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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 W Washington Bl Los Angeles, CA 90018	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49862 Based on observation and interview the facility failed to ensure call lights were placed within reach for three of 19 sampled residents (Resident 43, 65, and 72). This deficient practice had the potential to result in a delay in or inability for the residents to obtain necessary care and services in a timely manner. Findings: a)During observation and interview on 6/4/2024, at 10:36 a.m., Resident 65 was observed in his room, lying in his bed, awake, alert and was able to respond to questions with limited words and gestures. Resident 65 was observed pressing on the television (TV) remote control and continuously shouting for help. Resident 65's call light was observed tied on the nightstand and was not within the resident's reach. A review of Resident 65's of Admission Record (facesheet), the Admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnosis including of cerebral infarction (a lack of adequate blood supply to the brain cells, damage to tissues in the brain due to a loss oxygen to the area), contracture of the left hand (stiffening of the ligaments), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily living). A review of Resident 65's History and Physical (H&P), dated 4/18/2024, the H&P indicated, Resident 65 was able to make decisions for activities of daily living. A review of Resident 65' Minimum Data Set (MDS), specialized assessment and care screening tool, dated 4/08/2024, the MDS indicated, Resident 65was dependent on staff for toileting, personal hygiene and dressing. During observation and interview on 6/4/2024, at 10:36 a.m., Resident 65 was observed in his room, lying in his bed, awake, alert and was able to respond to questions with limited words and gestures. Resident 65 was observed pressing on the television (TV) remote control and continuously shouting for help. Resident 65's call light was observed tied on the nightstand and was not within the resident's reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2024 at 10:41 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated, the call light tied to the headboard was from the previous shift but forgot to check the call light during her rounds. CNA 4 stated if the call light was not within reach, then the resident was at risk for falls because they could not reach it. During an interview on 6/4/2024 at 10:50 a.m. with Licensed vocational Nurse (LVN) 2, LVN 2 stated the resident should be able to reach call light at all times. 47042 b. During a concurrent observation and interview on 6/4/2024 at 3:15 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 43 and Resident 72's room, the residents call lights were clipped to a string on the overhead light above the resident's bed, not within reach to the residents. CNA 1 stated the call light should not be hanging on the overhead light cord; it was not within reach. CNA 1 stated the call light should be within reach for an emergency or to get assistance from the staff. CNA 1 stated if the call light was not within reach the resident could potentially get hurt or their medical condition could get worse. A review of Resident 43's Admission Record, the Admission Record indicated, Resident 43 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 43's diagnoses included type 2 diabetes mellitus (abnormal blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities) and schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly). A review of Resident 43's History and Physical (H&P), dated 2023, indicated Resident 43 had the capacity to understand and make decisions. A review of Resident 43's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 5/18/2024, indicated Resident 43 was assessed to have clear cognition in daily decision making. The MDS indicated Resident 43 required supervision or touching assistance from staff for activities of daily living (ADLs) such as showering, dressing, putting on and off footwear, and was independents for personal hygiene, oral hygiene and eating. A review of Resident 43's Care Plan Fall Risk, initiated on 8/7/2019, the care plan's interventions indicated to place the call light within easy reach. c) A review of Resident 72's Admission Record, the Admission Record indicated, Resident 72 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 72's diagnoses included dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities), anxiety disorder (persistent and excessive worry that interferes with daily activities), and chronic kidney disease ([CKD], condition which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 72's H&P, dated 12/3/2023, indicated Resident 72 was able to make decisions for actives of daily living. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 72's MDS, dated [DATE], indicated Resident 72 was assessed to have a clear comprehension (the action or capability of understanding something). The MDS indicated Resident 72 required supervision or touching assistance from staff for activities of daily living (ADLs) such as showering, dressing, putting on and off footwear, and setup or clean up assistance for personal hygiene and oral hygiene. A review of Resident 43's Care Plan At Risk for Unavoidable Declines, initiated on 11/23/2021, the care plan's interventions indicated to place the call light within reach and attend to needs promptly. During an interview on 6/7/2024 at 10:16 a.m. with the Director of Nursing (DON), the DON stated if the call light is not within reach, the resident would not be able to call for help. The DON stated that it could potentially be harmful to the resident. The DON stated the call light should always be within the resident's reach, no matter what. A review of the facility's policy and procedure (P&P) titled, Call Lights, (undated), the P&P indicated, the staff shall know how to place the call light for a resident and how to use the call light system, ensuring that the call light is within the resident's reach when in his/her room or when on the toilet.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure residents who had physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) were evaluated regularly and less restrictive measures were attempted for one of one sampled resident (Resident 69). This deficient practice had the potential to place Resident 69 at risk for unnecessary prolonged use of restraint that could lead to decline in physical functioning and not being treated with respect and dignity. Findings: A review of Resident 69's Admission Record, the Admission Record indicated, Resident 69 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and seizure disorder (sudden change in movement or awareness due to a change in the electrical function of the brain). A review of Resident 69's Minimum Data Set ([MDS] resident assessment and care screening tool) under Section C (Cognitive Patterns), dated 4/6/2024, the MDS indicated, Resident 69's cognitive (ability to reason, understand, remember, judge, and learn) skills for daily decision making was severely impaired. The MDS under Section P (Restraints and Alarms) also indicated, Resident 69 had used trunk restraint in chair. A review of Resident 69's Order Summary Report, dated 6/7/2024, the Order Summary Report indicated, Resident 69 had an active order to apply lap buddy (a device that helps keep a wheelchair patient upright and prevents them from falling out) restraint while in wheelchair every Monday, Tuesday, Wednesday, Thursday, Friday for proper body alignment secondary to resident leaning forward. A review of Resident 69's Care Plan ([CP] a form that summarizes a resident's health conditions, care needs and current treatment) dated 3/31/2023, the CP indicated Resident 69 has lap buddy while in wheelchair. The intervention indicated to attempt to use less restrictive devices on an ongoing basis and quarterly assessment and follow up by Interdisciplinary Team ([IDT] teams members from different disciplines who come together to discuss resident care). During a concurrent observation and interview on 6/5/2024 at 12:24 p.m., with Licensed Vocational Nurse (LVN 3) in the dining room, observed Resident 69 sitting in wheelchair with lap buddy restraint. LVN 3 stated Resident 69 had the lap buddy restraint since she was admitted to the facility and Resident 69 unable to remove the lap buddy restraint by herself. LVN 3 stated the lap buddy restraint of Resident 69 was for her safety because she had involuntary movements (abnormal, unintended, and uncontrollable movements that are not under a person's control) that put her at risk for falling. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2024 at 12:31 p.m., with the Minimum Data Set (MDS) coordinator, Resident 69's clinical records were reviewed. The MDS coordinator stated Resident 69's last physical restraint assessment evaluation was done on 10/10/2023. The MDS coordinator stated since Resident 69 had a physical restraint, she was at risk for skin breakdown and decline in activities of daily living. The MDS coordinator stated the facility did not conduct an ongoing quarterly physical restraint assessment evaluation for Resident 69 and no less restrictive measures were attempted. During an interview on 6/5/2024 at 1:53p.m., with the Director of Nursing (DON), the DON stated physical restraint was not a permanent order and should be re-assed frequently and attempt a trial reduction and discontinue based on resident needs. A review of facility's policy and procedure (P&P) titled, Physical Restraint, undated, the P&P indicated, The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly. The facility is to engage in a systematic and gradual process towards reducing restraints and when physical restraint is no longer effective or appropriate, an attempt to discontinue, reduce or modify restraints shall be discussed at the Quarterly Care Plan Conference.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042 Based on interview and record review, the facility failed to: 1. Ensure one of eight sampled residents (Resident 2), Preadmission Screening and Resident Review ([PASRR] a tool to determine if the person had, or was suspected of having a mental illness, intellectual disability [a term used when a person has certain limitations in cognitive functioning and skills, including communication, social and self-care skills], or related condition) level one (I) screening was re-submitted after a hospital exemption and Resident 2 had stayed in the facility for more than 30 days the appropriate state-designated authority for a PASRR level two (II) evaluation and determination. This deficient practice had the potential for Resident 2 not receiving the necessary and appropriate psychiatric level of treatment and evaluation in the facility. Findings: A review of Resident 2's Admission Record, the Admission Record indicated, Resident 2 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body), anxiety disorder (persistent and excessive worry that interferes with daily activities), and schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly). A review of Resident 2's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 5/28/2024, indicated Resident 2 was assessed to have a clear comprehension (the action or capability of understanding something). The MDS indicated Resident 2 was dependent from staff for activities of daily living (ADLs) such as showering, dressing, putting on and off footwear, personal hygiene, oral hygiene and eating. During a concurrent interview and record review on 6/6/2024 at 12:20 p.m. with the Minimum Data Set coordinator (MDS coordinator), Resident 2's Department of Health Care Services Letter (PASRR Letter), dated 2/23/2024 was reviewed. The PASRR letter stated, if the individual remains in the NF (Nursing Facility) longer than 30 days, the facility should resubmit a new level I screening as a Resident Review on the 31st day. The MDS coordinator stated, Resident 2's PASRR should have been submitted on the 31st day that the resident was here at our facility. The MDS coordinator stated, it was not resubmitted, the PASRR I should have been resubmitted. The MDS coordinator stated the PASRR was to be completed if there was a change of condition, new diagnosis, or when the facility could not obtain it from the hospital. The MDS coordinator stated a PASRR was required to be submitted so make sure the resident is receiving the services they need. During an interview on 6/7/2024 at 10:16 a.m. with the Director of Nursing (DON), the DON stated a PASRR is for assessing the resident to see what services the resident may need to receive. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), dated June 2024, the P&P indicated, the facility will submit a new Level I PASRR if pre-admission screening was exempted for fewer than 30 days of admission and remained at the facility longer than 30 day.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Fill out the Preadmission Screening and Resident Review ([PASRR], a tool to determine if the person had, or was suspected of having, a mental illness, intellectual disability, or related condition) level one screening and refer one of eight sampled residents (Resident 15) who had a diagnoses of schizophrenia (a serious mental illness that affects how a person thinks, feels, and behave) to the appropriate state-designated authority for PASRR level two evaluation and determination. This deficient practice had the potential to result in Resident 15 not receiving appropriate treatment recommendations for schizophrenia. Findings: A review of Resident 15's Admission Record, the Admission Record indicated, Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included schizophrenia and dementia (loss of cognitive functioning, thinking, remembering, and reasoning). A review of Resident 15's History and Physical (H&P), dated 5/6/2024, indicated, Resident 15 did not have the capacity to understand and make decisions. A review of Resident 15's Minimum Data Set ([MDS] resident assessment and care screening tool) under Section GG (Functional Abilities and Goals), dated 3/6/2024, the MDS indicated Resident 15 was totally dependent in oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. During a concurrent interview and record review on 6/5/2024 at 12:05 p.m., with the Minimum Data Set (MDS) coordinator, Resident 15's PASRR Level 1 Screening, dated 5/2/2024, was reviewed. The MDS coordinator stated the PASRR Level 1 Screening did not indicate Resident 15 had a diagnosed schizophrenia. The MDS coordinator stated Resident 15's case was closed due to no serious mental illness and a PASRR level two evaluation and determination were not required. The MDS coordinator stated Resident 15's PASRR Level 1 Screening was completed inaccurately. The MDS coordinator stated Resident 15's PASRR Level 1 Screening should had been marked as an individual with a diagnosed mental disorder of schizophrenia to trigger PASRR Level 2 evaluation and redetermination so Resident 15 could be evaluated and possibly receive appropriate treatment recommendations for schizophrenia. A review of facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), revised 6/2024, the P&P indicated, To ensure each resident with serious mental illness and/or developmental disability related conditions will have the appropriate setting, as well as if any specialized services and/or rehabilitative services would be needed. The P&P also indicated The facility will submit a new Level 1 PASRR is any error/discrepancy in the previous PASRR screening.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Implement care plan intervention of placing a bed alarm while in bed for one of three sampled residents (Resident 69) who was identified at risk for fall. This failure had the potential to cause further fall for Resident 69. Findings: A review of Resident 69's Admission Record, the Admission Record indicated, Resident 69 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and seizure disorder (sudden change in movement or awareness due to a change in the electrical function of the brain). A review of Resident 69's Minimum Data Set ([MDS] resident assessment and care screening tool) under Section C (Cognitive Patterns), dated 4/6/2024, the MDS indicated, Resident 69's cognitive (ability to reason, understand, remember, judge, and learn) skills for daily decision making was severely impaired. The MDS under Section GG (Functional Abilities and Goals) also indicated, Resident 69 required maximum assistance in bed mobility and totally dependent in oral hygiene, toileting hygiene, and personal hygiene. A review of Resident 69's Fall Risk Assessment, dated 4/8/2024, the Fall Risk Assessment indicated, Resident 69 had a total score of 20 (a score of 18 or more is considered as high risk for fall). A review of Resident 69's Care Plan ([CP] a form that summarizes a resident's health conditions, care needs and current treatment) dated 3/31/2023, the CP indicated Resident 69 had history of fall and high risk for fall. The intervention indicated to put bed alarm and to continue with low bed with floor mat. During an observation on 6/4/2024 at 10:41 a.m., in Resident 69's room, Resident 69 was observed trying to get out of bed, with no bed alarm. Resident 69 was on low bed with bilateral half side rails up with floor mat. During an interview and record review on 6/5/2024 at 2:01 p.m., with the Director of Nursing (DON), Resident 69's Situation, Background, Assessment, and Recommendation ([SBAR] a communication tool used by licensed staff after a resident has a change of condition), dated 6/4/2024, was reviewed. The DON stated Resident 69's SBAR indicated she rolled over on the floor mat. The DON stated Resident 69 was assessed as high risk for fall because of her poor cognition and episode of involuntary movement (abnormal, unintended, and uncontrollable movements that are not under a person's control). The DON stated she didn't know Resident 69 had a care plan intervention to place a bed alarm. The DON stated the purpose of the bed alarm was to alert the staff when resident is getting up unassisted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 3:26 p.m., with Licensed Vocational Nurse (LVN 4), LVN 4 stated Resident 69 had no bed alarm in bed. LVN 4 stated she found Resident 69 on 6/4/2024 at around 5:00 p.m. on the floor mat and was leaning on her left side. LVN 4 stated bed alarm should had been implemented because Resident 69 was high risk for fall and to prevent further fall. A review of facility's policy and procedure (P&P) titled, Personal Alarm, undated, the P&P indicated, Facility will use, as indicated, a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall. A review of facility's P&P titled, Managing Falls and Fall Risk, undated, the P&P indicated, The staff will implement a resident-centered fall prevention plan to reduce the specific risk factors for each resident at risk or with a history of falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observations, interview and record review, the facility failed to ensure: 1. A nasal cannula for oxygen use was dated and properly stored to prevent contamination for one out of 5 residents (Resident 41). This deficient practice had the potential to result in complications associated with oxygen therapy, negatively impacting the health and well-being of the resident. Findings: A review of Resident 41's admission record (face sheet) indicated Resident 41 was initially admitted on [DATE] with a readmitted [DATE]. Resident 41's face sheet indicated diagnoses that included Klebsiella Pneumoniae (a type of bacteria that is resistant to antibiotics), peripheral vascular disease (a slow and progressive blockage disorder of the blood vessels), dementia (a mental condition resulting in the loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). A review of Resident 41's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], indicated Resident 38 was severely cognitively impaired. Resident 41's MDS also indicated Resident 41 required extensive assistance from staff in ADLs (activities of daily living- an individual's daily self-care activities) with toileting, showering, and upper/lower dressing). A record review of Resident 41's vital signs indicated Resident 41 had received oxygen via nasal cannula on [DATE] at 09:36 p.m. A record review of Resident 41's physician order indicated Resident 41 did not have an order for oxygen. During an observation, on [DATE] at 10:04 a.m., in Resident 41's room, an oxygen concentrator machine and nasal cannula was observed sitting at the resident's bedside. The oxygen concentrator machine was off, and the nasal cannula tubing was observed undated, sitting on top of the oxygen concentrator without a protective covering to prevent contamination. During a concurrent observation and interview, on [DATE], at 8:50 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 observed nasal cannula sitting on top of the oxygen concentrator machine freely and undated. LVN 1 stated the oxygen tubing and nasal cannula had no date and did not have a protective covering. LVN 1 stated oxygen tubing should be labeled and kept in a plastic bag covering to prevent contamination from room air. LVN 1 stated the risk of not dating and labelling oxygen tubing could result in a resident becoming ill due to contamination of tubing and not knowing if or when the tubing was expired. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on [DATE], at 9:00 a.m., with LVN 1, LVN 1 stated she was unsure if Resident 41 was oxygen. Upon record review, LVN 1 stated Resident 41 did not have a physician's order for oxygen. LVN 1 stated the risk of not having a physician's order for oxygen usage could result in hyperoxia (excess oxygen in the body), atelectasis (the collapse of a lung or part of a lung) and/or oxygen poisoning. During an interview, on [DATE] at 10:16 a.m., with the Director of Nursing (DON), the DON stated a physician order was required to administer oxygen and all oxygen tubing was to be dated. The DON stated when oxygen tubing was not in use, tubing was to be placed in a plastic bag with a label showing resident's name and room number. The DON stated the risk of not having a physician's order for oxygen could cause many complications for a resident. The DON stated the risk of not covering oxygen tubing could result in a infection control violation. A review of the facility's policy and procedures, titled Oxygen Administration, dated ,d+[DATE], indicated to verify that there is a physician's order for this procedure. And After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. A review of the facility's policy and procedures, titled Oxygen Administration, dated ,d+[DATE], did not disclose if oxygen tubing should be covered with a protective covering when not in use.

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NAME OF PROVIDER OR SUPPLIER Sunnyview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 W Washington Bl Los Angeles, CA 90018	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47923 Based on interview and record review, the facility failed to: 1. Ensure a competency assessment skill (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) checks were performed yearly for three of five randomly selected staff. This deficient practice had the potential for the facility not be able to assess the skills necessary to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident will not be performed within the acceptable standards of practice. Findings: During a concurrent interview and record review on 6/6/2024 at 9:08 a.m., with the Director of Staff Development (DSD), five randomly employee files were checked. Certified Nursing Assistant (CNA 2), Certified Nursing Assistant (CNA 3), and Certified Nursing Assistant (CNA 5), did not have competency assessment skills done yearly. The DSD stated competency assessment skills check to be done upon hire and yearly. The DSD stated she was responsible for completing competency assessment skills for all CNA's. The DSD stated if CNA's were not competent to perform their daily tasks it would jeopardize residents health and safety. During an interview on 6/6/2024 at 10:15 a.m., with the Director of Nursing (DON), the DON stated all nursing staff should have a current competency assessment skill so they could provide the standard of care and practice within the regulations to all residents. A review of facility's policy and procedure (P&P) titled, Sufficient and Competent Nursing Staffing, revised 8/2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46832

Based on observation, interview and record review, the facility failed to ensure:

1. A received-by and delivery dates were placed on 3 tubs of frozen ice cream in

freezer # 5.

2. Dirty aprons were not placed in the dry storage area of the kitchen.

This deficient practice had the potential to result in foodborne illnesses.

Findings:

During an observation, on [DATE] at 8:50 a.m., at Freezer # 5 in the kitchen, Freezer # 5 was observed to have had three ice cream tubs (3 gallons each) with no received-by and delivery date labeled on the items.

During a concurrent observation and interview, on [DATE] at 9:15 a.m., a dirty apron bin was observed sitting in the dry storage area. Dietary [NAME] 1 (DC 1) stated the dirty apron bin was not supposed to be in the dry storage area. DC 1 stated the risk of having a dirty apron bin in the dry storage care could result in contaminating the food.

During a concurrent observation and interview, on [DATE] at 9:05 a.m., with DC 1 at Freezer # 5, DC 1 stated the 3 tubs of ice cream (1 rainbow sherbet (opened) tub, 2 vanilla tubs) were not dated. DC 1 stated the 3 tubs of ice cream should had been dated. DC 1 stated the risk of not labeling dates on food items could result in not knowing whether the tubs were expired and cause residents to become sick.

During an interview, on [DATE] at 9:30 a.m., with the Dietary Supervisor 1 (DS 1), DS 1 stated all food items should be labeled with a received-by and delivery date. DS 1 stated the 3 ice cream tubs did not have a received by and delivery date. DS 1 stated the risk of not labeling food items could result in possible contamination, possible expiration and foodborne illnesses amongst residents.

During an interview, on [DATE] at 9:45 a.m., with the Dietary Supervisor 1 (DS 1), DS 1 stated all dirty apron bins are kept away from food items in the kitchen. DS 1 stated the dirty apron bin in the dry storage was not supposed to be there. DS 1 stated the risk of having the dirty apron bin in the dry storage area could result in contaminating items in the dry storage area and cause residents to become ill.

A review of the facility's policy and procedures, titled Storage of Canned and Dry Goods, undated, indicated the storage will be clean, dry, well-ventilated at all times.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures, titled Refrigerator/Freezer Storage, undated, indicated All items should be properly covered, dated and labeled. Food items should have the following appropriate dates: Delivery date- upon receipt, Open date- opened containers of PHF. And Frozen [NAME] taken from the original packaging should be labeled and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review the facility failed to: 1. Document one of one sampled resident (Resident 65)'s refusing splints (an external device used to support and immobilize an injury or joint) on the left hand and left knee. This failure had the potential to result in Resident 65's existing contractures (tightening of the muscles and tendons that causes the joints to shorten and become very stiff) to worsen. Findings: A review of Resident 65's of Admission Record (face sheet), the Admission Record indicated, Resident 65 was admitted to the facility on [DATE] with diagnosis including cerebral infarction (a lack of adequate blood supply to the brain cells, damage to tissues in the brain due to a loss oxygen to the area), contracture of the left hand, major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily living). A review of Resident 65's History and Physical (H&P), dated 4/18/2024, the H&P indicated, Resident 65 was able to make decision for activities of daily living. A review of Resident 65' Minimum Data Set (MDS), a specialized assessment and care screening tool, dated 4/8/2024, the MDS indicated, Resident 65's was dependent on staff in toileting, personal hygiene, upper and lower body dressing. The MDS indicated that the resident was provided passive range of motion (motion assisted by staff where the resident does not perform any movement independently) and splint or brace assistance was performed at least 15 minutes in the last 7 calendar days prior to the MDS assessment. A review of Resident 65's order summary report printed 6/6/2024 at 2:31 p.m., indicated an active physician's order for restorative nursing assistant (RNA) to apply left hand and left elbow splint for 4 to 8 hours as tolerated daily 7 times a week and to perform passive range of motion to both lower extremities daily, seven times a week. The RNA stated Resident 65 refused to wear the splints. During observation and interview on 6/4/2024, at 10:46., with Resident 65, the resident was observed in his room, lying in his bed. The resident was observed with no splints on the left hand and left knee. During an observation of Resident 65 on 6/6/2024 at 9:02 a.m., in the facility day room, the resident was observed to have no splint on the left hand and left knee. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2024 at 9:02 a.m. with Restorative Nurse Assistant (RNA) 1, RNA 1 stated he stored the splints in Resident 65's drawer. RNA 1 stated the reason for the RNA program was to avoid contractures and to keep the resident's level of functioning. RNA 1 stated he did not document Resident 65's refusal of the wearing the splints. A concurrent record review of Resident 65's medical record indicated no documentation on RNA services. RNA 1 stated he forgot to document weekly and needed to catch up. During a concurrent interview and record review on 6/6/2024, at 1:55 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was not aware Resident 65 was taking off his splints. A review of Resident 65's medical records indicated no documentations found regarding Resident 65 refusing to wear his splints. During an interview on 6/6/2024 at 2:49 p.m, with the Director of Nursing (DON), the DON stated the RNA was supposed to document the resident refusing the splints and report to the charge nurse. A review of facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, indicated, documentation in the medical record will be objective, complete, and accurate .documentation of procedures and accurate .documentation of procedures and treatments will include care-specific details including: a. date and time the procedure/treatment was provided. b. the name and title of individual's who provided the care.

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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** 47042 Based on observation, interview, and record review, the facility failed to: 1. Implement infection control measures for two of two sampled residents (Residents 15 and 24) by failing to wear Personal Protective Equipment ([PPE] gown - specialized clothing or equipment worn by an employee for protection against infectious materials) prior to entering and administering medication via g-tube to Resident 15 and Resident 24 on Enhanced Standard Precautions ([ESP] a resident-centered and activity-based approach for preventing Multiple Drug Resistant Organism ([MDRO]-are bacteria that have become resistant to certain antibiotics) transmission in skilled nursing facilities). This deficient practice had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another), spread of infections and placed other residents at risk for infection. Findings: A review of Resident 15's Admission Record, the Admission Record indicated, Resident 15 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included peripheral vascular disease (blood circulation disorder that causes the blood vessels outside of you heart and brain to narrow, often in legs), type 2 diabetes mellitus (abnormal blood sugar), and heart failure ([AKA: CHF], a condition that develops when your heart doesn't pump enough blood for your body's needs). A review of Resident 15's History and Physical (H&P), 5/6/2024, indicated Resident 43 did not have the capacity to understand and make decisions. A review of Resident 15's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 3/6/2024, indicated Resident 15 was assessed to rarely/never understands others. The MDS indicated Resident 15 was dependent on staff for activities of daily living (ADLs) such as showering, positioning, dressing, putting on and off footwear, and was independents for personal hygiene, and oral hygiene. A review of Resident 15's Order Summary Report (physician orders), dated 5/1/2024, indicated resident was placed on enhanced standard precautions due to gastrostomy tube ([g-tube] a tube inserted through the belly that brings nutrition directly to the stomach.) and wounds. A review of Resident 15's Care Plan: Moderate risk for infection feeding tubes, initiated on 1/24/2024, the care plan's interventions indicated provide enhanced standard precautions. A review of Resident 24's Admission Record, the Admission Record indicated, Resident 24 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 24's diagnoses included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Acute kidney failure (sudden loss of the ability of the kidneys to function), type 2 diabetes mellitus (abnormal blood sugar), and anxiety disorder (persistent and excessive worry that interferes with daily activities). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 24's H&P, dated 2/10/2024, indicated Resident 24 did not have the capacity to understand and make decisions. A review of Resident 24's MDS, dated [DATE], indicated Resident 24 was assessed to rarely/never understand others. The MDS indicated Resident 24 was dependent on staff for ADLs such as showering, positioning, dressing, putting on and off footwear, and was independents for personal hygiene, and oral hygiene. A review of Resident 24's physician orders, dated 4/4/2024, indicated resident was placed on enhanced standard precautions due to g-tube. A review of Resident 15's Care Plan: Enhanced Standard Precaution, initiated on 1/24/2024 and last revised on 2/26/2024, the care plan's interventions indicated provide enhanced standard precautions gloves, gown, and mask. During an interview on 6/6/2024 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 15 was on ESP, and proper PPE was not put on before administering the resident's g-tube medication. LVN 1 stated, by not wearing PPE there was a risk of infection to the resdients or from the resident or to the staff. LNV 1 stated ESP is used for all procedures that has close contact with the resident. During an interview on 6/6/2024 at 11:00 a.m. with the Infection Preventionist (IP) nurse, the IP nurse stated, ESP are needed when resdients have a g-tube, and the staff should wear proper PPE when caring for the resdients and doing treatment or procedures such as g-tube medication administration. The IP nurse stated, if proper PPE is not used when a resident is on ESP you can potentially compromise the residents or yourself. The IP nurse stated, the staff should have gowned up before they administered g-tube medication. During an interview on 6/7/2024 at 10:16 a.m. with the Director of Nursing (DON), the DON stated, ESP were put in place for infection control to help prevent the spread of infection. The DON stated, the nurse should use proper PPE when medications are given to residents with g-tubes. The DON stated if a treatment was performed to a resident with ESP and are not in proper PPE it would possibly affect the resident or the residents by spreading an infection. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier (Standard) Precautions, January 2024, the P&P indicated, Enhanced barrier precautions (EBPs or ESPs) are used as an infection prevention ad control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs/ESPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs/ESPs include device care or use (feeding tube).