of complete Instant mashed potatoes, and six jars of seasoned applesauce - none of these items were labeled with a use-by date. The DS stated, there should have been labels with the use-by dates, and if there were not, that could have affected the residents, and the residents could have gotten sick. During an interview on 10/24/2024 at 1:30 p.m. with Director of Nursing (DON), the DON stated food should have been labeled with a use-by date and should always have a use-by date label. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, reviewed on October 16, 2024, the P&P indicated, Dry food that stored in bins will be removed from original packing, labeled and dated (use by date) . All food stored in the refrigerator will covered, labeled and dated (use by date).

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47883 Based on observation, interview, and record review, the facility failed to ensure their trash was stored in the dumpster areas while being maintained in a sanitary manner. Two of two facility garbage dumpsters in use had their lids open. These failures had the potential for harborage and feeding of pests. Findings: During a concurrent observation and interview on 10/23/2024 at 12:07 PM with the Dietary Supervisor (DS), there were two facility dumpsters observed outside of the facility that were filled with trash bags. Two dumpsters had the lids open and positioned in close proximity to the wall, making it impossible to close them. The DS stated, the dumpsters should have been closed. The DS further stated, if the dumpsters were not closed, the smell would attract flies and there could be an infection control issue, because the flies could get inside the facility and go into the resident's food. During an interview on 10/23/2024 at 12:15 PM with the Maintenance Supervisor (MS), the MS stated the dumpster lids should have been closed. The MS further stated, if the dumpster lids were not closed, that could attract insects or rodents, and become an infection control problem if the insects or rodents enter the facility. During a review of the facility's policy and procedure (P&P) titled Food-Related Garbage and Refuse Disposal, dated January 2024, the P&P indicated, Garbage and refuse containing food waste will be stored in a manner that is inaccessible to pets . Outside dumpsters provided by garbage pickup services will kept closed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to ensure the implementation of their policy titled, Enhanced Barrier Precautions (EBP - an infection control method that uses targeted gown and gloves to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial [a substance that kills microorganisms such as bacteria or mold, or stops them from growing and causing disease agents]]) when: 1. Licensed Vocational Nurse 2 (LVN 2) did not don (to put on) a gown while administering medication via gastrostomy (G-Tube, a tube inserted through the abdomen that delivers directly to the stomach) for one of one sampled resident (Resident 48). 2. Licensed Vocational Nurse 1 (LVN 1) did not don a gown while administering medication through the rectum (the last part of the large intestine, where the body stores stool before it leaves through the anus [an opening at the end of the digestive system]) for one of one sampled resident (Resident 58), and Certified Nursing Assistant 1 (CNA 1) donned a gown while holding and opening Resident 58's briefs while assisting LVN 1 during the administration of medication via rectum. 3. Three sampled residents (Residents 22, 66, and 120) with other with medical devices (devices that are connected to a resident such as a G-tube or catheter) and wounds were placed on EBP without the posting of signs at the entrances into the residents' rooms and without providing personal protective equipment [PPE - equipment designed to protect the wearer from injury or the spread of illness or infection such as gloves and gowns] outside of the residents' rooms. These failures had the potential to transmit infectious microorganisms to the other residents in the facility. Findings: 1. During a review of Resident 48's Admission Record, the document indicated the facility admitted Resident 48 to the facility on [DATE], with diagnoses that included Huntington's disease (an inherited disease that causes the progressive breakdown [degeneration of the tissue to less functional active form] of nerve cells in the brain), dysphasia (difficulty swallowing), and essential hypertension (high blood pressure). During a review of Resident 48's History and Physical (H&P), the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 48's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/5/2024, the documentation indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning), and the resident was dependent on assistance of two or more helpers for eating, personal and toileting hygiene, and showering and dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's Physician's Order, dated 6/2/2022, the documentation indicated orders to crush all crushable medication and give them via G-Tube. During an observation on 10/22/2024 at 8:22 AM in Resident 48's room, observed Resident 48's door did not have signage that Resident 48 was on enhanced barrier precautions (EBP). During an observation on 10/22/2024 at 8:22 AM in Resident 48's room with Licensed Vocational Nurse 2 (LVN 2), LVN 2 was observed administering medication to Resident 48 via G-Tube at the resident's bedside. LVN 2 was observed wearing gloves and no gown while administering medication. During an interview on 10/22/2024 at 8:35 AM with LVN 2, LVN 2 stated, the gown should be used to prevent spreading an infection between residents, but this practice was not yet implemented in the facility. During an interview on 10/24/2024 at 11:25 AM with the Infection Prevention (IP), the IP stated, the Enhanced Barrier Precautions policy was not yet implemented in the facility. The IP stated, she was not aware that the implementation of enhanced barrier precautions was mandatory. The IP stated, enhanced precautions were not implemented for Resident 48, who had a G -tube. The IP further stated, according to the facility's policies regarding EBP, LVN 2 should have donned a gown prior to administering medication via G-Tube. During an interview on 10/24/2024 at 1:30 PM with the Director of Nursing (DON), the DON stated, Enhanced Barrier Precautions had to be initiated for residents with indwelling medical devices, like an indwelling catheter or G-tube, to prevent the spread of Multidrug Resistant Organisms (MDRO - bacteria or other microorganisms that have developed resistance to multiple types of antimicrobial agents). The DON further stated, all staff were required to use gowns and gloves when they were performing high-contact resident care activities and when providing device care or use, such as with a G-Tube or indwelling catheter. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, reviewed 10/16/2024, the P&P indicated, the facility was to implement enhanced barrier precautions for the prevention of spread of multidrug-resistant organisms. The P&P also indicated to wear gowns and gloves while performing the high contact resident care activity (activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated), including device care or use. During a review of the facility's P&P titled, Administration Medication through an Enteral Tube, reviewed 10/16/2024, the P&P indicated, The purpose of this procedure is to provide guidelines for safe administration of medication through an enteral tube . The following equipment and supplies will be necessary when performing this procedure . 13. Personal protective equipment (gown, gloves, mask as needed). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 58's Admission Record, the documentation indicated the facility admitted Resident 58 to the facility on [DATE], with a readmission on 9/9/2024, with diagnoses that included multiple sclerosis (MS - an inherited disease that causes the progressive breakdown [degeneration of the tissue to less functional active form] of nerve cells in the brain), quadriplegia (a form of paralysis that affects all four limbs, plus the torso), and methicillin resistant staphylococcus aureus infection (MRSA - a type of bacteria that's tough to treat because it has become resistant to many common antibiotics). During a review of Resident 58's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was mildly impaired (a slight decline in mental abilities, memory and completing complex tasks) and the resident was dependent on the assistance of two or more helpers for eating, personal and toileting hygiene, showering and dressing. During a review of Resident 58's Physician's Order, dated 9/7/2024, the documentation indicated orders for indwelling catheter (a thin, hollow tube that is inserted into the bladder [organ that stores urine] to drain urine) care every shift for Resident 58. During an observation on 10/24/2024 at 8:10 AM in Resident 58's room with Licensed Vocational Nurse 1 (LVN 1) and Certified Nursing Assistant 1 (CNA 1), observed LVN 1 administering medication to Resident 58 via rectum. LVN 1 was wearing gloves and no gown while administering the medication. CNA 1 was in Resident 58's room, positioning the resident on his left side and opening his briefs. CNA 1 was observed wearing gloves and no gown during the procedure. During an interview on 10/24/2024 at 8:11 AM with LVN 1, LVN 1 stated, a gown should be used when administering medication via rectum in residents who have an indwelling catheter, to prevent spreading an infection between residents, but this practice was not yet implemented in the facility. During an interview on 10/24/2024 at 11:25 AM with the Infection Preventionist (IP), the IP stated, the Enhanced Barrier Precautions policy was not yet implemented in the facility. The IP stated, she was not aware that the implementation of enhanced barrier precautions was mandatory. The IP stated, enhanced precautions were not implemented for Resident 58, who had an indwelling catheter. The IP further stated, according to the facility's policies regarding EBP, LVN 1 and CNA 1 should have donned gowns prior to administering medication via rectum. During an interview on 10/24/2024 at 1:30 PM with the Director of Nursing (DON), the DON stated, Enhanced Barrier Precautions had to be initiated for residents with indwelling medical devices, like an indwelling catheter or G-tube, to prevent the spread of Multidrug Resistant Organisms (MDRO - bacteria or other microorganisms that have developed resistance to multiple types of antimicrobial agents). The DON further stated, all staff were required to use gowns and gloves when they were performing high-contact resident care activities and when providing device care or use, such as with a G-Tube or indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, reviewed 10/16/2024, the P&P indicated, the facility was to implement enhanced barrier precautions for the prevention of spread of multidrug-resistant organisms. The P&P also indicated to wear gowns and gloves while performing the high contact resident care activity (activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated), including device care or use. During a review of the facility's P&P titled, Administration Medication through an Enteral Tube, reviewed 10/16/2024, the P&P indicated, The purpose of this procedure is to provide guidelines for safe administration of medication through an enteral tube . The following equipment and supplies will be necessary when performing this procedure . 13. Personal protective equipment (gown, gloves, mask as needed). 3a. During a review of Resident 22's Face Sheet, the document indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included diabetes mellitus (high blood sugar). During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/1/2024, the document indicated Resident 22 was moderately impaired in cognition with skills required for daily decision making. The MDS further indicated, Resident 22 required supervision (helper sets up or cleans up; resident completes activity) with oral hygiene, and personal hygiene. During a review of Resident 22's Physician's Orders, the documentation indicated the following: 1. Left heel deep tissue injury (DTI - deep red or purples areas of intact skin that hides the extent of the injury beneath the skin), cleanse with normal saline (a saltwater solution), pat dry, wipe with betadine (a type of disinfectant), cover with foam dressing daily and as needed if soiled or dislodged, dated 10/22/2024. 2. Sacrococcyx (area around the tailbone) stage III pressure injury (PI - also known as a pressure ulcer, a wound over an area where the bone is close to the skin's surface that involves damage to the subcutaneous tissue [layer of tissue closest to the muscle]), cleans with normal saline, pat dry, apply medihoney (a wound care ointment that is made from honey from the Leptospermum plant [a type of shrub and small tree]), zinc oxide (a type of barrier cream to prevent rashes caused by one wearing a brief) to peri-wound (around the wound) and cover with foam dressing daily and as needed if soiled or dislodged, dated 10/22/2024. During a general observation of the facility on 10/21/2024 at 10:00 a.m., the following was observed outside of the residents' rooms: Resident 48, Resident 58, Resident 22, Resident 66, and Resident 120 did not have EBP signs posted before the rooms' entrances nor PPE containers located outside the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with the facility's Infection Preventionist (IP) on 10/21/2024 at 11:50 a.m. , the IP stated, no resident was on any kind of contact isolation (when gloves and gown need to be worn to prevent spread of infection to other residents). When asked about EBP, the IP stated isolation gowns and gloves were used only for an active infection. Observed the rooms in the facility with the IP and confirmed there were no EBP signs or PPE containers outside any of the residents' rooms. The IP stated they would look at the Department of Health's EBP recommendations. During a concurrent interview and record review on 10/21/2024 at 2:00 p.m. with the IP, the Centers for Medicare and Medicaid Services (CMS, a federal agency that manages health coverage programs, which includes regulating skilled nursing facilities) Quality Safety & Oversight (QSO, documents to promote health and safety in skilled nursing facility) QSO-24-NH, dated 3/20/2024, was reviewed. The document indicated, residents that have wounds or indwelling medical device (such as G-Tube, nephrostomy tube, etc.) should use EBP. The IP stated, the facility would be following these guidelines for those with wounds or indwelling medical devices. During an observation on 10/22/2024 at 9:31 a.m., observed Resident 22 inside his room. Observed there was no EBP sign or PPE container outside Resident 22's room. During an interview with the IP on 10/23/2024 at 10:52 a.m., the IP stated the EBP signs were not posted yet because the facility was waiting for all the trash bins to be delivered. The IP stated the trash bins were to be placed inside the rooms for staff to dispose gown and gloves before exiting a resident's room. During a review of Resident 22's Care Plan for Impaired Skin Integrity, initiated 10/22/2024, the care plan indicated a goal that Resident 22's stage III sacrococcyx wound will be resolved within 30 days. The care plan further indicated to follow the physician's order in daily wound treatment. During a review of Resident 22's Care Plan for Enhanced Barrier Precautions, initiated 10/24/2024, the document indicated Resident 22 had an unhealed pressure ulcer wound. The care plan indicated a goal that Resident 22 would demonstrate reduced risk of MDRO transmission daily, through compliance with EBP guidelines by resident and staff for 90 days. The care plan further indicated a goal to always use gloves and gown during high-contact care activities (activities that would include dressing change). During a review of the facility's reference to QSO-24-08, effective date, 4/01/2024, the document indicated new guidance of EBP, in which EBP was indicated for residents with wounds and/or indwelling medical devices, even if the resident was not known to be infected with a MDRO. 3b. During a review of Resident 66's Face Sheet, the document indicated Resident 66 was admitted to the facility on [DATE], with diagnoses that included acute kidney failure (a sudden and often reversable condition the kidneys are not working properly). During a review of Resident 66's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/17/2024, the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS further indicated, Resident 22 required partial assistance with dressing and eating. (continued on next page)

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	555045	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Healthcare Center	10158 Sunland Blvd Sunland, CA 91040

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Resident 66 on 10/21/2024 at 9:20 a.m., Resident 66 stated, she had a nephrostomy tube and showed the right-side insertion site covered with a dressing. There were no EBP signs or containers with gloves and gowns outside of Resident 66's room. During a general observation of the facility on 10/21/2024 at 10:00 a.m., the following was observed outside of the residents' rooms: Resident 48, Resident 58, Resident 22, Resident 66, and Resident 120 did not have EBP signs posted before the rooms' entrances nor PPE containers located outside the rooms. During an observation and interview with the facility's Infection Preventionist (IP) on 10/21/2024 at 11:50 a.m. , the IP stated, no resident was on any kind of contact isolation (when gloves and gown need to be worn to prevent spread of infection to other residents). When asked about EBP, the IP stated isolation gowns and gloves were used only for an active infection. Observed the rooms in the facility with the IP and confirmed there were no EBP signs or PPE containers outside any of the residents' rooms. The IP stated they would look at the Department of Health's EBP recommendations. During a concurrent interview and record review on 10/21/2024 at 2:00 p.m. with the IP, the Centers for Medicare and Medicaid Services (CMS, a federal agency that manages health coverage programs, which includes regulating skilled nursing facilities) Quality Safety & Oversight (QSO, documents to promote health and safety in skilled nursing facility) QSO-24-NH, dated 3/20/2024, was reviewed. The document indicated, residents that have wounds or indwelling medical device (such as G-Tube, nephrostomy tube, etc.) should use EBP. The IP stated, the facility would be following these guidelines for those with wounds or indwelling medical devices. During an interview with the IP on 10/23/2024 at 10:52 a.m., the IP stated the EBP signs were not posted yet because the facility was waiting for all the trash bins to be delivered. The IP stated the trash bins were to be placed inside the rooms for staff to dispose gown and gloves before exiting a resident's room. During a review of Resident 66's Physician's Orders, the document indicated an order to drain the output every shift for Resident 66's right nephrostomy tube (a tube that drains urine from the kidney into a bag outside the body), dated 9/10/2024. During a review of Resident 66's Care Plan for Right Nephrostomy Tube, initiated 9/10/2024, the document indicated a goal that there would be no signs or symptoms of infection for three months. The care plan indicated an intervention to monitor for signs and symptoms of infection. During a review of the facility's reference to QSO-24-08, effective date, 4/01/2024, the document indicated new guidance of EBP, in which EBP was indicated for residents with wounds and/or indwelling medical devices, even if the resident was not known to be infected with a MDRO. 3c. During a review of Resident 120's Face Sheet, the document indicated Resident 120 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing). Resident 120 also had a gastrostomy tube (G-Tube, a plastic tube inserted into the stomach to give food and medications to for those who have trouble swallowing). (continued on next page)

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	555045	A. Building B. Wing	10/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 120's Admission Assessment, dated 10/16/2024, the document indicated the resident was unable to be oriented to the facility due to confusion. The Admission Assessment further indicated, Resident 120 was dependent on staff for personal hygiene. During a review of Resident 120's Physician's Orders, the document indicated an order to cleanse the G-Tube site with normal saline, pat dry, and cover with a dry dressing for every dayshift, dated 10/17/2024. During a review of Resident 120's Care Plan for Enhanced Barrier Precautions, initiated 10/24/2024, the care plan indicated Resident 120 had a G-tube and a goal that the resident would demonstrate reduced risk of MDRO transmission daily, through compliance with EBP guidelines by resident and staff for 90 days. The care plan further indicated an intervention to always use gloves and gown during high-contact care activities. During a general observation of the facility on 10/21/2024 at 10:00 a.m., the following was observed outside of the residents' rooms: Resident 48, Resident 58, Resident 22, Resident 66, and Resident 120 did not have EBP signs posted before the rooms' entrances nor PPE containers located outside the rooms. During an observation of Resident 120's room on 10/21/2024 at 11:15 a.m., observed Resident 120 had a G-tube. Observed there was no EBP sign posted before the room's entrance and no PPE container located outside the room. During an observation and interview with the facility's Infection Preventionist (IP) on 10/21/2024 at 11:50 a.m. , the IP stated, no resident was on any kind of contact isolation (when gloves and gown need to be worn to prevent spread of infection to other residents). When asked about EBP, the IP stated isolation gowns and gloves were used only for an active infection. Observed the rooms in the facility with the IP and confirmed there were no EBP signs or PPE containers outside any of the residents' rooms. The IP stated they would look at the Department of Health's EBP recommendations. During a concurrent interview and record review on 10/21/2024 at 2:00 p.m. with the IP, the Centers for Medicare and Medicaid Services (CMS, a federal agency that manages health coverage programs, which includes regulating skilled nursing facilities) Quality Safety & Oversight (QSO, documents to promote health and safety in skilled nursing facility) QSO-24-NH, dated 3/20/2024, was reviewed. The document indicated, residents that have wounds or indwelling medical device (such as G-Tube, nephrostomy tube, etc.) should use EBP. The IP stated, the facility would be following these guidelines for those with wounds or indwelling medical devices. During an interview with the IP on 10/23/2024 at 10:52 a.m., the IP stated the EBP signs were not posted yet because the facility was waiting for all the trash bins to be delivered. The IP stated the trash bins were to be placed inside the rooms for staff to dispose gown and gloves before exiting a resident's room. During a review of the facility's reference to QSO-24-08, effective date, 4/01/2024, the document indicated new guidance of EBP, in which EBP was indicated for residents with wounds and/or indwelling medical devices, even if the resident was not known to be infected with a MDRO. 47883

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 F912 Based on observation, interview, and record review, the facility failed to meet the requirement of 80 square feet (SF, a unit of measure) per resident in multiple resident bedrooms for 15 of 28 resident rooms (room [ROOM NUMBER], 2, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21). This deficient practice had the potential to result in inadequate space for safe nursing care and privacy for the residents. Findings: On 10/21/2024, the Administrator (ADM) submitted the Client Accommodation Analysis Form (a form designed to provide a record of resident accommodations approved for licensed care) and the facility letter requesting for continuation of its room size waiver. A review of the Client Accommodation Analysis Form, dated 10/21/2024, it indicated the Administrator submitted the form with the rooms and space measurements as follows: Room No. Room Size (SF: Square Feet) Beds SF per resident 1 156 2 78 2 156 2 78 7 228 3 76 8 228 3 76 9 228 3 76 10 228 3 76 11 228 3 76 12 228 3 76 14 228 3 76 15 228 3 76 16 228 3 76 17 228 3 76 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	18 228 3 76 19 228 3 76 21 228 3 76 A review of the letter from the Administrator to request for a room size waiver, dated 10/21/2024, it indicated a request for a continuing room size waiver for room [ROOM NUMBER], 2, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 21. The letter indicated there is still enough space to provide for each resident's care, dignity, and privacy. The rooms are in accordance with the special needs of residents and will not have an adverse effect on the residents' health and safety or impede the ability of any resident in the room to attain his or her highest practicable well-being. During an observation on 10/21/2024 at 11:30 a.m. (location/room), both residents and staff had enough space to move about freely inside the rooms. Throughout the survey, the survey team observed there to be enough space for residents and staff to move about freely inside the rooms. The nursing staff had enough space to safely provide care to the residents with space for the beds, side tables, dressers, and resident care equipment. Residents who were in these rooms with limited size were not adversely affected. During a follow-up interview on 10/24/2024 at 10 a.m. with the ADM, the ADM stated there should be at least 80 square feet per resident in multiple resident rooms. The minimum requirement for two residents (two bed) in a room should be at least 160 square feet and for three residents (three bed) in a room should be at least 240 square feet.