STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555085	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Manor Care Center	621 W Bonita Ave Claremont, CA 91711

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 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** 48905 Based on interview and record review, the facility failed to implement the facility's policy on Advance Directives (AD, legal document that indicates wishes for medical care if unable to speak for self) by failing to ensure one of one sampled resident's (Resident 27) code status was correct when Resident 27 had a Medical Doctor (MD) order for full code (when the resident's heart stops beating and/or the resident stops breathing, the resident or the resident's representative wish to perform all lifesaving procedures to keep the resident alive) and an emergency Medical Services Prehospital Do Not Resuscitate (DNR, medical order by MD to not provide cardiopulmonary resuscitation [CPR, an emergency lifesaving procedure, consisting of a combination of chest compressions, mouth-to-mouth, or mechanical breathing [a device used to help someone breathe]) Form (EMSPDNR). This failure had the potential to result in Resident 27 to receive incorrect emergency services. Findings During a review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic (long standing) systolic heart failure (heart cannot pump blood effectively in the body), atrial fibrillation (irregular heart rhythm), and hyperlipidemia (high levels of cholesterol [fat] in the body). The AR indicated Resident 27 was a full code. During a review of Resident 27's Order Summary Report (OSR), active orders as of [DATE], the OSR indicated an MD order, dated [DATE], the order indicated Resident 27 had an MD order for full code status. During a concurrent interview and record review on [DATE] at 3:43 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 27's EMSPDNR form, dated [DATE], and OSR with MD order, dated [DATE] were reviewed. LVN 1 stated the EMSPDNR form was signed for DNR and there was an active MD order indicating full code in Resident 27's electronic medical record (EMR). LVN 1 stated based off the EMSPDNR form, Resident 27 should be a DNR and stated the code status on both forms were not consistent. LVN 1 stated the risk of not having the correct code status was that the resident could receive the incorrect emergency services. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:56 PM with the Social Services Designee (SSD), the SSD stated staff verified the resident's code status during the initial care plan meeting. The SSD stated the SSD spoke with Resident 27's responsible party (RP) and the RP stated Resident 27 should be DNR and signed for DNR form on [DATE]. The SSD stated there was still an order for full code and stated the code status should've been updated to DNR when the MD signed the EMSPDNR form. The SSD stated the risk of not updating the code status for the resident was that the resident could have possibly received the wrong emergency services. During an interview on [DATE] at 4:49 PM with the Director of Nursing (DON), the DON stated nursing staff should've updated the resident's code status from full code to DNR in the EMR once nursing staff saw the signed EMSPDNR form. The DON stated the risk was that staff could've seen the resident was full code on the EMR and provided care that the resident would not have wanted. During a review of the facility's policy and procedure (P&P) titled, Advance Directives revised ,d+[DATE], the P&P indicated staff will inquire about the existence of a pre-existing medical order for DNR, or another document that directs the resident's health care such as a do not hospitalize (DNH).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interviews and record review, the facility failed to ensure Registered Nurse 1 (RN 1) notified one of one sampled resident's (Resident 92) physician/medical doctor (MD 1) regarding Resident 92's increased agitation (unable to relax and be still) and confusion (unable to think clearly) when Resident 92 attempted to stand up unassisted from Resident 92's wheelchair (WC) multiple times on 1/20/2025 as indicated in the facility's policy and procedure (P&P) titled, Change in Resident Condition. This deficient practice had the potential to result in a physical decline to Resident 92. Cross Reference F744 Findings: During a review of Resident 92's Admission Record (AR), the AR indicated Resident 92 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's Disease (AD, a progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks), and psychosis (a mental health condition characterized by a loss of contact with reality). During a review of Resident 92's Progress Notes (PN), dated 1/16/2025, timed at 3:10 PM, the PN indicated Resident 92 was alert (a state of careful watching and readiness) and had some forgetfulness. During an interview with Registered Nurse (RN)1 on 1/22/2025, at 11:48 PM, RN 1 stated upon Resident 92's admission (1/16/2025), Resident 92 was non-verbal and did not attempt to get out of bed. RN 1 stated on 1/20/2025, during the AM shift, Resident 92 was placed at the nurse's station for constant (occurring continuously oer a period of time) monitoring because Resident 92 consistently attempted to stand up, mumbled, and spoke to herself. RN 1 stated, she (RN 1) did not notify MD 1 about the change in Resident 1's condition/mentation (the ability, activity, or result of using your mind to think). During an interview and concurrent record review with the Director of Nursing (DON) on 1/24/2025, at 8:55 AM, the DON stated a change in resident's condition (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), was defined as someone not at their baseline (an initial condition taken at an early time and used for comparison over time to look for changes). The DON stated on 1/20/2025, when Resident 92 had an increase in confusion and was attempting to get up [from the bed/ wheelchair], this behavior made Resident 92 at risk for falling. The DON stated RN 1 needed to call and notify MD 1 to make MD 1 aware of what was going on when Resident 92 had an increase in confusion and started to get up unassisted while on the WC. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RN Consultant (RNC) on 1/24/2025, at 11:09 AM, the RNC stated a COC was defined as anything out of the normal for a resident. The RNC stated a COC was a sudden or progressive change; the occurrence of something unusual for the resident. The RNC stated increased confusion was considered a COC. The RNC stated, during a COC, the facility should immediately inform the resident's physician (MD 1). The RNC stated it was important to inform MD 1 to see if further investigation was needed, additional labs, increased monitoring, medication changes, and to make MD 1 aware of Resident 92's condition. During an interview with Hospice (medical care for people who are expected to live six months or less) Registered Nurse (HRN) 1 on 1/24/2025 at 11:13 AM, HRN 1 stated Resident 92 was confused, disoriented, and was at risk for falls. HRN 1 stated increased confusion was considered a COC and HRN 1 expected the facility to inform the hospice agency. HRN 1 stated the hospice agency or MD 1 were not informed of Resident 92's increased confusion and the agency was not aware of Resident 92's multiple attempts to get up from the WC. HRN 1 stated if informed, we [hospice agency] would have sent out a nurse to reassess or to rule out the cause of the change in mentation and notified MD 1 to obtain new physician orders with new interventions that benefited Resident 92. During a review of the facility's P&P, titled Change in Resident Condition, revised 11/2016, the P&P indicated changes in a resident condition will be communicated to the physician timely. The P&P indicated any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior, will be communicated to the physician . The P&P indicated the nurse in charge is responsible for notification of physician prior to the end of the assigned shift when a change in a resident's condition is noted.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to ensure the facility's Advance Beneficiary Notice of Non-coverage (SNFABN, a form that informs residents/responsible parties [RPs] Medicare may not cover certain items or services) form was signed for one of one sampled resident (Resident 26). This failure had the potential to result in the resident or the resident's RP to not make informed decisions regarding possible denied medical coverage. Findings: During a review of Resident 26's Admission Record (AR), the AR indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks), hearing loss, and visual loss. During a review of Resident 26's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 10/21/2024, the H&P indicated Resident 26 did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/26/2024, the MDS indicated Resident 26's cognitive abilities (ability to think, learn, and process information) were severely impaired. During a concurrent interview and record review on 1/24/2025 at 10:34 AM with the Social Services Designee (SSD), Resident 26's SNFABN form was reviewed. The SNFABN form indicated the form was not signed by Resident 26 or the resident's RP. The SSD stated the SNFABN form's purpose was to indicate the resident or resident's RP were aware of the services for the last covered date which would include payment and pricing after the last covered date. The SSD stated there were no signatures in Resident 26's SNFABN form and stated the risk of not having the SNFABN form signed was that the resident or resident's RP could dispute it because the form indicated they were not aware of the billing and costs. During a review of the facility's undated form titled, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566, the form indicated the ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to develop and implement an individualized person-centered care plan (CP), for four of four sampled residents (Resident 37, Resident 27, Resident 6, and Resident 5), as indicated in the the facility's policy and procedure (P&P), tilted, Care Plan, by failing to, a. Develop a care plan (CP) for Resident 37 when there was a change in skin condition on 1/11/2025. b. Develop a CP for Resident 27 for anticoagulant (class of medication that help prevent blood clots from forming in the heart and blood vessels) use when Resident 27 received Eliquis (medication used to prevent blood clots) tablet 2.5 milligrams (mg, unit of measurement) by mouth twice a day. c. Develop a CP for Resident 6 for antipsychotic (class of medications used to treat symptoms such as hearing voices and hallucinations) use when Resident 6 received Quetiapine (antipsychotic medication to that helps regulate mood, behavior, and thoughts) 25 mg by mouth at bedtime for poor impulse control manifested by yelling and screaming spells. d. Develop a CP that addressed Resident 5's diagnosis of Dementia (a decline in mental ability severe enough to interfere with daily life). These failures had the potential to result in unmet individual needs and incorrect care and services for Residents 37, 27, 6, and 5 to achieve optimal level of function and the potential to affect the resident's physical well-being. Cross reference F686 Findings: a. During a review of Resident 37's Admission Record (AR), the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included anxiety, Raynaud's Syndrome (condition that causes blood vessels in the extremities to narrow), and dysphagia (difficulty swallowing). During a review of Resident 37's History and Physical (H&P), formal document of a medical provider's examination of a patient) dated 12/27/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 1/2/2025, the MDS indicated Resident 37's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 37 required maximal assistance with rolling left and right. During a review of Resident 37's Continuous Pressure Ulcer Prevention (CPUP) form dated 1/11/2025, the CPUP form indicated a skin change with a circle on the rear side of the anatomical diagram. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 27's AR, the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic systolic heart failure (heart cannot pump blood effectively in the body), atrial fibrillation (a-fib, irregular heart rhythm), and hyperlipidemia (high levels of cholesterol in the body). During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27's cognitive abilities were intact and indicated Resident 27 was taking an anticoagulant. During a review of Resident 27's Order Summary Report (OSR) dated 1/13/2025, the OSR indicated Resident 27 had a Medical Doctor (MD) order for Eliquis tablet 2.5 milligrams by mouth twice a day for a-fib. c. During a review of Resident 6's AR, the AR indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included dementia. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6's cognitive abilities were moderately impaired and indicated Resident 6 was taking an antipsychotic medication. During a review of Resident 6's H&P dated 1/9/2024, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's OSR dated 1/10/2025, the OSR indicated Resident 6 was receiving Quetiapine Fumarate 25 mg one tablet by mouth at bedtime for poor impulse control manifested by yelling/screaming spells. During an interview on 1/24/2025 at 8:48 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 27 was on Eliquis and stated there was no CP for Eliquis. RN 1 stated RN 1 was unsure if residents required a CP for anticoagulant therapy and stated the purpose of a CP was to ensure staff are meeting the needs of the resident and to guide staff in implementing interventions. RN 1 stated the risk of not having a CP for anticoagulant therapy was that there would be no identification resident was a high risk for bleeding or bruising. During an interview on 1/24/2025 at 8:53 AM with RN 1, RN 1 stated Resident 6 was on Quetiapine and stated there was no CP for antipsychotic use. RN 1 stated there should be a CP for antipsychotics for monitoring of the drug, goal of the drug usage, and specific interventions for staff to follow. RN 1 stated the risk of not having a CP for specific antipsychotic drug use was that staff could miss the specific interventions for the specific target behavior and put the resident at risk for unnecessary medication use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/24/2025 at 1:52 PM with RN 1, Resident 37's PN dated 1/11/2025 timed at 9:34 AM was reviewed. The PN indicated a new order for Optifoam (dressing used to treat pressure ulcers, lacerations, abrasions, skin tears, and first- and second-degree burns) for protection of bony prominence of bilateral heels and coccyx and indicated the CP was updated. RN 1 stated RN 1 was made aware by a CNA on 1/11/2025 of a skin change for Resident 37. RN 1 stated the skin on the coccyx area was an unstageable pressure injury (UPU, bed sore where the severity of the wound cannot be accurately determined because it is covered by thick layer of dead tissue) or deep tissue injury (DTI, damage to soft tissue underneath the skin). RN 1 stated RN 1 did not create a CP when the skin change was identified on 1/11/2025 and stated there should've been a CP indicating when the injury started to ensure it was not getting worse. RN 1 stated the risk of not creating a CP for the wound on the coccyx was that there would be no monitoring and implementation of specific interventions. 38108 d. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnosis that included Dementia, depressive disorder (causes feelings of sadness and/or a loss of interest in activities once enjoyed), lack of coordination (inability to control the movement of one's body) and feeding difficulties. During a review of Resident 5's H&P, dated 8/3/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of a MDS, dated [DATE], the MDS indicated Resident 5's hearing and vision were highly impaired (absence of) and Resident 5 did not speak. The MDS indicated Resident 2 was dependent (helper does all the effort) on eating, personal hygiene, showering, dressing, and sit to lying position. During an interview with Licensed Vocational Nurse (LVN) 5 and concurrent record review of Resident 5's paper and electronic medical records, on 1/24/2025 at 9:46 AM, LVN 5 stated Resident 5 did not have a CP for Dementia. LVN 5 stated Resident 5 should have a CP for cognitive impairment related to Dementia to address Resident 5's specific behaviors. LVN 5 stated CPs were necessary to address resident needs and continuity of care, especially for residents with behavioral issues. During a review of the facility's P&P, titled Care Planning, revised on 2/2021, indicated a comprehensive written plan is developed based on the Minimum Data Set (assessment and care-screening tool), to meet the individual needs of the resident in 14 days with corrections or addition made within 21 days. Resident care plan will be written in black in and maintained as part of the resident's health record. The P&P indicated the CP will identify problems or needs and should indicate the date when the problem was identified and potential problems as identified by the MDS, such as, drug therapy. The P&P indicate the CP is to be updated quarterly and upon a change of condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to revise a care plan (CP) for two of two sampled residents (Resident 92 and Resident 5) when, A. Resident 92's CP for alteration in cognitive function related to Alzheimer's Disease (AD, a progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks)/Dementia was not updated to include Resident 92's increased confusion on 1/20/2025. B. Resident 5's CP for depression was not updated to include use and current physician order for trazadone (medication used to treat depression [causes feelings of sadness and/or a loss of interest in activities]). These deficient practices had the potential to result in Residents 92 and 5 to not receive the necessary care and services in accordance with their specific needs. Findings: A. During a review of Resident 92's Admission Record (AR), the AR indicated Resident 92 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's Disease, and psychosis (a mental health condition characterized by a loss of contact with reality) and psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review of Resident 1's PN, dated 1/19/2025, timed at 7:41 pm, the PN indicated Resident 1 was confused. During a review of Resident 92's Baseline CP, signed on 1/17/2025, indicated Resident 92 was confused, non-verbal, and was unable to be oriented due to Dementia (a decline in mental ability severe enough to interfere with daily life). During an interview with Licensed Vocational Nurse (LVN) 3, on 1/21/2025 at 3:43 PM, LVN 3 stated Resident 92 was more confused and needed to be placed at the nurse's station for 1:1 monitoring (one staff supervising one resident). During an interview with Certified Nurse Assistant 3 (CNA 3) on 1/22/2025, at 11:23 AM, CNA 3 stated the morning of 1/20/2025, Resident 92 seemed to be more confused. CNA 3 stated the resident attempted to get out of the wheelchair (WC) unassisted and needed to be wheeled to the nurse's station for constant (occurring continuously over a period of time) monitoring. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1) and a concurrent record review of Resident 92's CP for alteration in cognitive function related to Alzheimer's Disease/Dementia, on 1/24/2025 timed 2:51 PM, RN 1 stated, on 1/20/2025, Resident 92 constantly attempted to stand up and get out of Resident 92's WC. RN 1 stated Resident 92 experienced increased agitation (nervous excitement) and confusion (lack of understanding). RN 1 stated Resident 92's (CP) was not updated to indicate the resident's increased confusion. RN 1 stated CPs should be updated for appropriate interventions to be put in place. B. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnosis that included Dementia, depressive disorder (causes feelings of sadness and/or a loss of interest in activities once enjoyed), lack of coordination (inability to control the movement of one's body) and feeding difficulties. During a review of a History and Physical (H&P), dated 8/3/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of a Minimum Data Set (MDS, a federally mandated resident assessment and care-screening tool), dated 11/8/2024, the MDS indicated Resident 5's hearing and vision were highly impaired (absence of) and Resident 5 did not speak. The MDS indicated Resident 2 was dependent (helper does all the effort) on eating, personal hygiene, showering, dressing, and sit to lying position. During a review of Resident 5's Order Summary Report (OSR) dated active as of 1/22/2025, the OSR included a physician's order, dated 1/16/2025, the order indicated Trazadone 100 milligrams (mg, unit of measurement) taken by mouth at bedtime for depression manifested by insomnia (persistent problems falling and staying asleep). During a review of Resident 5's Medication Administration Record (MAR) for January 2025, the MAR indicated Resident 5 was administered Trazadone 100 mg from 1/1/2025 to 1/20/2025. During an interview with LVN 5 and concurrent record review of Resident 5's paper and electronic medical records, on 1/24/2025 at 9:46 AM, LVN 5 stated Resident 5's CP for depression was not updated; the CP indicated Trazadone 50 mg daily. The CP did not reflect the current physician order for Trazadone 100 mg. LVN 5 stated it was important to update CPs for staff to be aware of any updates and to know how to properly care for Resident 5. During a review of the facility's policy and procedure titled Change in Resident Condition, revised 11/2016, the P&P indicated . update resident CP as indicated. During a review of the facility's P&P titled Care Planning, revised on 2/2021, the P&P indicated resident care planning includes . with continual reassessment and updating at least quarterly and upon [resident] change of condition . Assessing and evaluating CPs. When evaluating and reassessing the plan of care for the resident, the following shall be considered: are the resident's problems still current? Are there new problems? Are the actions/approaches appropriate? Effective?

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview and record review, the facility failed to ensure residents who were at risk for skin breakdown and pressure injuries (PIs, localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) received treatment and services to prevent skin breakdown for two of three sampled residents (Resident 32 and Resident 37) who had PIs by failing to ensure, A. Resident 32's LAL mattress (LAL Mattress -air filled mattress used to relieve pressure) was set according to Resident 32's weight of 138 pounds (lbs.). Resident 32's LAL mattress was set at 550 pounds (lbs.). B. For Resident 37, 1.The facility did not Provide documented evidence to show Resident 37 was repositioned every two hours during the night shift (10:30 PM to 6:30 AM) from 12/26/2024 to 1/24/2024. 2. Perform weekly skin assessments as indicated in Resident 37's care plan (CP), dated 1/2/2025, for two weeks. 3. Perform treatment for the unstageable PI (UPI, pressure ulcer [injuries to the skin and underlying tissue that are result of pressure on the skin for long periods of time] that is not stageable due to coverage of the wound by slough [white, yellow, tan, gray, or green in color that consist of dead tissue] and or eschar [thick, dry, black or brown scab like covering that forms over the wound]) on the coccyx (small triangle shaped bone at the end of the vertebral [spine] column) for Resident 37 on 1/12/2025. 4. Initiate pressure relieving devices when the UPI on the coccyx was discovered on 1/11/2025. 5. Registered Nurse 1 (RN 1) created a change of condition (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains, an initial assessment and used to monitor progress), when the UPI on Resident 37's coccyx was discovered on 1/11/2025. These deficient practices had the potential to result the development of new PIs and worsened existing PIs to Residents 32 and 37. Cross reference F656 Findings: A. During a review of Resident 32's Admission Record (AR), the AR indicated the facility admitted Resident 32 on 6/26/2024, and readmitted the resident on 10/30/2024, with diagnoses including hemiplegia/hemiparesis (paralysis [complete or partial loss of muscle function] on one side of the body), and hemiparesis, muscle weakness (generalized), and need for assistance with personal care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/4/2024, the MDS indicated Resident 32 had severe cognitive (the ability to think and process information) impairment. The MDS indicated Resident 32 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During a review of Resident 32's Pressure Sore Risk, dated-signed 11/6/2024, indicated Resident 32 was at high risk for pressure sores. During a review of Resident 32's Order Summary Report (OSR), dated 1/23/2025, the OSR indicated low air loss mattress (LAL Mattress) related to (R/T) wound management every day shift. During an observation on 1/21/2025 at 11:25 AM, Resident 32's LAL Mattress was set at 550lbs. During a review of Resident 32's Order Summary Report, dated 1/23/2025, indicated low air loss mattress (LAL Mattress) related to (R/T) wound management every day/shift. During a concurrent interview and record review on 1/22/2025 at 11:20 AM, with Licensed Vocational Nurse (LVN) 3, Resident 32' s Clinical Weights and Vitals, dated 1/20 /2025, was reviewed in the electronic medical record. The Clinical Weights and Vitals indicated Resident 32 was 138lbs. LVN 3 stated Resident 32's LAL mattress setting was set too high. LVN 3 stated the LAL Mattress was designed to help prevent and treat PIs by redistributing pressure on the body and promoting skin health. LVN 3 stated a LAL mattress was only effective when properly adjusted and setting the mattress too high reduced its ability to maintain proper pressure redistribution, airflow, and moisture management, which were critical to preventing skin damage and PIs. During an interview on 1/24/2025 at 11:41 AM, with the Director of Nursing (DON), the DON stated that the purpose of setting the LAL mattress to the patient's correct weight was to ensure that the mattress provided effective pressure relief, maximized comfort, and helped prevent skin damage, particularly for residents who were at risk of pressure ulcers. The DON stated that when the setting isn't accurately adjusted, it could lead to inadequate pressure relief, which defeated the purpose of using the LAL mattress intended to prevent or treat pressure ulcers. During a review of the facility's policy and procedure (P&P) titled, Mattress, Low Air Loss, revised 2/2009, the P&P indicated the purpose of the policy was to reduce the mechanical forces of pressure, shear, friction, and moisture, which contribute to skin breakdown and to promote wound healing. During a review of the LAL Mattress Operation Manual Protekt Aire 8000, the operation manual indicated the pump and mattress system is intended to reduce the incidence of pressure ulcers while optimizing patient comfort. The manual indicated the product function press pressure range was adjustable pressure range selected by the patient's weight guide listed on the panel providing pressure range options. The manual indicated, - Individual home care setting and long-term care. - Pain management as prescribed by a physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/2025 at 10:48 AM with the Infection Prevention Nurse (IPN), the IPN stated the facility did not have a designated Treatment Nurse, so staff take turns on doing wound treatments and care. The IPN stated there was no COC documented for the change in skin condition that occurred on 1/11/2025. The IPN stated the risk of not completing a COC was that the wound would not be monitored and would worsen. The IPN stated wound treatment was missed on 1/12/2025 and stated the risk of missing treatment was that the wound could worsen. The IPN stated the wound opened on 1/13/2025. The IPN stated weekly skin evaluations/assessments were not completed as indicated in Resident 37's CP and stated skin evaluations were completed on 12/26/2024, 1/15/2025, and 1/22/2025. The IPN stated weekly skin evaluations should've been completed weekly to follow the CP and stated the purpose of doing weekly skin evaluations was to ensure staff was not missing any new skin issues. The IPN stated the risk of not implementing the CP intervention was that staff would not be able to assess the skin for any new changes especially since Resident 37 was a high risk for skin breakdown. Concurrent interview and record review on 1/24/2025 at 1:49 PM with the Director of Staff Development (DSD), Resident 37's POC Response History dated 12/26/2024 to 1/24/2025 were reviewed. The DSD stated there was no documentation indicating Resident 37 was turned or repositioned every two hours during the night shift as the night shift documented once at the end of the shift. The DSD stated staff should be documenting turning and repositioning every two hours to follow the resident's CP. The DSD stated if there was no documentation indicating turning and repositioning, this indicated it was not done. During an interview on 1/24/2025 at 1:52 PM with RN 1, RN 1 stated RN 1 was made aware of the change in skin condition by staff on 1/11/2025. RN 1 stated the wound on Resident 37's coccyx was either an UPI or a DTI (deep tissue injury, damage to deeper underlying structures overlaid with intact or non-intact skin) with some slough (layer of soft, yellow, or white dead tissue in the wound bed) around it. RN 1 stated RN 1 did not complete a COC and stated the purpose of creating a COC was to notify the care team of the change, assess, and monitor the change. RN 1 stated the risk of not creating a COC was that there was no initial assessment completed which could put the UPI at risk of getting worse. RN 1 stated CNAs were responsible for turning and repositioning the residents every two hours and stated RN 1 did not see any documentation for turning and repositioning during the shift from 12/26/2024 to 1/24/2025. RN 1 stated no documentation indicated the task was not done and possibly could lead to skin breakdown. RN 1 stated weekly skin assessments were not done based on the CP's interventions and stated two weeks were missed. RN 1 stated the importance of doing weekly skin assessments was to monitor the progress of the wound and stated the risk of not doing skin assessments was that the wound could get worse. RN 1 stated treatment to the coccyx was missed on 1/12/2025 and stated the wound opened on 1/13/2025, one day after the missed treatment. RN 1 stated the importance of following treatment orders was to prevent the wound from getting worse. RN 1 stated a LAL mattress is initiated when residents have a wound and stated a LAL mattress should have been initiated on 1/11/2025 when the UPI was found. RN 1 stated the delay in implementing pressure relieving devices was that it could make the UPI worse. During an interview on 1/24/2025 at 2:58 PM with Resident 37 in Resident 37's room, Resident 37 was observed to be lying in bed on Resident 37's back. Resident 37 stated staff turn Resident 37 sometimes and stated Resident 37 was unsure how Resident 37 acquired the UPU on the coccyx. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/2025 at 4:49 PM with the Director of Nursing (DON), the DON stated staff were to call the physician, notify the responsible party (RP), create a COC and implement a CP when a PI was developing. The DON stated the purpose of creating a COC was to inform the care team of the new condition and if any interventions or orders were placed. The DON stated if turning and repositioning every two hours was indicated in Resident 37's CP, the task should be added to the medical record, if the task was not added it meant staff did not complete the task. The DON stated it was important the resident received treatment as ordered and stated that if treatment was missed there was a possibility the wound would not heal. The DON stated the risk of not doing skin assessments weekly per the CP was that staff could miss a new skin issue and stated once a change in skin condition was identified a LAL mattress should've been implemented to reduce pressure on the wound as soon as possible. During an interview on 1/24/2025 at 5:20 PM with the IPN, the IPN stated the order for the LAL mattress for Resident 37 was placed on 1/14/2025. The IPN stated, the facility received the mattress on the same day and the LAL was implemented on 1/14/2025. During a review of the facility's policy and procedure (P&P) titled Skin/Wound Assessment and Treatment revised 12/2013, the P&P indicated the first step was to complete a thorough assessment of the skin/wound which would include: a. Size of the wound: length, width, depth, undermining, and tunneling. b. Specific location of the wound. c. Type of wound: pressure, venous, arterial, diabetic, and or neuropathic. d. Stage of the wound: stage one to four, any presence of eschar or slough. e. Additional assessments: presence of exudate, edema, pain, condition of the wound bed, and signs and symptoms of infection. The P&P indicated to place adaptive equipment such as pressure reducing mattresses, pressure relieving cushions, positioning devices, etc. The P&P indicated a treatment sheet will be initiated to record each treatment site and will be signed by the nurse when the treatment is completed. The P&P indicated the CP will be updated to address the plan of care for each site along with preventative measures to prevent further breakdown. The P&P indicated nursing notes will include and initial nursing note describing the skin/wound and treatment ordered and ongoing wound assessment.

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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** 48905 Based on observation, interview, and record review, the facility failed to implement the facility's policy titled Oxygen Therapy by failing to: a. Connect Resident 12's Nasal Cannula (NC, medical device that provides oxygen through a tube and into the nose) tubing to the oxygen concentrator machine when Resident 12's NC was observed to be disconnected and on the floor. b. Label and date Resident 12's humidifier bottle when opened. These failures had the potential to result in complications associated with oxygen therapy for Resident 12. Findings: During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (damage to airways that limits the movement of oxygen), asthma (inflammation and tightening of muscles around the airways causing difficulty in breathing), and dependence of supplemental oxygen. During a review of Resident 12's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 12/4/2024, the MDS indicated Resident 12's cognitive abilities (ability to think, learn, and process information) were intact and indicated Resident 12 was receiving oxygen therapy. During a review of Resident 12's Order Summary Report (OSR), active orders as of 1/22/2025, the OSR included a physician's order, dated 11/5/2024, the OSR indicated Resident 12 had an order for oxygen at 3 liters (L, unit of measurement for volume) through NC as needed for shortness of breath. During a concurrent observation and interview on 1/21/2025 at 10:10 AM with Resident 12 while in Resident 12's room, Resident 12's NC tubing was observed to be disconnected from the oxygen concentrator machine and was laying on the floor. The oxygen concentrator machine was observed to be on at 3L and the humidifier bottle was observed to be opened with no date. Resident 12 stated Resident 12 was unsure if Resident 12 was feeling the oxygen through the NC tubing and stated the oxygen helps Resident 12 with breathing. During an interview on 1/21/2025 at 10:11 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 12's NC tubing was disconnected from the oxygen concentrator machine and stated there was no date indicated on the humidifier bottle. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/2025 at 10:57 AM with LVN 2, LVN 2 stated staff are responsible for dating the humidifier bottle and it should be changed weekly. LVN 2 stated the risk of not dating the humidifier bottle was putting the resident at risk of infection. LVN 2 stated a staff member must have accidentally pulled off the NC tubing during repositioning and it should've been reconnected. LVN 2 stated the risk of the NC tubing being disconnected was that the resident could have desaturated and put the resident at risk for infection because the NC was touching the floor. During an interview on 1/24/2025 at 4:49 PM with the Director of Nursing (DON), the DON stated the humidifier bottle was good for 30 days, if there were no open date listed staff would not be able to know how long the bottle has been sitting. The DON stated the NC tubing should've been connected to the oxygen concentrator machine, and stated the risk of not being connected would be that the resident would not be receiving oxygen. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy revised 7/2022, the P&P indicated to label the humidifier with the date opened and to connect the cannula or mask with tubing to the humidifier outlet or directly to flow meter as appropriate.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 38108 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 92), who had a diagnosis of dementia (loss of memory and other mental abilities severe enough to interfere with daily life) and history of falling, received care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) by failing to: a. Ensure Registered Nurse 1 (RN 1) notified Resident 92's physician/medical doctor (MD 1) regarding Resident 92's increased agitation (unable to relax and be still) and confusion (unable to think clearly) when Resident 92 attempted to stand up unassisted from Resident 92's wheelchair (WC) multiple times on 1/20/2025 as indicated in the facility's policy and procedure (P&P) titled, Change in Resident Condition. b. Ensure Certified Nurse Assistant 5 (CNA 5) did not wheel/take Resident 92 to Resident 92's room, placed Resident 92 in bed and left Resident 92 in Resident 92's bed, unsupervised, on 1/20/2025, when Resident 92 was agitated (irritable/distressed) and confused (lost, losing sense of time, place, or identity). As a result, on 1/20/2025, at 4:30 PM, Resident 92 fell out of Resident 92's bed. Resident 92 sustained a laceration (deep cut or tear on the skin), bruising (kin discoloration from damaged, leaking blood vessels [channels that carry blood throughout your body] underneath the skin) on Resident 92's right eyebrow, and abrasions (a superficial rub or wearing off from the skin) on both knees. The facility transferred Resident 92 to the General Acute Care Hospital 1's (GACH 1) Emergency Department (ED) via emergency services by calling 911 (phone number used to contact emergency services in the event of a medical emergency). Cross reference F580 Findings: During a review of Resident 92's Admission Record (AR), the AR indicated the facility admitted Resident 92 on 1/16/2025 with diagnosis that included Alzheimer's Disease (AD, a progressive brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks), and psychosis (a mental health condition characterized by a loss of contact with reality). During a review of Resident 92's Progress Notes (PN), dated 1/16/2025, timed at 3:10 PM, the PN indicated Resident 92 was alert (a state of careful watching and readiness) and had some forgetfulness. The PN indicated Resident 92's gait (manner of walking) was unsteady, and Resident 92 had poor balance. During a review of Resident 92's PN, dated 1/16/2025, timed at 9:34 PM, the PN indicated Resident 92 was confused, needed full assistance with activities of daily living (ADL, term used in healthcare that refers to self-care activities), and was at risk for falls (fall risk was not indicated). (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 92's Baseline Care Plan (BCP), signed on 1/17/2025 by RN 1, the BCP indicated Resident 92 was unable to be oriented due to Dementia. During a review of Resident 92's CP for alteration in cognitive function related to AD and Dementia, initiated on 1/17/2025, the CP's interventions indicated to provide reorientation, and redirection as needed to Resident 92. During a review of Resident 92's CP for at risk for falls related to impaired cognition, lack of safety awareness, and poor communication/comprehension, initiated on 1/17/2025, the CP's goal indicated to decrease the risk of falls and minimize injuries from falls. The CP's interventions indicated to remind Resident 92 not to get up [from the bed or WC] without assistance [from staff]. During a review of Resident 92's PN, dated 1/20/2025, timed at 6:40 PM, the PN indicated on 1/20/2025 at 4 PM, Resident 1 was placed in Resident 92's bed. The PN indicated Resident 92 had episodes of getting out of bed unassisted. The PN indicated at 4:30 PM, Resident 1 was found on the floor next to Resident 92's bed in a prone (lying flat with chest and face down) position. The PN indicated Resident 1 was confused, disoriented, (losing sense of time, place, or identity), and had a laceration on Resident 1's right eyebrow that measured 5.2 centimeters (cm-unit of measurement) in length by 0.3 cm in width by 0.1 cm in depth, and abrasions on both knees. The PN indicated (on 1/20/2025), at 4:35 PM, 911 was called due to Resident 1 sustaining a head injury. During a review of Resident 92's Situation, Background, Assessment and Recommendation Communication Form (SBAR, a communication tool that helps teams share information about the condition of a resident), dated 1/20/2025, the SBAR indicated Resident 92 was found on the floor (inside Resident 92's room) and Resident 92 had a laceration on the right eyebrow and abrasions on both knees. During a review of Resident 92's GACH 1 History and Physical (H&P), dated 1/20/2025, timed at 6:40 PM, the H&P indicated Resident 92 had a history of Dementia. The H&P indicated Resident 92 presented to the ED due to an unwitnessed fall. The H&P indicated Resident 92 had a laceration on the right eye with contusions (bruising or skin discoloration), abrasions on both knees, and a contusion on the right knee. During an observation on 1/21/2025, at 12:10 PM, Resident 92 was sitting on a WC in the dining room and eating lunch. Resident 92's right eye had light gray skin discoloration around the eye. There was swelling under the right eye, and a laceration on the right side of the eye that measured 4 cm, three steri strips (adhesive strips used to close wounds) covered the laceration. During an interview with Certified Nursing Assistant (CNA) 3 on 1/22/2025 at 11:23 AM, CNA 3 stated CNA 3 was assigned to care for Resident 92 on 1/20/2025 during the AM shift (7 AM to 3 PM). CNA 3 stated, on 1/20/2025 during the AM shift (unable to remember exact time frame), Resident 92 was trying to get up from Resident 92's WC multiple times and was, more confused. CNA 3 stated when Resident 92 was left by herself, Resident 92 attempted to get up from the [WC]. CNA 3 stated, The moment you turn your back [on Resident 92] she [Resident 92] will get up. CNA 3 stated Resident 3 was at risk for falls. CNA 3 stated to ensure safety and constant (continuous) supervision for Resident 92, CNA 3 wheeled/took Resident 92 to the nurse's station and informed RN 1 and LVN 3 of Resident 92's increased confusion. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview with RN 1 on 1/22/2025 at 11:48 AM, RN 1 stated upon admission (1/16/2025), Resident 92 was non-verbal and did not attempt to get out of bed/WC. RN 1 stated on 1/20/2025, during the AM shift, Resident 92 was placed at the nurse's station for constant monitoring because Resident 92 consistently attempted to stand up, mumbled, and spoke to herself. RN 1 stated, She (Resident 92) would just stand up. RN 1 stated, she (RN 1) did not tell the physician (MD 1) about the changes in Resident 1's condition (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains). RN 1 stated, on 1/20/2024, during shift change (changing from AM shift to PM shift), RN 1 endorsed to LVN 6 that Resident 92 attempted to stand up from the WC multiple times and was placed in the nurse's station for constant monitoring. RN 1 stated RN 1 would have continued to monitor Resident 92. RN 1 stated RN 1 would not have placed Resident 92 back in bed and left Resident 92 unsupervised. During a concurrent interview with LVN 3 on 1/23/2025, at 10:54 AM, LVN 3 stated (on 1/20/2025) during the AM shift, Resident 92 was placed in the nurse's station for constant monitoring due to Resident 92's constant attempts to stand up from the WC unassisted. LVN 3 stated during shift change report (on 1/20/2025), LVN 3 reported to LVN 6 that Resident 92 had attempted multiple times to get out of Resident 92's WC and reported Resident 92 needed constant supervision. During an interview with LVN 6, on 1/23/2025, at 3:12 PM, LVN 6 stated on 1/20/2025, at 3 PM [start of LVN 6's shift], LVN 6 stated while Resident 92 was sitting at the nursing station, Resident 92 attempted to get up from the WC. LVN 6 stated LVN 3 and RN 1 informed LVN 6 that Resident 92 attempted to get up from Resident 92's WC multiple times during the AM shift, and Resident 92 needed to be placed in the nurse's station for constant monitoring. LVN 6 stated after 3 PM (exact time unknown), CNA 5 wheeled/took Resident 92 to Resident 92's room located at the end of the hallway, five to six rooms [down the hall] away [not within eyesight] from the nursing station and CNA 5 placed Resident 92 in Resident 92's bed. LVN 6 stated, I thought CNA 5 was watching her [Resident 92]. LVN 6 stated at 4:30 PM, LVN 6 walked inside Resident 92's room and Resident 92's bed was empty. LVN 6 stated LVN 6 found Resident 92 on the floor, face toward the floor (no staff was inside Resident 92's room supervising the resident). LVN 6 stated LVN 6 saw blood on the floor and Resident 92 had a long and big laceration with active bleeding ((blood pumping out from a wound) on the right side of Resident 92's eye and abrasions on both knees. Resident 92 was very confused, disoriented, and unable to state any pain. LVN 6 stated, I needed to make sure there is visual checks on [Resident 92] at all times. LVN 6 stated, Resident 92 should have been constantly monitored for the Resident 92's safety. During an interview with Certified Nurse Assistant 5 (CNA 5) on 1/23/2025, at 3:53 PM, CNA 5 stated Resident 92's mind did not follow directions. CNA 5 stated during shift change (on 1/20/2024, at 3 PM), CNA 3 endorsed to CNA 5 that Resident 92 was placed at the nurse's station for constant monitoring due to Resident 92's agitation and confusion. CNA 5 stated from 3 PM to 4 PM, Resident 92 was at the nurse's station being monitored by LVN 6. CNA 5 stated at around 4 PM, CNA 5 informed LVN 6 that CNA 5 would take Resident 92 back to Resident 92's room and put her (Resident 92) back to bed, to rest before dinner. CNA 5 stated LVN 6 did not say to not take Resident 92 to Resident 92's room. CNA 5 stated CNA 5 placed Resident 92 in Resident 92's bed and CNA 5 left Resident 92's room to care for other residents [leaving Resident 92 unsupervised]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Claremont Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Bonita Ave Claremont, CA 91711	

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review with the Director of Nursing (DON) on 1/24/2025, at 8:55 AM, the DON stated on 1/20/2025, CNA 5 should not have taken Resident 92 back to Resident 92's room and left Resident 92 unsupervised when Resident 92 had an increase in confusion and was attempting to get up [from the bed/ WC] multiple times. The DON stated Resident 92 needed constant monitoring during the day shift and more than likely Resident 92 required constant monitoring during the evening shift (3 PM to 7 AM) because Resident 92 could fall. The DON stated RN 1 needed to call and notify MD 1 to make MD 1 aware when Resident 92 had a COC such as increased in confusion and started to get up, unassisted, from the WC. During a telephone interview with MD 1 on 1/24/2025, at 4:23 PM, MD 1 stated MD 1 was not aware of Resident 92's mentation change/COC or the fall that occurred on 1/20/2025. MD 1 stated MD 1 should have been made aware for MD 1 to give [appropriate] orders. MD 1 stated MD 1 should have been notified upon Resident 92's change in behavior, trying to get out of bed/WC [unassisted], for MD 1 to evaluate Resident 1 and write new order and for the facility to implement safety measures to prevent falls. MD 1 stated MD 1 would write an order for 1:1 supervision (one staff supervising one resident) as intervention for Resident 1's COC. During a review the facility's P&P titled, Dementia, Caring of Residents, revised 1/2015 (most updated), the P&P indicated Residents who exhibited new or worsening behavioral or psychological symptoms (affecting, or arising in the mind; related to the mental and emotional state of a person) of dementia (BPSD) should have an evaluation by the physician in order to identify and address treatable [conditions] that may be contributing to behaviors. The P&P indicated Individualized approaches to care utilizing a consistent process that focuses on a resident's individual needs and tries to understand behavior as a form of communication may help to reduce behavioral expressions of distress in some residents. During a review of the facility's P&P titled, Change in Resident Condition, revised 11/2016 (most updated), the P&P indicated Changes in a resident condition will be communicated to the physician timely. The P&P indicated Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior, will be communicated to the physician . The P&P indicated The nurse in charge is responsible for notification of physician prior to the end of the assigned shift when a change in a resident's condition is noted. During a review of the facility's P&P titled, Falls Prevention and Management Program, revised on 12/14/2022 (most updated), the P&P indicated Staff, in conjunction with the attending physician . will properly assess a resident's risk for falling, provide accurate interventions to minimize that risk and try to prevent a resident from falling. The P&P indicated Interventions for fall prevention included, frequent (often, occurring or done on many occasions) observation of the resident, especially following admission, to learn their habits and to accommodate needs: assign a resident's room near the nurse's station, strategies for residents with dementia and those who have recurrent falls.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40913 During an observation, interview, and record review, the facility failed to ensure a routine pain medication was available for one of one sampled resident (Resident 7). This deficient practice had the potential to result in pain and psychosocial decline to Resident 7. Findings: During a review of Resident 7's Admission Record (AR), the AR indicated the facility admitted Resident 7 on 9/9/2017, with diagnoses that included unspecified fracture (broken bone) of the lower end of the left humerus (a long bone that runs from the shoulder and scapula [shoulder blade] to the elbow) with routine healing. During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/27/2024, the MDS indicated Resident 7's cognition (ability to understand and process information) was intact. The MDS indicated Resident 7 had frequent pain and Resident 7 was on a scheduled pain medication regimen and was receiving prn (as needed) pain medication. During a review of Resident 7's Order Summary Report (OSR), dated active orders as of 1/24/2025. the OSR indicated an order, dated 11/4/2024, indicating Lidocaine (medication used to relief aches and pains causing numbness and loss of feeling) external patch 4%, applied to the right shoulder topically (applied on the surface of the body such as the skin) one time a day for pain. During a review of Resident 7's Progress Notes (PN) dated 1/21/2025 at 10:04 AM, the PN indicated Resident 7's MD was notified and to wait for delivery. During a review of Resident 7's Medication Administration Record (MAR), dated 1/1/2025 to 1/31/2025, the MAR indicated the Lidocaine patch was schedule to be applied at 9AM and removed at 9PM. The MAR indicated a 9 for 1/21/2025 for Resident 7's Lidocaine External Patch. was) The MAR indicated documenting 9 indicated other/see progress notes. During a medication administration observation and a concurrent interview, on 1/21/2025 at 9:32 AM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 7's Lidocaine external patch was scheduled at 9 AM and the patch was not applied because it was not available. During an interview on 1/21/2025 at 2:55 PM, with LVN 3, LVN 3 stated LVN 3 had not administered the Lidocaine external patch because the patch had not been delivered to the facility by the pharmacy. During an interview on 1/22/24 at 12:15 PM, LVN 4 stated the medication was delivered yesterday, 1/21/24 in the afternoon. LVN 4 stated Resident 7's Lidocaine external patch was to treat Resident 7's pain on the right shoulder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2024 at 12:35 PM, Resident 7 stated Resident 7 needed the Lidocaine patch applied on her right shoulder because Resident 7 used the right arm more than the left arm. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration dated 01/2023, the P&P indicated medications are administered within 60 minutes of scheduled time. The P&P indicated unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center.

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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** 48905 Based on interview and record review, the facility failed to implement the facility's policy titled Ordering and Receiving Non-Controlled Medications for two of two sampled residents (Resident 27 and 28) by failing to: a. Document the correct drug allergies into Resident 28's electronic medical record (EMR) when Resident 28 had 12 drug allergies and received Ambien (medication used to treat insomnia [difficulty in falling asleep]) nine times in 12/2024 which was indicated as one of the 12 drug allergies. b. Document the correct drug allergies in Resident 27's EMR when Resident 27's EMR did not indicate Resident 27 was allergic to clindamycin (type of antibiotic) and Norco (prescription medication used to treat moderate to severe pain) and incorrectly indicated an allergy to prednisone and prednisolone (medications used to treat swelling, redness, itching, and allergic reactions). These failures had the potential to result in Resident 27 and Resident 28 to sustain an adverse reaction to medications, such as, an anaphylactic reaction (severe, life-threatening allergic reaction that affects the entire body) and sustain a serious injury. Findings A. During a review of Resident 28's Admission Record (AR), the AR indicated Resident 28 was originally admitted to the facility on [DATE] with diagnoses that included major depressive disorder (MDD, mood disorder that causes persistent feelings of sadness and loss of interest), muscle weakness, and atrial fibrillation (a-fib, an irregular heart rhythm). The AR indicated Resident 28 was allergic to C. Indicium extract (extract from chamomile plant) and C. Sinesis leaf extract (oil from the leaves of the Camellia sinensis plant). During a review of Resident 28's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 10/3/2024, the H&P indicated Resident 28 can make needs known but cannot make medical decisions. During a review of Resident 28's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/24/2024, the MDS indicated Resident 28's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 28's Medication Administration Record (MAR) dated 12/1/2024-12/31/2204, the MAR indicated Resident 28 received Ambien (Zolpidem Tartrate) 5 mg one tablet by mouth at bedtime for insomnia on the following days: 12/7/2024 12/8/2024 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/9/2024 12/14/2024 12/15/2024 12/18/2024 12/19/2024 12/20/2024 12/21/2024 During a review of Resident 28's Order Summary Report (OSR) dated 1/9/2025, the OSR indicated Resident 28 had a Medical Doctor (MD) order for Zolpidem Tartrate Tablet five milligrams (mg, unit of measurement) by mouth as needed for inability to sleep at night for 14 days. B. During a review of Resident 27's AR, the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic systolic heart failure (heart cannot pump blood effectively in the body), a-fib, and hyperlipidemia (high levels of cholesterol in the body). The AR indicated Resident 27 was allergic to penicillin (type of antibiotic), prednisolone, prednisone, and sulfa (type of antibiotic). During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27's cognitive abilities were intact. During an interview on 1/21/2025 at 3:25 PM with Resident 27 while in Resident 27's room, Resident 27 stated Resident 27 had an allergy to penicillin, sulfa, Norco, and some antibiotics and stated if Resident 27 received those medications it causes Resident 27 to stop breathing. During a concurrent interview and record review on 1/21/2025 at 3:43 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 27's EMR was reviewed. LVN 1 stated there was no indication that Resident 27 was allergic to clindamycin or Norco in Resident 27's EMR. LVN 1 stated there should be an indication Resident 27 is allergic to those medications because it would put Resident 27 at risk for receiving those medications and having an allergic reaction. During an interview on 1/22/2025 at 10:11 AM with Resident 28, Resident 28 stated Resident 28 was allergic to a lot of different medications and was unsure of the names of the medications. Resident 28 stated if Resident 28 received medications Resident 28 was allergic to it would cause Resident 28 to throw up and make Resident 28's throat swell up. During a concurrent interview and record review on 1/22/2025 at 12:25 PM with the Director of Nursing (DON), Resident 27's General Acute Care Hospital (GACH) record titled History and Physical Reports (H&P) dated 12/18/2024, Resident 28's GACH record titled Clinics-Offsite (CO) dated 12/6/2024, and Resident 28's MAR dated 12/1/2024 to 12/31/2024 were reviewed. Resident 27's H&P indicated Resident 27 was allergic to Norco, clindamycin, penicillin, and sulfa drugs. Resident 28's CO indicated Resident 28 was allergic to the following medications: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Ambien with a reaction of confusion. b. Compazine (medication used for nausea and vomiting) causing a reaction of hives (itchy, raised, red bumps or welts that appear on the skin caused by an allergic reaction) c. Darvocet-N 50 (mediation used to treat mild to moderate pain) causing an unknown reaction. d. Darvon (medication used to treat mild to moderate pain) causing a reaction of hives. e. Hydromorphone (medication used to treat moderate to severe pain) causing unknown reaction. f. Percocet (medication used to treat moderate to severe pain) causing a vomiting reaction. g. Codeine (medication used to treat moderate to severe pain) causing an unknown reaction. h. Droperidol (medication used to prevent nausea and vomiting) causing a reaction of hives. i. Fentanyl (medication used to treat chronic severe pain or pain following surgery) causing an anaphylactic reaction. j. Morphine (medication used to treat severe, acute pain) causing respiratory distress (life-threatening lung injury that causes fluid to leak into the lungs making breathing difficult and not allowing oxygen into the body). k. Prochlorperazine (medication used to treat nausea and vomiting and nervous, emotional, and mental conditions, such as, schizophrenia [serious mental disorder in which people interpret reality abnormally]) causing an anaphylactic reaction. l. Propoxyphene (medication used to treat mild to moderate pain) causing an anaphylactic reaction; and m. Zolpidem (Ambien) causing a reaction of anxiety. The DON stated if residents are coming from a GACH, allergies should be verified from the discharge paperwork from the hospital and the MD. The DON stated drug allergies are not the same for Resident 27 and 28's EMR when compared to Resident 27's H&P and Resident 28's CO. The DON stated the EMR was directly connected to pharmacy and stated if there were discrepancies in medication orders pharmacy would let staff know. The DON stated if staff entered a medication the resident was allergic to or the same class of medication, it wouldn't trigger a notification to pharmacy as a drug allergy in the resident's EMR because the drug allergy was not entered correctly. The DON stated the risk of not having the correct allergies in the resident's EMR was that it can interact with other medications and the resident could have an anaphylactic reaction and cause harm. The DON stated the pharmacy wouldn't know the correct drug allergies and put the resident at risk if there was a drug allergy in the same drug class and cause a reaction. During a review of the facility's undated policy and procedure (P&P) titled, Ordering and receiving non-controlled medication the P&P indicated for newly admitted residents the pharmacy should be given mediation allergies.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50016 Based on interviews and record review, the facility failed to ensure psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were not used unnecessarily for one of five sampled residents (Resident 32) by: 1. Ensuring that the use of Quetiapine (medication used alone or together with other medicines to treat bipolar disorder [depressive and manic episodes] and schizophrenia [a serious mental health condition that affects how people think, feel, and behave]) was clinically indicated and necessary for Resident 32. This deficient practice had the potential to result in use of unnecessary psychotropic drugs and could have led to side effects (injuries resulting from medication use including physical and mental harm, or loss of function) and adverse consequences to Resident 32. Findings: During a review of Resident 32's Admission Record (AR), the AR indicated the facility admitted Resident 32 on 6/26/2024, and readmitted the resident on 10/30/2024, with diagnoses including hemiplegia/hemiparesis (paralysis [complete or partial loss of muscle function] on one side of the body), muscle weakness (generalized), and need for assistance with personal care. During a review of Resident 32's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/4/2024, the MDS indicated Resident 32 had severe cognitive (the ability to think and process information) impairment. The MDS indicated Resident 32 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During a review of Resident 32's Order Recap Report (ORR), dated 1/24/2025, the ORR indicated the following physician orders: - Resident 32 had a discontinued order for Quetiapine 25 mg (milligrams, unit of measurement) tablet to give 0.5 tablet orally at bedtime for psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) manifested by constantly calling for help even after assistance [was provided]. The order indicated a start date of 11/11/2024 and end date of 1/16/2025 - Resident 32 had an active order for Quetiapine 25 mg tablet give 0.5 tablet orally at bedtime for impulse control disorder manifested by constantly calling for help. The order had a start date of 1/16/2025. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 1/23/2025 at 4:42 PM, with the Psychiatric-Mental Health Nurse Practitioner (PMHNP), the PMHNP stated Resident 32 should have not been prescribed quetiapine without a clear, documented diagnosis in Resident 32's medical record. The PMHNP stated Resident 32 had no medical diagnosis in Resident 32's medical record that supported the administration of Quetiapine. The PMHNP stated quetiapine should only be prescribed when there is a clear medical indication based on a documented diagnosis and it was essential healthcare providers ensured Resident 32 was properly assessed, and the medication was used safely and appropriately. The PMHNP stated it was important that any prescribed medication was in the best interest of the resident's overall health and well-being. The PMHNP stated during the next clinical meeting with the psychiatric medical team, Resident 32's impulse control disorder would be updated and included as a documented diagnosis in Resident 32's medical record. During an interview on 1/24/2024 at 11:41 AM, with the Director of Nursing (DON), the DON stated that antipsychotics should generally only be prescribed to a resident if there is a clear medical diagnosis in their medical record that justified its use. The DON stated if there was no documented diagnosis in the Resident 32's medical record, prescribing quetiapine could be considered inappropriate or risky. The DON stated that it was important to have a thorough clinical evaluation, including a clear diagnosis and rationale for the medication, to ensure the medication was used safely and effectively. During a review of the facility's P&P titled, Psychotherapeutic Medication Use revised dated 2/2014, the P&P indicated: - Residents who exhibit new or worsening behavioral or psychological symptoms of dementia (BPSD) should have an evaluation by the interdisciplinary team, including the physician, in order to identify and address treatable medical, physical, emotional, psychiatric, psychological, functional, social, and environmental factors that may be contributing to behaviors. - The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record. Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort discontinue these drugs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50016 Based on observation, interview, and record review, the facility failed to ensure the dietary staff stored and prepared food under sanitary conditions in one of one kitchen (Kitchen 1). This deficient practice placed the residents at risk for foodborne illness (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During an observation of Kitchen 1 on [DATE] at 9:20 AM with the Sous-Chef (SC) (sous-chef-the second-in-command in a kitchen, responsible for helping the head chef run the kitchen smoothly) the following findings were observed: 1. [NAME] (CK) 1 was observed prepping rice with a ball cap (a soft hat with a rounded crown and a stiff front bill) and without a hairnet underneath the cap. 2. Four cottage cheese containers were stored in a walk-through refrigerator with a best if used by date of [DATE]. 3. One cake mix was stored in the dry foods area with a best if used by date of [DATE]. 4. Two dented cans of Marinara sauce were stored in the ready to use dry food area. Findings: During an interview on [DATE] at 9:30 AM, with the SC, the SC stated expired food should never be stored in the refrigerators or in the dry food area. The SC stated proper food handling, storage, and adherence to expiration dates were crucial to maintaining health standards, preventing foodborne illness, and ensured patients received safe and nutritious meals. The SC stated dented food cans should be discarded because the dents could compromise the safety and integrity of the food inside the can. The SC stated damaged cans could create conditions where bacteria or contaminants could enter, leading to the potential for spoilage or foodborne illness. The SC stated ball caps should not replace hairnets during food preparation. The SC stated cooks should always wear hairnets during food preparation. The SC stated ball caps did not adequately cover all the hair, particularly longer hair and loose or uncovered hair could fall into food during preparation, potentially contaminating the food with hair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:58 PM, with the Director of Dining Services (DDS), the DDS stated cooks should wear a hairnet underneath the ball cap to ensure complete hair containment, meet food safety regulations, and maintain hygiene standards. The DDS stated ball caps should not replace hairnets. The DDS stated wearing hair nets helped prevent food contamination and contributed to maintaining a clean and safe kitchen environment. The DDS stated expired food should be discarded and not stored in the refrigerators, freezers or the dry food area. The DDS stated discarding expired food ensured food safety, which helped protect vulnerable residents, and complied with health regulations. The DDS stated by disposing of expired food, the facility reduced the risk of foodborne illness, maintained high standards of nutritional quality, and ensured a safe, clean environment for the residents. The DDS stated dented food cans should be discarded due to the risk of contamination, the potential for foodborne illness, and compromised food quality. The DDS stated damaged cans could lead to leaks, bacterial growth, and spoilage, which could endanger the health of the residents. The DDS stated one of the most serious risks associated with dented cans was the potential for botulism (rare but serious condition caused by a toxin [could be found in dented cans] that attacks the body's nerves). During a review of the facility's policy and procedure (P&P) titled Food-Nutrition Services, dated revised , d+[DATE], indicated that the facility: 1. Must store, prepare, distribute and serve food in accordance with professional standards for food service safety. 2. Will follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, beginning when food is received from the vendor and continuing throughout the food handling processes.

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NAME OF PROVIDER OR SUPPLIER Claremont Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Bonita Ave Claremont, CA 91711	

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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** 50016 Based on observation, interview, and record review, the facility failed to follow the facility's infection prevention guidelines by failing to: A. Ensure enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics] in nursing homes) were followed during peri-care (washing the genitals [sexual organs located outside of the body] and anal [end of large intestine, allows feces to come out] area) in one of one sampled resident's room (Resident 4's room). B. Ensure a portable HEPA filtration system (filtration system designed to easily create a negative pressure isolation room) was in one of one sampled resident's room (Resident 190's room) per facility policy when Resident 190 tested positive for Coronavirus Disease (COVID-19, highly contagious and infectious disease that spread quickly door was observed to be opened through droplets released when an infected person coughs, sneezes, or talks) when the door was observed to be left opened on 1/21/2025. C. Ensure visitors and family members donned on the correct personal protective equipment (PPE, equipment that protects people from injury or illness at work) when one of one family member (Family Member 1, FM 1) was observed to be sitting in Resident 190's COVID-19 positive room without gloves, face shield, and not properly wearing the N95 mask (respiratory protective device designed to provide a close facial fit and efficient filtration of airborne particles). D. Ensure one of one laundry staff (Laundry Aide, LA), accurately documented in the facility's disinfection and dryer lint trap logs when the LA prefilled the logs on 1/23/2025. These deficient practices had the potential result in the transmission of infectious microorganisms throughout the facility and increased the risk of infection amongst the residents residing at the facility. Findings: A) During a review of Resident 4's Admission Record (AR), the AR indicated the facility admitted Resident 4 on 6/27/2019, and readmitted the resident on 10/15/2024, with diagnosis including contracture (a permanent tightening of muscles, tendons, ligaments, or skin that limits movement in a joint) of muscle, hemiplegia/hemiparesis (paralysis [complete or partial loss of muscle function] on one side of the body), and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 4's History and Physical (H&P), dated 9/23/2024, the H&P indicated Resident 4 could make needs known but could not make medical decisions. (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 4's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/27/2024, the MDS indicated Resident 4 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During an observation on 1/21/2025 at 11:30 AM, Certified Nursing Assistant (CNA) 2 was observed entering Resident 4's room without a gown. Resident 4's room had signage indicating enhanced based precautions. CNA 2 began performing peri-care on Resident 4 without a gown. During an interview on 1/21/2025 at 11:38 AM, with CNA 2, CNA 2 stated Resident 4 had a bowel movement and entered Resident 4's room without proper personnel protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). CN 2 stated CNA 2 should have donned (put on) a gown to assist Resident 4 with peri-care. CNA 2 stated PPE served as a barrier to protect both staff and patients from the spread of infectious agents, particularly in cases where the patient is known to have a contagious disease. CNA 2 stated proper use of gowns, along with other PPE, helped prevented cross-contamination (process by which bacteria could be transferred from one area to another), reduced the risk of healthcare-associated infections, and ensured the safety of vulnerable residents. During an interview on 1/22/2025 at 9:33 AM, with the Infection Prevention Nurse (IPN), the IPN stated staff should don proper PPE when they have direct contact with a resident who is under enhanced based precautions. The IPN stated peri-care did require the use of gloves and gown to reduce the risk of transmission of multidrug resistant organisms (MDROs-bacteria that resist treatment with more than one antibiotic). The IPN stated enhanced precautions aimed at minimizing the spread of MDROs to other residents and healthcare workers while promoting effective infection prevention practices. During a review of Resident 4's Order Summary Report (OSR), dated active as of 1/22/2025, the OSR indicated a physician's order, date 11/5/2024, indicating enhanced standard precautions related to Gastrostomy Tube (GT- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for Resident 4. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention & Control Program revised dated 1/2024, the P&P indicated: - The Infection Prevention & Control Program is designed to provide a safe, sanitary and comfortable environment and, to the extent possible, includes a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases. - Enhanced Standard Precautions (ESP): a resident-centered and activity-based approach for preventing MDRO transmission through healthcare personnel (HCP) use of gowns and gloves during high-contact resident care activities for those known to be colonized or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infected with a MDRO as well as those at risk of MDRO acquisition, even if blood and body fluid exposure is not anticipated. ESP are indicated for high-risk skilled nursing facility (SNF) residents, those with infection or colonization with an MDRO when contact precautions do not otherwise apply and/or with wounds and/or indwelling medical devices (urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters) and/or may be considered for residents with functional disability and total dependence. ESP include activities that have demonstrated transfer of MDRO to hands and or clothing of HCP (i.e., helping a resident out of bed). ESP allows high-risk SNF residents to participate in activities outside of the room under specified conditions 48905 B. During a review of Resident 190's AR, the AR indicated Resident 190 was admitted to the facility on [DATE] with diagnoses that included COVID-19. During a review of Resident 190's untitled care plan (CP) dated 1/14/2025, the CP indicated Resident 190 was positive for COVID-19 and indicated for staff to place Resident 190 in a contact and droplet isolation room. During a concurrent observation and interview on 1/21/2025 at 10:38 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 190's door was observed to be opened. LVN 2 stated Resident 190 was positive for COVID-19 and stated LVN 2 was instructed by the Infection Preventionist Nurse (IPN) that it was okay to have the door open. During a concurrent observation and interview on 1/21/2025 at 11:14 AM with the IPN, an air purifier was observed to not be placed inside of Resident 190's room. The IPN stated Resident 190's door needed to be opened because Resident 190 was a fall risk so staff can monitor Resident 190. The IPN stated to reduce the risk of transmission of COVID-19 to other residents and staff, staff are to place an air purifier in the room. The IPN stated there was no air purifier in Resident 190's room and stated not having an air purifier would put other residents, staff, and family members at risk for getting COVID-19. C. During a concurrent observation and interview on 1/21/2025 at 12:10 PM with the IPN, FM 1 was observed to be sitting in Resident 190's room with a gown and the N95 partially on FM 1's face. The IPN stated FM 1 was not wearing the correct PPE and stated FM 1 should've had on gloves, a face shield, and wore the N95 mask improperly. The IPN stated family members and visitors are required to don on all PPE prior to entering the room and stated the risk of not donning on the correct PPE is that it would pass to other residents, family members, and visitors. During an interview on 1/24/2025 at 4:49 PM with the Director of Nursing (DON), the DON stated if a resident was positive with COVID-19 and unable to close the door, staff should open the window if the weather permits and place an air purifier in the room to increase ventilation. The DON stated the risk of not placing an air purifier in the room was that there could be a small chance that someone could get COVID-19. The DON stated if staff members saw the family member not donning the correct PPE staff should educate the family member and stated the risk of not having the family member donning the correct PPE was that COVID-19 could spread to others. (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, Suspected or Confirmed COVID-19 Policy revised 2/2024, the P&P indicated infection prevention and control recommendations for residents with suspected or confirmed COVID-19 in healthcare settings included using a resident isolation room for risk reduction and use of a portable HEPA filtration system and indicated staff are to inform visitors about appropriate PPE use. 48729 D. During a concurrent interview and record review on 1/23/2025 at 9:33 AM with the LA, the facility's Daily Disinfection Log (DDL) was reviewed. The LA stated the LA's initials were indicated in the slots under the date 1/23/2025 and timed at 6 AM, 10 AM, and 2 PM. The LA stated the LA mistakenly wrote the LA''s initials in the 10 AM and 2 PM slot and the LA did not usually mark the log ahead of time. The LA stated the LA always made sure the tasks were done. The LA stated the initials meant the task was completed. During a concurrent interview on 1/23/2025 at 12:20 PM with the LA, the LA stated the LA knew the LA should not be marking the disinfection and dryer lint trap log with the LAs initials ahead of time. During a concurrent interview and record review on 1/23/2025 at 4:56 PM with the Environmental Services Director (EVS), the facility's DDL and Dryer Lint Trap (DLT) log was reviewed. The EVS stated staff was not supposed to sign the log before the task was completed. The EVS stated the log was supposed to be done as the tasks were completed and if the log was signed ahead of time, there was a possibility that the tasks would not get done at all. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised 1/2024, the P&P indicated under Guidelines, the Infection Prevention Control Program includes 13. Monitoring for proper implementation of and adherence to infection control policies and procedures: f. Environmental cleaning/ disinfection.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50016 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of one sampled resident (Resident 4). This deficient practice had the potential to result in a delay or the inability for Residents 4 to obtain necessary care and services. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated the facility admitted Resident 4 on 6/27/2019, and readmitted the resident on 10/15/2024, with diagnosis including contracture (a permanent tightening of muscles, tendons, ligaments, or skin that limits movement in a joint) of muscle, hemiplegia/hemiparesis (paralysis [complete or partial loss of muscle function] on one side of the body), and hemiparesis, and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 4's History and Physical (H&P), dated 9/23/2024, the H&P indicated Resident 4 could make needs known but could not make medical decisions. During a review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/27/2024, the MDS indicated Resident 4 was dependent (helper does all the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During an observation on 1/21/2025 at 10:20 AM, Resident was lying in bed and Resident 4's mechanical pad call button was tucked and hanging on the backside of Resident 4's bed between the wall and Resident 4's bed headboard. Resident 4 was unable to access the call light. During an interview on 1/21/2025 at 10:32 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 4's call light should have not been hanging on the backside of Resident 4's headboard and should have been clipped to Resident 4's gown or side rail for easy accessibility. CNA 1 stated call lights were important for residents' safety, comfort, and well-being. CNA 1 stated a call light should always be placed within the resident's (in general) reach. CNA 1 stated placing the call light within reach ensured residents could call for help quickly in emergency situations, maintained their dignity and independence, and received timely care for both urgent and non-urgent needs. During an interview on 1/24/2025 at 11:41 AM, with the Director of Nursing (DON), the DON stated call lights should always be placed within the resident's reach. The DON stated if the resident needed immediate assistance having the call light within reach ensured they could alert staff quickly. The DON stated call lights within reach ensured safety and reduced the risk for accidents, such as falls. The DON stated call lights helped residents feel more secure and cared for, knowing they could quickly get the attention they needed. During a review of the facility's policy and procedure (P&P) titled Call System, dated revised 2/2009, indicated the facility will: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Provide each resident with a call system to enable them to request assistance. 2. Make sure call cords are placed within the resident's reach at all times. When the resident is out of bed, the call cord will be clipped to the bed linen in such a way as to be available to a wheelchair bound resident.