STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555099	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to verify the code status (a resident's instructions to a medical team about the type of treatment they want to receive in the event of a cardiac [heart] or respiratory [breathing] arrest) of a resident prior to initiating cardiopulmonary resuscitation (CPR- a lifesaving technique used in emergencies when a resident's breathing or heartbeat has stopped) for one out of one sampled resident (Resident 285). This deficient practice resulted in the administration of CPR and the utilization of an ambu bag (a medical tool which forces air into the lungs of patients who have either ceased breathing completely) for greater than ten minutes before paramedics took over and continued CPR. This deficient practice did not allow Resident 285 to pass comfortably during her last minutes of life. Findings: During a review of Resident 285's Admission Record, the Admission Record indicated Resident 285 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 285's diagnoses included dementia (a progressive state of decline in mental abilities), cancer (disease in which some of the body's cells grow uncontrollably and spread to other parts of the body) of the skin, and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 285's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 285's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 285 required set up or touching assistance when activities of daily living (ADLs, daily self-care activities such as dressing, personal hygiene, dressing, and toileting hygiene) were performed. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 285's History and Physical (H&P), dated [DATE], the H&P indicated that Resident 285 had a past medical history of basal cell carcinoma (skin cancer) with multiple chronic wounds that spread to the liver (a large organ in the upper abdomen that performs many functions to support the body). The H&P indicated that the Power of Attorney (POA- a legal authorization that gives the agent or attorney-in-fact the authority to act on behalf of an individual) refused further tests and exams at the general acute care hospital (GACH). The H&P indicated the POA wanted to focus on palliative care (a type of medical care that aims to improve quality of life and reduce suffering for people with serious illnesses) for Resident 285 and did not want Resident 285 to go back to the emergency room . The H&P also indicated for the licensed nursing staff to review the initial admitting orders that had been placed. During a review of Resident 285's Advanced Healthcare Directive (a legal document that allows a resident to specify health care preferences and name someone to make decisions for the resident if the resident is unable to), dated [DATE], Resident 285's Advanced Healthcare Directive indicated Resident 285 selected that she did not want life pro-longing measures to be performed. During a review of Resident 285's Physician Orders, dated [DATE], the Physician Orders indicated Resident 285's code status was Do Not Resuscitate (DNR- a directive that advises healthcare professionals not to conduct CPR on the patient). During a review of Resident 285's Change of Condition Note, dated [DATE], the note indicated a certified nursing assistant (CNA) informed Licensed Vocational Nurse (LVN) 4 Resident 285 exhibited respiratory distress at 4:50 a.m. The note indicated LVN 4 observed Resident 285 had shallow breathing and was not tracking (following movement) with her eyes. The following vital signs were obtained: blood pressure (the pressure of circulating blood against the walls of blood vessels) of ,d+[DATE] millimeters of mercury (MM/HG- unit of measurement [normal blood pressure range: 61 and older: ,d+[DATE] mm Hg / ,d+[DATE] mm Hg); heart rate of 116 beats per minute (bpm [normal range: between 60 and 100 bpm]; and oxygen saturation (concentration of oxygen in the blood) was unattainable. The note indicated 911 was called. The note indicated, at 5:15 a.m., Resident 285 became unresponsive and stopped breathing, and CPR was initiated with an ambu bag. At 5:30 a.m., paramedics arrived and continued CPR. At 5:35 a.m., Resident 285 was pronounced expired. The note indicated Resident 284's code status was Do Not Resuscitate (DNR). There was no documentation that indicated that the code status of Resident 285 was verified. During an interview, on [DATE], at 10:36 a.m., with LVN 4, LVN 4 stated that she was the LVN assigned to care for Resident 285 for the 11 p.m. to 7 a.m. shift on [DATE]. LVN 4 stated she was told by the CNA that Resident 285 was in respiratory distress. LVN 4 stated Resident 285's breathing was labored and the resident's blood pressure was low. LVN 4 stated she attempted to obtain an oxygen saturation value two or three times before she told Registered Nurse (RN) 2 of the resident's condition. LVN 4 stated RN 2 assessed Resident 285 and went back to the nurse's station on two occasions but could not recall why. LVN 4 stated RN 2 finally called 911 and when she came back from the nurses' station, Resident 285 was unresponsive and stopped breathing. LVN 4 stated RN 2 and LVN 4 started CPR. LVN 4 stated that she did not recall verifying Resident 285's code status and relied on what RN 2 told her to do (to start CPR). LVN 4 stated the usual practice was to verify the code status before the initiation of CPR by reviewing the resident's physical chart and verifying the code status order in the electronic medical record (EMR) system. LVN 4 stated she was not aware Resident 285 had DNR orders in the EMR system and stated that if she had known, she (LVN 4) would have not administered CPR. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE], at 11:05 a.m., with RN 2, RN 2 stated LVN 4 called RN 2 to immediately go into Resident 285's room. RN 2 stated upon her assessment, she knew things were not good. RN 2 stated she got CPR started immediately with the aid of the ambu bag. RN 2 stated 911 was called and the paramedics arrived and continued compressions. RN 2 stated she could not recall the code status of Resident 285 and did not verify the code status of Resident 285 in the EMR. RN 2 stated that the process was to check the physical chart and check the EMR to verify the code status of the resident. RN 2 stated that she may have recalled LVN 4 stated that Resident 285 was a full code. RN 2 stated that a DNR order meant that the licensed staff would not perform chest compressions and allow the resident to pass comfortably. RN 2 stated that an Advanced Healthcare Directives outlined a patient's wishes in the event he or she could not make decisions about his or her life. RN 2 stated that it was important to honor what was indicated in Resident 285's Advanced Healthcare Directives because it was Resident 285's right to have to her wishes honored. During a concurrent interview and record review, on [DATE], at 1:27 p.m., with RN 1, Resident 285's orders, dated [DATE], were reviewed. The orders indicated Resident 285 had a DNR order. RN 1 stated that if there was a clear DNR order in the EMR, CPR should not have been performed. RN 1 stated she was familiar with the care and the involvement of the family in Resident 285's care and recalled the resident's family wished for Resident 285's code status to remain DNR due to Resident 285's diagnoses. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated [DATE], the P&P indicated the facility was to treat all residents with dignity and honor the exercise of residents' rights. During a review of the facility's P&P titled, Cardiopulmonary Resuscitation, dated [DATE], the P&P indicated the facility was to verify or instruct a staff member to verify the code status of an individual in the event of a cardiopulmonary emergency. The P&P also indicated that CPR shall be initiated unless the code status specifically prohibits CPR. During a review of the facility's P&P titled, Advanced Directive, dated [DATE], the P&P indicated the facility was to respect a resident's right to request, refused, and or discontinue treatment. During a review of the facility's Licensed Vocational Nurse Job Description (undated), the job description indicated that the licensed nursing staff were to provide nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for resident needs for five of 15 sampled residents (Residents 91, 196, 80, 156, and 255) by failing to ensure the call light (a device that residents use to request assistance from staff) was within reach at the bedside. This deficient practice had the potential to negatively impact the psychosocial well-being of Residents 91, 196, 80, 156, and 255 or result in delayed provision of care and services. Findings: a. During an observation on 9/30/2024 at 10:57 a.m., in Resident 91's room. Resident 91 was observed lying in bed. Resident 91's call light was on the floor on the right side of Resident 91's bed. During a review of Resident 91's Admission Record (Face Sheet), the Face Sheet indicated Resident 91 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 91's diagnoses including anxiety (feeling of fear, dread, and uneasiness), schizophrenia (a serios mental illness that affects how a person thinks, feels, and behaves), diabetes (abnormal blood sugar), hypertension (high blood pressure), and abnormalities of gait (a manner of walking) and mobility. During a review of Resident 91's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 9/19/2024, the MDS indicated Resident 91's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 91 required supervision or touching assistance (staff provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for toileting hygiene, shower, and personal hygiene. During a review of Resident 91's care plan titled, At risk for falls related to gait and balance problems, revised 3/28/2024, the care plan indicated staff interventions included be sure Resident 91's call light was within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 9/30/2024 at 4:09 p.m., in Resident 91's room, Resident 91 was observed lying in bed in a semi-Fowler's position (head of the bed elevated 30-45 degree). Resident 91's call light was on the floor on the right side of Resident 91's bed. Resident 91 called out for nurse assistance and asking for water. Resident 91 was not able to locate her call light. b. During an observation on 9/30/2024 at 10:59 a.m., in Resident 196's room, Resident 196 was observed lying in bed. Resident 196's call light was on the floor under Resident 91's bed. During a review of Resident 196's Face Sheet, the Face Sheet indicated Resident 196 was admitted to the facility on [DATE]. Resident 196's diagnoses included anxiety, hypertension, and unsteadiness on feet (an abnormal way of walking). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 91's MDS dated [DATE], the MDS indicated Resident 196's cognitive skills was severely impaired. The MDS indicated Resident 196 required supervision or touching assistance from staff for toileting hygiene, shower, oral and personal hygiene. During a review of Resident 196's care plan titled, At risk for falls related to impaired balance, revised 1/21/2024, the care plan indicated staff interventions included to be sure Resident 196's call light was within reach and encourage the resident to use it for assistance as needed. During an observation on 10/1/2024 at 8:30 a.m., in Resident 196's room, Resident 196's call light was observed on the floor and not within reach. During a concurrent observation and interview on 10/1/2024 at 8:40 a.m., in Resident 196's room, with Certified Nurse Assistant (CNA 1), Resident 196's call light was observed on the floor and not within reach. CNA 1 stated Resident 196's call light should have been attached to the resident's bed and within reach. CNA 1 stated it was important that Resident 196 was able to reach the call light and was able to use it when assistance was needed during an emergency. During an interview on 10/1/2024 at 4:45 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated everyone working on the unit was responsible for checking on the residents' status and make sure the call light was within reach next to the resident and at the bedside. LVN 1 stated if a resident was unable to reach the call light and call for assistance, it could delay the resident assessment and care. During an interview on 10//4/2024 at 1:00 p.m., with Registered Nurse (RN 1), RN 1 stated the call light should be placed within resident reach at the residents' bedside. RN 1 stated the call light was important for residents' to be able to communicate with staff. RN 1 stated the facility's licensed staff were responsible for checking the residents' call light and placing it within reach at the bedside. RN 1 stated if the call light was not within reach the residents would not be able to use the call light and would not be able to call for help. RN 1 stated the call light not within reach was the residents' safety, and placed residents at risk for falls, and injury. c. During a review of Resident 80's Admission Record, dated 10/3/2024, the admission record indicated Resident 80 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 80's diagnoses included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction caused by another health condition), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing sudden, uncontrolled jerking, blank stares, and loss of consciousness) suicidal ideations (thoughts of self-harm or ending one's life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), absence of the right and left leg below the knee ([BKA] - below the knee amputation - a surgical removal of the portion of the leg below the knee), contracture of the left knee (a stiffening/shortening at any joint, that reduces the joint's range of motion), lack of coordination (difficulty moving body parts smoothly, accurately, or efficiently), and history of falling. During a review of Resident 80's History and Physical (H&P) dated 4/9/2024, the H&P indicated Resident 80 was able to make needs known but was not able to make medical decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 80's MDS, dated [DATE], the MDS indicated Resident 80's cognition was moderately impaired. The MDS indicated Resident 80 had the ability to make himself understood and the ability to understand others. The MDS indicated Resident 80 had impairment on both sides of the lower extremities and required a wheelchair for mobility. During a review of Resident 80's care plan with a focus of Resident at risk for falls, initiated on 8/8/2023 and revised on 8/7/2024, the care plan indicated Resident 80 was at risk for falls related to psychoactive drug use, unaware of safety needs, BKA, epilepsy, schizoaffective disorder, and anemia (lack of healthy red blood cells). The staff interventions indicated to be sure the resident's call light was within reach and encourage Resident 80 to use the call light for assistance as needed. During a concurrent observation and interview on 9/30/2024 at 12:15 a.m. with Resident 80, in Resident 80's room, Resident 80 was observed awake and alert, and lying in bed. Resident 80's call light was observed hanging on a hook behind the head of the resident's bed. Resident 80 stated he could not reach the call light because he had no feet. During a concurrent observation and interview on 9/30/2024 at 12:28 p.m. with the Infection Preventionist (IP), in Resident 80's room, the IP observed Resident 80's call light that hung behind the head of his bed. The IP stated Resident 80 could not reach the call light when it was hung in that area. The IP stated that a certified nursing assistant (CNA) was responsible for ensuring the call light was within reach once Resident 80 returned to bed. The IP stated if the resident could not reach the call light, it could cause a delay in care, or the resident could injure himself. d. During a concurrent observation and interview on 10/1/2024 at 8:14 a.m. with Resident 156, in Resident 156's room, Resident 156 was observed awake and lying on her bed. The call light cord was placed next to Resident 156's pillow, and the call button was not visible. Resident 156 was unable to grab the call light twice while she was in bed. Resident 156 stated she was not able to reach her call light and needed a toothbrush to brush her teeth. During a review of Resident 156's Admission Record, the record indicated Resident 156 was originally admitted to facility on 9/21/2017 and readmitted on [DATE]. Resident 156's diagnoses included encephalopathy (damage or disease that affected the brain), dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that was characterized by disturbances in thought), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 156's H&P dated 11/16/2023, the H&P indicated Resident 156 could make needs known but could not make medical decisions. During a review of Resident 156's MDS, dated [DATE], the MDS indicated Resident 156's for daily decision making was moderately impaired. The MDS indicated Resident 156 had impairment on one side of the upper extremities and required supervision in eating and oral hygiene. The MDS indicated Resident 156 required maximal assistance in showering self, lower body dressing, toileting and personal hygiene, and rolling left and right. The MDS indicated Resident 156 was dependent (staff did all of the effort) with bed to chair transfer, sit to stand, sit to lying, and lying to sitting on side of bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 156's care plan titled, The resident has a communication problem related to (r/t) weak or low voice, is usually understood/understands, and at risk for social isolation r/t diagnoses dementia and schizophrenia, revised on 6/26/2024, the care plan interventions indicated call light in reach. e. During a concurrent observation and interview on 10/1/2024 at 9:04 a.m. with Resident 255, in Resident 255's room, Resident 255 was observed sitting in a wheelchair on the right side of her bed. The call light was observed on the floor under Resident 255's bed. Resident 255 stated she was unable to reach the call light and needed help with water and the bedside table. During a review of Resident 255's Admission Record, the record indicated Resident 255 was originally admitted to facility on 5/9/2023 and readmitted on [DATE]. Resident 255's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affected the brain's normal functioning), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), muscle weakness, and major depressive disorder. During a review of Resident 255's H&P, dated 7/3/2024, the H&P indicated Resident 255 was able to make decisions for activities of daily living. During a review of Resident 255's MDS, dated [DATE], the MDS indicated Resident 255's cognitive skills for daily decisions making was severely impaired. The MDS indicated Resident 255 had no impairment on all extremities and used a wheelchair for mobility. The MDS indicated Resident 255 required supervision with oral hygiene, personal hygiene, bed to chair transfer, chair to bed transfer, and toilet transfer. During a review of Resident 255's care plan titled, The resident has an adult daily living (ADL) self-care performance deficit r/t weakness, aggressive behavior, confusion, altered mental status, revised on 3/4/2024, the care plan interventions indicated staff were to encourage Resident 255 to use bell to call for assistance. During an interview on 10/2/2024 at 11:39 a.m. LVN 3, LVN 3 stated the call light should be placed on the bed and within reach. LVN 3 stated if a resident was in bed, the call light should be where the resident could reach. LVN 3 stated it was not appropriate to have the call light on the floor, hanging on the light, or placed in drawers because the resident could not reach. LVN 3 stated there would be safety concerns the resident may fall, trip over the call light cord, or get injured if the call light was not placed properly. LVN 3 stated the CNAs and charge nurses were responsible in ensuring resident call lights were within reach and working. During a review of the facility's Policy and Procedure (P&P) tilted Communication-Call System, revised 1/1/2012, the P&P indicated the facility would provide a call light system that would enable residents to alert the nursing staff from their rooms. The P&P indicated the call light would be placed within the resident's reach in the resident's room. The P&P indicated when the resident is out of bed, the call cord will be dipped to the bedspread in such a way as to be available to a wheelchair bound resident.

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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** 49900 Based on observation, interview, and record review, the facility failed to notify the resident's responsible party (RP 1) when there was a room change for one of 11 sampled residents (Resident 101). This deficient practice violated RP 1's right to be promptly informed of changes. Findings: During an observation on 10/1/2024 at 9:32 a.m., outside of room [ROOM NUMBER], Resident 101 was observed sitting down on the bed. During a review of Resident 101's Admission Record, The record indicated Resident 101 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 101's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), and schizophrenia (a mental illness that was characterized by disturbances in thought). The Admission Record indicated Resident 101 was assigned to room [ROOM NUMBER]. During a review of Resident 101's History and Physical (H&P) dated 10/20/2023, the H&P indicated Resident 101 did not have the capacity to understand and make decisions. During a review of Resident 101's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/10/2024, the MDS indicated Resident 101's cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 101 had disorganized thinking (incoherent and illogical thoughts and behaviors). The MDS indicated Resident 101 did not exhibit wandering behavior. The MDS indicated Resident 101 had impairments on lower extremities and used wheelchair for mobility. During a telephone interview on 10/1/2024 at 12:11 p.m., with Resident 101's Responsible Party (RP 1), RP 1stated the facility did not notify her of Resident 101's room change two months ago. RP 1 stated she found out of the room change when she visited Resident 101 at the facility. RP 1 stated she was told the reason of the room change was because Resident 101 kept going into another resident's (unidentified) room so they placed Resident 101 and the unidentified resident in the same room. During a concurrent record review and interview on 10/2/2024, at 11:40 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 101's nurses notes, as of 10/2/2024, were reviewed. The notes indicated no documentations on notifying RP 1 regarding Resident 101's room change. LVN 3 stated Resident 101 had a room change about a month ago, and she was unable to see any documentation in notifying RP 1 regarding the room changes in the nurses notes. LVN 3 stated the charge nurse was responsible for notifying RP 1 and documenting in the nurses notes when there was a room change. LVN 3 stated if it was not documented and did not know the reason of room change and the family may be upset about not being notified. LVN 3 stated it was RP 1's right to be notified of any room changes. (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 on 10/2/2024, at 2:06 p.m. with Registered Nurse (RN) 1, RN 1 stated the nurse should document in the nurses note when a resident had a room change with proper reason and notify the resident and RP. RN 1 stated it was the resident's and RP's right to be notified of a room change. RN 1 stated the risk of not notifying RP 1 of the room change was that Resident 101 would go back to the old room and might lay on another resident's bed. During a review of the facility's policy and procedure (P&P) titled, Room or roommate change, revised on 3/2018, the P&P indicated Prior to changing a room or roommate assignment, the resident, the resident's representative (if available), and the resident's new roommate will be provided timely advance notice of such a change. The notice of a change in room or roommate assignment must be given in writing and will include the reason(s) for such change . Information regarding room or roommate changes will be documented in the resident's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review the facility did not provide a home like environment for two residents out of eight sampled residents (Resident 211 and 225) by not ensuring, 1. Resident 211 had a bedside table during mealtimes. 2. Resident 225 had a bedside table to use when coloring, and during mealtimes. These deficient practices did not provide dignity to Residents 211 and 225 and it did not provide comfort during mealtimes and activities. Findings: 1. During an observation on 9/30/2024 at 12:52 p.m., in Resident 211 room, Resident 211 was observed sitting on the edge of his bed eating lunch. Resident 211's food tray was resting on Resident 211's walker. Resident 211 did not have a bedside table. During a review of Resident 211's Admission Record, the admission record indicated Resident 211 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 211's diagnoses included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and depressive disorder (a common and serious medical illness that negatively affects how a person feels, thinks, and acts, causing feelings of sadness and/or a loss of interest in activities they once enjoyed). During a review of Resident 211's History and Physical (H&P) dated 4/12/2024, the H&P indicated Resident 211 could make needs known but could not make medical decisions. During a review of Resident 211's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/8/2024, the MDS indicated Resident 211's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 211 required supervision for all activities of daily living. During an interview on 9/30/2024 at 12:52 p.m. with Resident 211, in Resident 211's room, Resident 211 stated his food tray was always placed on top of his walker. Resident 211 stated he ate off of his walker every day. Resident 211 stated it was uncomfortable for him to eat off his walker because his food tray was at a lower height and the food was too far from him. Resident 211 stated when he ate, he dropped his food when bringing it to his mouth because his food tray was so far from him. Resident 211 stated he asked for a bedside table but staff stated they did not have enough tables for every resident. Resident 211 stated it was not right to eat off of his walker but he had no choice. 2. During an observation on 10/1/2024 at 12:20 p.m., in Resident 225's room, Resident 225 was observed sitting on his wheelchair and coloring. Resident 225's coloring book and colors were laid out on the bed. Resident 225 was coloring on top of the bed. Resident 225 did not have a bedside table in his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/2024 at 12:45 p.m., in Resident 225's room, Resident 225 was observed eating lunch. Resident 225's lunch tray was placed on top of the nightstand. Resident 225 was eating off of the nightstand while reaching to get closer to the lunch tray. During a review of Resident 225's Admission Record, the admission record indicated Resident 225 was admitted to the facility on [DATE]. Resident 225's diagnoses included depression (a common and serious medical illness that negatively affects how a person feels, thinks, and acts. It causes feelings of sadness and/or a loss of interest in activities they once enjoyed) and muscle weakness (a lack of muscle strength when a full effort doesn't produce a normal muscle contraction or movement). During a review of Resident 225's H&P dated 7/4/2024, the H&P indicated Resident 225 could make needs known but could not make medical decisions. During a review of Resident 225's MDS, dated [DATE], the MDS indicated Resident 225's cognitive skills for daily decision making was intact. The MDS indicated Resident 225 required supervision for dressing, shower/bathing, dressing and for personal hygiene. During an interview on 10/1/2024 at 12:45 p.m. with Resident 225, in Resident 225's room, Resident 225 stated his food tray was always placed on top of his nightstand. Resident 225 stated he always ate off of his nightstand and it was uncomfortable for him because the food tray was far away from him. Resident 225 stated he wanted a table for mealtimes and to use when he colored. Resident 225 stated he asked for a table and staff told him they did not have extra tables for him. Resident 225 stated he did not know why staff had not accommodated him by providing him a bedside table because he had seen other residents with a bedside table. During an interview on 10/3/2024 at 10:06 a.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated residents used the bedside table to eat, and to place their belongings and water on. CNA 2 stated not all residents have a bedside table. CNA 2 stated for the residents that did not have a bedside table, their food tray was placed on top of the nightstand. CNA 2 stated the residents sit on their bed and twist their body to face the nightstand to eat. CNA 2 it was not appropriate to have a resident eat off a nightstand because at home no one eats off their nightstand. CNA 2 stated it was important to provide a table for residents to eat because this was their home and it had to be a homelike environment. During an interview on 10/3/2024 at 11:05 a.m. with Licensed Vocational Nurse (LVN 6), LVN 6 stated all residents should have a bedside table. LVN 6 stated it was not acceptable to have residents eat off their nightstands because nightstands were to store belongings and not to eat from. LVN 6 stated it was important for residents to have a bedside table during mealtimes and activities to provide comfort to residents. During an interview 10/4/2024 11:30 a.m. with Registered Nurse (RN 6), RN 6 stated the facility was the residents' home and staff must accommodate resident's needs. RN 6 stated residents eating off their nightstands and walkers was not a safe practice because food and drinks were warm and may spill or fall and burn the residents. RN 6 stated eating off the nightstand required residents to be in an uncomfortable position and they might slide off the bed. RN 6 stated staff should accommodate resident needs by providing a bedside table to residents for their comfort, safety, dignity, and it was basic human need. (continued on next page)

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F 0584 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 Resident Rights-Accommodation of Needs, dated 1/1/2012, the P&P indicated the facility's purpose was to provide an environment and services that met residents' individual needs. The P&P indicated the facility's environment was designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being and facility staff would assist in achieving those goals.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility staff failed to ensure one of seven sampled residents (Resident 115) was free from an unnecessary restraint, as evidenced by: 1. Failing to ensure an appropriate assessment for less restrictive measures were done prior to placing Resident 115's bed against the wall. This deficient practice had the potential to inhibit Resident 115's freedom of movement. Findings: During an observation on 9/30/2024 at 10:43 a.m., in Resident 115's room, Resident 115 was observed lying in bed. Resident 115's bed was observed against the wall on the right side, and a floor mat on the left side of Resident 115's bed. During a review of Resident 115's Admission Record (Face Sheet), the Face Sheet indicated Resident 115 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 115's diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning, diabetes (abnormal blood sugar), major depression (loss of interest in activities), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), and hypertension (high blood pressure). During a review of Resident 115's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/9/2024, the MDS indicated Resident 115 had severely impaired (never/rarely made decisions) cognitive skills for daily decision making (ability to think and process information). The MDS indicated Resident 115 required supervision or touching assistance (helper provides verbal cues and guard assistance as resident completes activities) from staff for toileting hygiene, showering, and personal hygiene. During a review of Resident 115's care plan titled, At risk for falls related to confusion, unaware of safety needs related to dementia,, revised on 1/31/2024, the care plan indicated staff's interventions included to use landing mats bilaterally (both sides). The care plan had no indication for restraints. During an observation on 10/1/2024 at 12:45 p.m., in Resident 115's room, Resident 115's bed was observed against the wall on the right side. Resident 115 attempted to get out of bed from the right side of the bed and was not able to so. During a concurrent observation and interview on 10/2/2024 at 11:30 a.m., in Resident 115's room, with the Director of Staff Development (DSD 1), DSD 1 stated Resident 115's bed was observed against the wall on the right side. DSD 1 stated Resident 115 was at risk for falls, and the bed was placed against the wall to prevent Resident 115 from falling. DSD 1 stated having the bed against the wall was considered a restraint and should be removed right away. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 1:00 p.m., with Registered Nurse (RN 1), RN 1 stated the facility placed Resident 115's bed against the wall to prevent Resident 115 from getting out of bed unassisted and to prevent Resident 115 from falling and having an injury. RN 1 stated the bed against the wall was a physical restraint and should not be used for staff convenience. During a concurrent interview and record review on 10/3/2024 at 1:22 p.m., with RN 1, Resident 115's Electronic Medical Record (EMR) was reviewed. RN 1 stated there was no documentation that least restrictive measures were implemented prior placing Resident 115's bed against the wall. RN 1 stated there was not a physician order for the use of restraints for Resident 115. During a review of the facility's policy and procedure (P&P) titled Restraints, revised 11/16/2022, the P&P indicated: 1. The facility would honor the resident's right to be free from any restraints that are imposed for reasons other than that of treatment and the resident medical symptoms. The P&P indicated restraints require a physician order and are used as a last resort measure to be used only, when necessary, in accordance with the resident assessment and care plan. 2. Restrains are defined as: a. Convenience -any action taken by the facility to control a resident behavior or manage resident behavior with a lesser amount of effort by the facility and not in the resident best interest. b. Freedom of movement-any change in place or position for the body or any part of the body that the person is physical able to control.

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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** 45009 Based on interview and record review, the facility failed to develop a comprehensive care plan with interventions for three out of nine sampled residents (Residents 148, 15, and 274), by failing to: 1. Ensure an individualized care plan for oxygen administration and respiratory therapy was developed for Resident 148 and Resident 15. 2. Ensure an individualized care plan was developed addressing Resident 274's hand tremors. These deficient practices had the potential to negatively affect the delivery of oxygen therapy and interventions for Residents 148 and 15 and potentially delayed the care for Resident 274. Findings: 1. During a review of Resident 148's Admission Record, dated 10/2/2024, the admission record indicated Resident 148 was admitted to the facility on [DATE]. Resident 148's diagnoses included schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), acute kidney failure (the sudden and rapid loss of kidney's ability to filter waste and balance fluid in blood), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long-term poor airflow), anemia (a condition in which the body does not have enough healthy red blood cells), hypertension (high blood pressure), and atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure). During a review of Resident 148's History and Physical (H&P), dated 1/18/2024, the H&P indicated Resident 148 was able to make decisions for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 148's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 9/17/2024, the MDS indicated Resident 148's cognitive skills (ability to learn, reason, remember, understand, and make decisions) were severely impaired (never or rarely able to make decisions regarding tasks of daily life). The MDS indicated Resident 148 required setup and clean up assistance from a helper for eating and partial assistance (helper does less than half the effort) for toileting and personal hygiene. During a review of Resident 148's Order Summary Report, dated 6/13/2024, the order summary report indicated Resident 148 had an active order to be suctioned for excessive secretions (fluids produced by the lungs and airways, such as mucus and phlegm) as needed. (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 review of Resident 148's Order Summary Report, dated 6/13/2024, the order summary report indicated Resident 148 had an active order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 3 milligrams (MG, unit of measurement) per (/) 3 milliliter (ML, unit of measurement), inhale 3 ML every 4 hours as needed for shortness of breath and wheezing (a high-pitched, whistling sound that can occur during breathing when the airways become narrowed or blocked) via nebulizer (small device that turns liquid medicine into a mist that can be inhaled through a mask or mouthpiece). During a review of Resident 148's Order Summary Report, dated 9/1/2024, the order summary report indicated Resident 148 had an active order for Oxygen at 2 liter per minute nasal cannula (medical device that provides supplemental oxygen to a patient through their nose) to keep oxygen saturation (the percentage of oxygen you have circulating in your blood) above 92 percent (%) for COPD. During a review of Resident 148's Nursing Progress Notes, dated 10/2/2024, the progress note indicated Resident 148 verbalized wanting suction available at bedside as needed for increased secretions. During a review of Resident 148's medical records, on 10/1/2024, the medical records indicated there were no care plans initiated for oxygen administration, respiratory therapy, or the use of a suction device. During a concurrent interview and record review on 10/3/2024 at 9:44 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 148's care plans and physician orders dated 6/14/2024 and 9/1/2024 were reviewed. LVN 6 stated there were no care plans for Resident 148's oxygen administration or respiratory therapy treatments. LVN 6 stated whenever there was an order there should be a care plan. LVN 6 stated the care plan would have interventions of when to change the oxygen tubing, monitoring of the resident's saturation, and to watch out for desaturation (a decrease in the amount of oxygen in the blood). LVN 6 stated with no care plan there was no communication to the staff of how to care for the resident and something could be missed. During an interview on 10/3/2024 at 4:23 p.m., with the Director of Nursing (DON), the DON stated the care plan provided individualized care for the resident. The DON stated the care plan for Resident 148 should have interventions on how to take care of a resident receiving oxygen. 2. During a review of Resident 15's Admission Record, indicated Resident 15 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with a diagnosis of respiratory failure (serious condition that makes it difficult to breath, lungs can't get enough oxygen into the blood) and COPD. A review of Resident 15's H&P dated 9/24/2024, the H&P indicated Resident 15 could make needs known but could not make medical decisions. During a review of Resident 15's MDS, dated [DATE], the MDS indicated that Resident 15's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 15 required moderate assistance (staff does less than half the effort) for personal hygiene and toileting hygiene. During a review of Resident 15's Order Summary Report, dated 9/24/2024, the Order Summary report indicted Resident 15 had an oxygen order for 2 Liters per Minute (LPM) via nasal cannula. (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 review of Resident 15's medical chart, the medial chart did not have a care plan for Resident 15's oxygen administration. During an interview on 10/4/2024 at 11:54 a.m. with Registered Nurse (RN 6), RN 6 stated a care plan for oxygen administration should have been developed for Resident 15. RN 6 stated a care plan indicated the plan of care for a resident and it provided guidance for nurses because it set resident goals and interventions to help the residents. 3. During a review of Resident 274's Admission Record, the admission record indicated Resident 274 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including idiopathic peripheral neuropathy (a condition where the peripheral nerves are damaged but the cause is unknown, causing numbness, tingling or burning sensation, pain and loss of sensation) and bipolar disorder (a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). During a review of Resident 274's H&) dated 8/2/2024, the H&P indicated Resident 274 could make needs known but could not make medical decisions. During a review of Resident 274's MDS, dated [DATE], the MDS indicated that Resident 274's cognitive skills for daily decision making was intact. The MDS indicated Resident 274 required supervision for toileting hygiene, dressing, shower/bathing, and personal hygiene. During a review of Resident 274's medical chart, the medial chart did not have a care plan for Resident 274 hand tremors. During an interview on 10/3/2024 at 11:34 a.m. with Licensed Vocational Nurse (LVN 9), LVN 9 stated medications, change of conditions, and behaviors were care planned. LVN 9 stated it was important to develop care plans to inform staff the goals and interventions that were developed for residents' issues. LVN 9 stated if something did not get care planned it could get missed and staff would not appropriately care for the resident. LVN 9 stated the new onset of hand tremors for Resident 274 should have been care planned when they filled out the change of condition form. During an interview on 10/4/2024 at 11:54 a.m. with Registered Nurse (RN 6), RN 6 stated when there was a change of condition, a care plan should have been developed. RN 6 stated Resident 274's hand tremors was a change of condition and a care plan should have been developed, indicating the monitoring of the hand tremors. RN 6 stated it was important to develop care plans because it provided information on the residents' health and informed staff what issues the residents have. RN 6 stated that if something did not get care planned, staff would not know what interventions to do to help residents. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning effective date 9/7/2023 and revised on 8/24/2023, the P&P indicated the facility would ensure a comprehensive person-centered care plan would be developed for each resident. The P&P indicated a care plan would address resident-specific health and safety concerns to prevent decline or injury. The P&P indicated each care plan would include initial goals based on the admission orders and the physician's orders to properly care for a resident.

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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** 49900 Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan intervention for one of 11 sampled resident (Resident 216), after Resident 216 kept wandering into other resident's rooms. This deficient practice had the potential to increase the likelihood of Resident 216 getting injured and harmed from another resident and was a violation of the other residents' privacy. Findings: During an observation on 9/30/2024 at 10:00 a.m., in the facility's East Wing Hallway, Resident 216 was observed wheeling herself into another resident's (Resident 181) room. During an observation on 9/30/2024 at 11:48 a.m., in the facility's East Wing Hallway, Resident 216 was observed wheeling herself into Resident 181's room. During a record review of Resident 216's Admission Record, the admission record indicated Resident 216 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 216's diagnoses included encephalopathy (a group of conditions that caused brain dysfunction), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), delusional disorders (having false or unrealistic beliefs), and paranoid schizophrenia (a mental illness that was characterized by disturbances in thought). During a record review of Resident 216's History and Physical (H&P) dated 3/20/2024, the H&P indicated Resident 216 was able to make decisions for activities of daily living. During a record review of Resident 216's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/24/2024, the MDS indicated Resident 216's cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 216 had disorganized thinking (incoherent and illogical thoughts). The MDS indicated Resident 216 had impairment on the lower extremities and used a manual wheelchair for mobility. During a record review of Resident 216's care plan titled, Resident has tendency of wandering around and going into other resident's room, revised on 10/2/2024, the care plan indicated the staff's intervention included to monitor Resident 216's location frequently and redirect the resident from other resident's room. During an interview on 10/3/2024 at 9:10 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 216 needed constant redirection from wandering into other resident's room. CNA 3 stated redirecting was not effective to manage Resident 216's wandering behavior. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 9:32 a.m., with Licensed Vocational Nurse (LVN) 8, Resident 216's care plan titled, Resident has tendency of wandering around and going into other resident's room, revised on 10/2/2024, was reviewed. LVN 8 stated Resident 216 manifested wandering behavior daily and went into different residents' rooms. LVN 8 stated staff redirected Resident 216 but it was ineffective. LVN 8 stated the interventions were not effective and the care plan should be revised. LVN 8 stated it was important to make sure Resident 216 did not to go into other resident's room because they did not want to disturb the other resident's privacy. LVN 8 stated it was the other residents' rights to stay in their assigned rooms. LVN 8 stated Resident 216 may get hit by other residents if Resident 216 wandered into other residents' rooms. LVN 8 stated there would be potential for a resident-to-resident altercation if Resident 216 wandered into other residents' rooms. LVN 8 stated the LVNs and Registered Nurses (RN) were the ones responsible for revising the care plan. During a review of the facility's policy and procedure (P&P) titled, Wandering and elopement, revised on 1/31/2023, the P&P indicated, preventative interventions would be reviewed and re-evaluated by the interdisciplinary team (IDT - group of different disciplines working together for a common goal of a resident) upon admission, readmission, quarterly, and upon change in condition. During a review of the facility's P&P titled, Comprehensive person-centered care planning, revised on 8/24/2023, the P&P indicated, the comprehensive care plan would be revised by the IDT after each MDS assessment and at other times as appropriate or necessary.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure staff used a communication board and/or interpreter services for one of seven sampled residents (Resident 262) who did not speak the predominant (most spoken or used language) language of the facility. This deficient practice had the potential to negatively affect Resident 262's physical, mental, and psychosocial needs by preventing the resident from communicating with staff and potentially causing missed or delayed care and treatments. Findings: During a review of Resident 262's Admission Record (Face Sheet), the Face Sheet indicated Resident 262 was admitted to the facility on [DATE]. Resident 262's diagnoses included major depression (major depression (loss of interest in activities), dementia (a group of thinking and social symptoms that interferes with daily functioning), and hypertension (high blood pressure). During a review of Resident 262's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 3/3/2024, the MDS indicated Resident 262 's cognitive (ability to think and process information) skills for daily decision making was severely impaired (never/rarely made decisions). During a review of Resident 262's History and Physical (H&P), dated 8/7/2024, the H&P indicated Resident 262 did not have the capacity to understand and make decisions. During a concurrent observation and interview on 9/30/2024 at 3:44 p.m., in Resident 262's room, with Certified Nurse Assistant (CNA 5), Resident 262 was observed speaking Cambodian (language spoken of the population of country of Cambodia) language. Resident 262 was observed making hands gestures. CNA 5 stated she could not understand the language Resident 262 was speaking. CNA 5 was asked if Resident 262 had any type of communication device and/or board to assist her (CNA 5) with communication. CNA 5 stated she was not aware of any type of communication devices and /or boards used to communicate with Resident 262. CNA 5 stated I am trying my best to understand the facial and hands gestures. During an interview on 10/3/2024 at 1:00 p.m., with Registered Nurse (RN) 1, RN 1 stated residents with communication challenges and/or language barriers should be provided communication devices and/or communication boards and should be always accessible to residents. RN 1 stated Resident 262 using hand gestures could be misunderstood and/or misinterpreted and had the potential for delay care and/or treatment. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights-Quality of Life, revised 3/2017, the P&P indicated, the facility would ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Accommodation of Residents 'Communication Needs, revised 3/2017, the P&P indicated, the facility would provide assistance to residents with communication challenges through a number of adaptive services: a. Writing pad and pen. b. Communication boards/charts. c. Interpreter services for foreign languages.

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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** 45009 Based on observation, interview, and record review, the facility failed to ensure low-air-loss mattresses ([LALM] a mattress that provides airflow to help keep skin dry, as well as to relieve pressure, and used to treat and prevent pressure ulcers [injuries to the skin and underlying tissue]) were inflated properly for five of 13 sampled residents (Resident 117, 133, 155, 206, and Resident 255) when: 1. Resident 155's LALM was inflated based on a weight of 350 pounds (Lbs., unit of weight). Resident 155 weighed 222.4 Lbs. on 9/15/2024. 2. Resident 206's LALM was inflated based on a weight of 320 Lbs. Resident 206 weighed 147.8 Lbs. on 9/4/2024. 3. Resident 255's LALM was inflated based on a weight of 350 Lbs. Resident 255 weighed 106.2 Lbs. on 9/4/2024. 4. Resident 133's LALM was inflated based on a weight of 200 Lbs. Resident 133 weighed 135 Lbs. 5. Resident 117's LALM was inflated based on a weight of 350 Lbs. Resident 117 weighed 245 Lbs. These deficient practices had the potential to result in pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) development and skin breakdown for Residents 117, 133, 155, 206, and 255. Findings: 1. During an observation on 9/30/2024 at 10:32 a.m., in Resident 155's room, Resident 155's Drive Brand low-air-loss mattress (LALM - a mattress that provides airflow to help keep skin dry, as well as to relieve pressure, and used to treat and prevent pressure ulcers [injuries to the skin and underlying tissue]) was observed. The LALM's pump indicated the LALM was inflated based on a weight of 350 Lbs. During a concurrent observation and interview on 10/2/2024, at 10:48 a.m., with Licensed Vocational Nurse (LVN) 5, in Resident 155's room, the pump indicated the LALM was inflated based on a weight of 350 pounds ([Lbs.] unit of weight). LVN 5 stated the LALM pump indicated Resident 155 weighed 350 Lbs. During a review of Resident 155's Admission Record, the admission record indicated Resident 155 was originally admitted to facility on 7/23/2019 and readmitted on [DATE]. Resident 155's diagnoses included Diabetes Mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), obesity (having too much body fat), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). (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 155's History and Physical (H&P) dated 8/18/2024, the H&P indicated Resident 155 had the capacity to understand and make decisions. During a review of Resident 155's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/24/2024, the MDS indicated Resident 155's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 155 was at risk of developing pressure ulcers. The MDS indicated Resident 155 had impairment on one side of the lower extremities and required moderate assistance in toileting hygiene, personal hygiene, and rolling left and right. During a review of Resident 155's order summary report as of 10/2/2024, the report indicated an order dated 8/17/2024 for LALM every shift for skin management. During a review of Resident 155's care plan titled, The resident at risk for pressure ulcer due to immobility, revised on 8/28/2024, the care plan indicated staff were to Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. During a concurrent record review and interview on 10/2/2024, at 10:50 a.m., with LVN 5, Resident 155's weights summary was reviewed. The summary indicated Resident 155 weighed 222.4 Lbs. on 9/15/2024. LVN 5 stated the Drive LALM pump was set up wrong and needed to be fixed. LVN 5 stated the LALM was to prevent pressure ulcers, and it might not be providing the right amount of firmness if it was inflated improperly. LVN 5 stated the potential risk of not inflating the LALM properly would be pressure ulcer development. 2. During an observation on 9/30/2024 at 11:17 a.m., in Resident 206's room, Resident 206 was observed sleeping on a Drive Brand LALM. The LALM pump indicated the LALM was inflated based on a weight of 320 Lbs. During a review of Resident 206's Admission Record, the admission record indicated Resident 206 was originally admitted to facility on 11/1/2022 and readmitted on [DATE]. Resident 206's diagnoses included Stage IV pressure ulcer of the sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), dementia, bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 206's H&P, dated 1/16/2024, the H&P indicated Resident 206 could make needs known but could not make medical decisions. During a review of Resident 206's MDS, dated [DATE], the MDS indicated Resident 206's cognitive skills for daily decisions making was severely impaired. The MDS indicated Resident 206 was at risk of developing pressure ulcers. The MDS indicated Resident 206 had impairment to both extremities and used a wheelchair for mobility. The MDS indicated Resident 206 required moderate assistance on rolling left and right. The MDS indicated Resident 206 was dependent (helper did all the effort) with toileting hygiene and personal hygiene. During a review of Resident 206's order summary report as of 10/2/2024, the report indicated LALM every shift was ordered on 1/14/2024 for skin management. (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 206's care plan titled, The resident at risk for pressure ulcer due to immobility, revised on 7/2/2024, the care plan indicated staff were to Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. During a review of Resident 206's Weights Summary dated 10/2/2024, the summary indicated Resident 206 weighed 147.8 Lbs. on 9/4/2024. 3. During an observation on 10/1/2024 at 9:04 a.m., in Resident 255's room, Resident 255's Proactive Brand LALM was observed. The pump indicated the LALM was inflated based on a weight of 350 Lbs. During a review of Resident 255's Admission Record, the admission record indicated Resident 255 was originally admitted to facility on 5/9/2023 and readmitted on [DATE]. Resident 255's diagnoses included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affected the brain's normal functioning), diabetes mellitus, muscle weakness, and major depressive disorder. During a review of Resident 255's H&P, dated 7/3/2024, the H&P indicated Resident 255 was able to make decisions for activities of daily living. During a review of Resident 255's MDS, dated [DATE], the MDS indicated Resident 255's cognitive skills for daily decisions making was severely impaired. The MDS indicated Resident 255 was at risk of developing pressure ulcers. The MDS indicated Resident 255 had no impairment to all extremities and used a wheelchair for mobility. During a review of Resident 255's care plan titled, The resident has potential for pressure ulcer development related to (r/t) decreased immobility, incontinence (inability to control) revised on 5/22/2024, the care plan indicated staff were to Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. During a review of Resident 255's Weights Summary, dated 10/2/2024, the summary indicated Resident 255 weighed 106.2 Lbs. on 9/4/2024. During an interview on 10/2/2024 at 2:35 p.m. with Treatment Nurse (TN) 1, TN 1 stated the LALM pump was to control the firmness of the mattress based on the resident's weight. TN 1 stated the licensed nurse was the one responsible for adjusting the pump and rechecking at least quarterly. TN 1 stated the pump should be adjusted if there was a change in the resident's weight. TN 1 stated the purpose of the LALM was to reduce pressure to prevent pressure ulcer and skin breakdown. TN 1 stated if the LALM was inflated improperly the resident would have the potential for skin breakdown. 4. During an observation on 9/30/2024 at 10:46 a.m., in Resident 133's room, Resident 133 was observed resting on a LALM that was set for a weight of 200 Lbs. During a review of Resident 133's Admission Record, the admission record indicated Resident 133 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 133's diagnoses included diabetes mellitus and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). (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 133's H&P dated 8/15/2024, the H&P indicated Resident 133 did not have the capacity to understand and make medical decisions. During a review of Resident 133's MDS, dated [DATE], the MDS indicated Resident 133's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 133 required maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathing, and dressing, and required moderate assistance (helper does less than half the effort) with personal hygiene. During a review of Resident 133's Weight and Vital Summary dated 9/9/2024, the summary indicated Resident 133 weighed 126 Lbs. 5. During an observation on 10/1/2024 at 8:43 a.m., in Resident 117's room, Resident 117 was observed resting on a LALM that was set for a weight over 350 Lbs. During a review of Resident 117's Admission Record, the admission record indicated Resident 117 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and chronic kidney disease (gradual loss of kidney function). During a review of Resident 117's H&P dated 5/9/2024, the H&P indicated Resident 117 could make needs known but could not make medical decisions. During a review of Resident 117's MDS, dated [DATE], the MDS indicated that Resident 117's cognitive skills for daily decision making was intact. The MDS indicated Resident 117 was dependent on staff for toileting hygiene, shower/bathing, dressing, and personal hygiene. The MDS indicated Resident 117 required supervision (helper provides verbal cues and touching as resident completes activity) for eating and oral hygiene. During a review of Resident 117's Weight and Vital Summary dated 9/2/2024, the summary indicated Resident 117 weighed 249 Lbs. During an interview on 10/1/2024 at 8:45 a.m. with Resident 117, in Resident 117's room, Resident 117 stated his back was killing him. Resident117 stated he notified staff that his bed was uncomfortable but no one came to check on the bed. Resident 117 stated that no one came to check on his mattress to see if it was working properly or if it was set appropriately. During an interview on 10/3/2024 at 10:56 a.m. with LVN 9, LVN 9 stated the purpose of a LALM was to prevent skin issues. LVN 6 stated licensed nurses were supposed to check if the LALM was set according to the residents' weight and check if it was working. LVN 9 stated if the LALM was not set to the correct weight it could potentially hurt the resident and cause pressure injuries. LVN 9 stated if the LALM was over inflated it would not be therapeutic for the resident and the LALM would be too hard. LVN 9 stated if the LALM was underinflated it would not create a therapeutic effect and the resident might fall into the bed frame. (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 10/4/2024 at 11:30 a.m. with Registered Nurse (RN 6), RN 6 stated checking the LALM was part of the licensed nurses' rounds. RN 6 stated licensed nurses should check if the LALM was working, set according to the residents' weight and should ask the resident if the bed was comfortable. RN 6 stated it was important to set the LALM according to the residents weight to prevent the residents from getting hurt while in bed. During a review of the Proactive brand's manufacturer manual, undated, the manual indicated the user could adjust the pressure level of the air mattress to a desired firmness according to the suggestions from a health care professional. During a review of the Drive brand's manufacturer manual, revised on 6/30/2016, the manual indicated the pump can be used to adjust the pressure of the inflated mattress based on the resident's weight. During a review of the facility's Policy and Procedure (P&P) titled, Mattress, revised on 1/1/2012, the P&P indicated the facility would provide mattresses to provide pressure reduction to residents at risk for skin breakdown and to distribute body weight relieving areas of pressure. The P&P indicated the staff would make sure the mattress was inflating properly and staff would check the air mattress routinely to ensure it was working properly.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure quality Restorative Nursing Aide (RNA) services were provided, as ordered, for three out of eight sampled residents (Residents 132, 166 and 223) by failing to: 1. Ensure enough Certified Nursing Assistants (CNAs) were staffed to ensure RNAs would not be utilized to perform both CNA and RNA duties. 2. Ensure RNA documentation tasks were made accessible in the electronic medical record (EMR) to allow RNAs to review and document RNA services that were ordered. 3. Ensure RNA orders were performed, as ordered by the physician. These failures had the potential to cause a decline in the mobility and range of motion for Residents 166, 132, and 223. Findings: a. During a review of Resident 132's Admission Record, the Admission Record indicated Resident 132 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 132's diagnoses included Parkinson's Disease (a chronic, progressive brain disorder that affects the nervous system and causes movement problems), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), severe protein-calorie malnutrition, and lack of coordination. During a review of Resident 132's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/8/2024, the MDS indicated Resident 132's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 132 was dependent on staff when activities of daily living (ADLs, daily self-care activities such as dressing, personal hygiene, dressing, and toileting hygiene) were performed. During a review of Resident 132's care plan titled Limited Physical Mobility, initiated 12/7/2021, and revised on 1/20/2023, the staff interventions indicated to provide passive range of motion (PROM- the maximum range of motion a joint can achieve when an outside force, such as a therapist or machine, causes movement) exercises on the left and right upper and lower extremities (arms, legs) once a day, five times a week as tolerated. During a review of Resident 132's Physician Orders, dated 7/23/2024, the Physician Orders indicated to perform PROM on the left and right upper extremities once a day, five times a week as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 132's Physician Orders, dated 8/7/2024, the Physician Orders indicated to perform PROM exercises on the left and right lower extremities once a day, five times a week as tolerated. The Physician Orders also indicated to don (apply) and doff (take off) the right Prafo boot (an assistive device to aid in range of motion) for two and half hours once a day for five times a week. During a review of Resident 132's RNA Documentation Report, dated 8/1/2024 to 10/1/2024, no documentation was provided to indicate Resident 132 was provided PROM exercises for both upper extremities from 8/1/2024 to 10/1/2024 (two months). The report also indicated Resident 132 was not provided PROM exercises for both lower extremities on 8/14/2024 and 9/10/2024. During a concurrent observation and interview, on 10/1/2024, at 9:10 a.m., with RNA 1 and RNA 2, Resident 132's range of motion exercises were observed. RNA 1 and RNA 2 completed PROM to Resident 132's lower extremities. PROM exercises were not performed for Resident 132's upper extremities. RNA 1 and RNA 2 stated that Resident 132 did not have orders for PROM exercises for the upper extremities. During an interview, on 10/3/2024, at 11:09 a.m., with RNA 1, RNA 1 stated she had been assigned as Resident 132's RNA for the past three months and was familiar with Resident 132's RNA orders. RNA 1 stated that she was unaware that Resident 132 had orders to perform PROM exercises for the upper extremities. RNA 1 stated that she did not perform PROM exercises for Resident 132's upper extremities because she did not have access to review the active RNA orders in the EMR, nor did she see a task for the RNA order on her version of the EMR. RNA 1 stated she solely relied on the task screen of the EMR to review and confirm RNA orders and to complete documentation. b. During a review of Resident 223's Admission Record, the Admission Record indicated Resident 223 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 223's diagnoses included contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the left and right knee, contractures of the left and right elbow, and gastrostomy. During a review of Resident 223's MDS, dated [DATE], the MDS indicated Resident 223's cognition was severely impaired. The MDS indicated Resident 223 required substantial assistance (helper performs more than half the effort of the task) when activities of daily living were performed. During a review of Resident 223's Physician Orders, dated 11/24/2023 to 3/20/2024, the Physician Orders indicated to perform AROM on the left and right upper extremities once a day; and perform PROM exercises for both lower extremities once a day, five times a week as tolerated. During a review of Resident 223's care plan titled, At Risk for Bilateral Lower Extremity Decline in ROM and Strength, dated 3/20/2024, the staff's interventions indicated to provide active range of motion exercises (AROM-the range of movement a person can achieve by using their muscles to contract and relax, without assistance) on both upper extremities once a day, five times a week; provide PROM exercises for both lower extremities once a day, five times a week; and apply the right and left knee extension splint (an assistive device to aid with contractures) for one and a half hours for five days a week as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 223's Physician Orders, dated 4/6/2024, the Physician Orders indicated to apply right and left knee extension splint for one and a half hours for five days a week as tolerated. During a review of Resident 223's RNA Documentation Report, dated 7/1/2024 to 10/1/2024, no documentation was provided to indicate Resident 223 had a right knee extension splint applied for one and a half hours from 7/1/2024 to 10/1/2024 (three months). The report also indicated Resident 223 did not receive any RNA services on 7/2/2024, 7/9/2024, 7/29/2024, 8/7/2024, 8/12/2024, 8/14/2024, and 9/10/2024. c. During a review of Resident 166's Admission Record, the Admission Record indicated Resident 166 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 166's diagnoses included contracture of the right knee, dysphagia (trouble swallowing), and cerebral infarction (interruption in the blood flow of the brain). During a review of Resident 166's MDS, dated [DATE], the MDS indicated Resident 166's cognition was severely impaired. The MDS indicated Resident 166 required substantial assistance when activities of daily living were performed. During a review of Resident 166's Physician Orders, dated 6/21/2024, the Physician Orders indicated to perform PROM exercises on both lower extremities once a day, five times a week as tolerated. The Physician Orders also indicated to apply the right knee extension splint and to apply the right Prafo splint five times a week for up to four hours. During a review of Resident 166's RNA Documentation Report, dated 6/1/2024 to 10/1/2024, there was no documentation provided to indicate the RNAs had applied Resident 166's right knee extension splint and the right Prafo splint five days a week for up to four hours, as ordered per the physician from 6/24/2024 to 10/1/2024 (for approximately three months). During a review of Resident 166's RNA Documentation Report, dated 6/1/2024 to 10/1/2024, the report indicated Resident 166 did not receive any RNA services on 6/27/2024, 7/2/2024, 7/14/2024, 7/29/2024, 8/7/2024, 8/12/2024, 8/14/2024, and 9/10/2024. During a concurrent interview and record review, on 10/2/2024, at 4:15 p.m., with RNA 1, Resident 166's, 132's, and 223's RNA Documentation Reports, dated 7/1/2024 to 10/1/2024, were reviewed. RNA 1 stated that she worked on 9/10/2024 and was originally assigned to provide RNA services to Residents 166, 132, and 223. RNA 1 stated that she recalled that she was asked to fulfill CNA duties, and that was why she could not perform RNA duties that day. RNA 1 stated that RNAs were usually asked to fulfill CNA duties if there was not enough CNA staff, which was why there was gaps in the provision of RNA services and a lack of documentation. RNA 1 stated six RNAs were usually needed to meet the needs of the facility and fulfill the RNA orders. RNA 1 stated RNAs were usually asked to work on the floor as CNA's about once or twice a week. RNA 1 stated that this adversely affected the quality of care delivered to the residents who needed RNA services because she had less time to complete her RNA tasks. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 10/4/2024, at 9:24 a.m., with Registered Nurse 1, RN 1 stated she would usually ask the RNAs to perform CNA duties on days that the facility was short staffed. RN 1 stated that it was best practice to keep six RNAs on the floor so the RNAs could complete the RNA orders for the residents. RN 1 stated there was a potential for the care of the residents receiving RNA services to have been negatively affected, which could have resulted in an overall, decline in their ROM. During an interview, on 10/3/2024, at 11:32 a.m., with the Director of Staff Development (DSD), the DSD stated that she was responsible for double checking that the RNAs were assigned the RNA order task in the EMR. The DSD stated that this allowed the RNAs to document and visualize their workload for the shift. The DSD stated that some of the RNA orders were assigned to the CNA task list, which was why RNAs could not chart for the task. The DSD stated that this error resulted in the RNAs not performing the RNA orders and not documenting the RNA tasks. The DSD stated that a better process needed to be set in place. During an interview, on 10/3/2024, at 10:02 a.m., with the Director of Rehabilitation (DOR), the DOR stated the physician orders were ordered for residents based on the rehabilitation department's suggestions. The DOR stated that if the services were not rendered, as ordered, there would be a potential for a decline. During a review of the facility's Policy and Procedure (P&P), titled, Range of Motion Exercise Guidelines, dated 1/1/2012, the P&P indicated the facility was to provide ROM exercises per an order from the attending physician or physical therapist. The P&P also indicated that nursing staff should document the application of the device and the effects on the resident. During a review of the facility's P&P, titled, Restorative Nursing Program Guidelines, dated 9/19/2019, the P&P indicated the program was to provide nursing interventions that promoted a patient's ability to attain, and maintain his or her optimal functional potential. The P&P indicated restorative care implied that the possibility for progress existed and that improvement can be expected, or there was a risk of imminent decline that can be prevented. During a review of the facility's Restorative Aide Job Description (undated), the Job description indicated that the RNA was to perform ROM of exercises as per physician's order and perform the application of splints. The Job Description indicated that the RNA was to document on the RNA sheet on a daily basis.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to monitor and record the urine output from the indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine) for two of two sampled residents (Residents 71 and 246). This deficient practice had the potential to cause undetected fluid overload (a condition where the body has too much water), or fluid deficit (occurs when the body loses more fluids than it takes in), and an undetected malfunction of the indwelling urinary catheter. Findings: a. During a review of Resident 246's Face Sheet, the Face Sheet indicated Resident 246 was admitted to the facility on [DATE]. Resident 246's diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), major depression, schizophrenia (a serious mental illness that affects how a person thinks feels, and behaves), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). During a review of Resident 246's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/29/2024, the MDS indicated Resident 246 had severely impaired cognition (ability to think and reason). The MDS indicated Resident 246 was dependent from staff for toileting hygiene, shower, and personal hygiene. During a review of Resident 246's physician order, dated 9/29/2024, the physician order indicated for an indwelling catheter related to urinary retention (difficulty urinating). During a review of Resident 246's care plan dated 9/30/2024, the care plan indicated Resident 246 had indwelling catheter related to urinary retention (difficulty urinating). The care plan interventions indicated to monitor Resident 246's output related to indwelling catheter use as per the facility's policy. During an observation on 9/30/2024 at 12:31 p.m., and 4:30 p.m., in Resident 246's room, Resident 246 was observed lying in bed. The indwelling catheter urine collection bag was empty (without urine). During an observation on 10/1/2024 at 8:30 a.m., in Resident 246's room, Resident 246's indwelling catheter urine collection bag was empty. During a concurrent observation and interview on 10/1/2024 at 8:40 a.m., in Resident 246's room, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 246's catheter urine bag was emptied during Resident 246' morning personal hygiene care. CNA 1 stated she did not record the urine output amount. CNA 1 stated she was not aware that Resident 246's urine output should have been recorded. CNA 1 stated Resident 246's indwelling catheter was new, and she did not have the task assigned to her daily resident care assignment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/2024 at 9:00 a.m., with the Director of Staff Development (DSD) 1, DSD 1 stated indwelling catheter urine output would be monitored by licensed nurses and recorded on Resident 246's Medication Administration Record (MAR). During a concurrent interview and record review on 10/3/2024 at 1:00 p.m., with Registered Nurse (RN) 1, Resident 246's MAR dated 9/29/2024 thought 10/1/2024 was reviewed. RN 1 stated Resident 246's indwelling catheter was inserted on 9/29/2024. RN 1 stated there was no documentation indicating the nurses monitored Resident 246's urine output. RN 1 stated it was a standard of practice to monitor residents with indwelling catheter urine output every shift for 30 days. RN 1 stated failure to monitor could result in Resident 246 urinary retention, infection, and could lead to the death of the resident. b. During a review of Resident 71's Admission Record, the record indicated Resident 71 was originally admitted to facility on 12/10/2021. Resident 71's diagnoses included chronic kidney disease (condition when kidneys were damaged and could not filter blood the way they should), obstructive uropathy (a disorder of the urinary tract that occurred when urine was blocked from flowing through the urinary tract), benign prostatic hyperplasia (BPH - a noncancerous enlargement of the prostate gland), dementia, and schizophrenia. During a review of Resident 71's H&P dated 2/9/2024, the H&P indicated Resident 71 had a indwelling urinary catheter due to urinary retention. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 71 had no impairment to the extremities (arms, legs) and use a wheelchair and walker for mobility. During a review of Resident 71's Order Summary Report, dated 10/2/2024, the Order Summary Report indicated to provide indwelling urinary catheter care every shift on 1/19/2022. The Order Summary report indicated to assess the amount of urine output every shift for indwelling urinary catheter usage on 8/30/2023. During a review of Resident 71's care plan titled, The resident has indwelling catheter, revised on 6/28/2024, the care plan interventions indicated for staff to monitor and document Resident 71's intake and output as per the facility policy, and provide indwelling urinary catheter care every shift. During a review of Resident 71's Treatment Administration Record (TAR) for September 2024 was reviewed, the TAR indicated Resident 71's indwelling urinary catheter was changed on 9/1/2024. The TAR indicated missing documentation for indwelling urinary catheter care on the 9/3/2024 night (11 pm - 7 am) shift, 9/7/2024 evening (3 pm - 11 pm) shift, 9/19/2024 evening shift, 9/21/2024 morning (7 am - 3 pm) shift, 9/27/2024 night shift, and 9/28/2024 night shift. During a concurrent observation and interview on 10/2/2024 at 10:01 a.m., with CNA 4, CNA 4 she did not know how to record the amount of indwelling urinary catheter urine output for Resident 71 on the electronic charting system. CNA 4 stated she checked the amount of urine when emptying the indwelling urinary catheter, recorded the amount of urine output on a piece of paper, and reported it to charge nurse. CNA 4 stated it might cause harm to Resident 71 if staff was not checking the urine output and it might be neglect. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024 at 11:17 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she did not know where to find Resident 71's urine output records since she was not assigned for Resident 71. LVN 3 stated it was important to record the indwelling urinary catheter urine output because the nurse could see if the resident was losing any amount of fluid, check the intake and output balance, and make sure the indwelling urinary catheter was working correctly. LVN 3 stated the charge nurse was responsible for recording the amount of urine output. During a concurrent interview and record review on 10/2/24 at 1:44 p.m. with Registered Nurse (RN) 1, Resident 71's Medication Administration Record (MAR) for the month of September 2024 was reviewed. The MAR did not show that the indwelling urinary catheter urine output was recorded. RN 1 stated Resident 71's MAR for the month of September 2024 indicated no signs or symptoms of infection from the indwelling urinary catheter but did not indicate the amount of urine output. During a concurrent interview and record review on 10/2/24 at 1:46 p.m. with RN 1, Resident 71's nurses notes for September and October 2024 were reviewed, the notes indicated no documentation on Resident 71's indwelling urinary catheter urine output. RN 1 stated nurses sometimes documented urine output on the nurses' notes. RN 1 stated she was unable to see the indwelling urinary catheter urine output in the nurses' notes. During a concurrent interview and record review on 10/2/24 at 1:48 p.m. with RN 1, Resident 71's care plan titled, The resident has indwelling catheter, revised on 6/28/2024 was reviewed. The care plan indicated staff were to assess Resident 71's urinary drainage for the amount of urine output every shift for infection control. RN 1 stated the care plan indicated to assess the urine output which meant the charge nurse needed to document the amount of urine output every shift on the MAR. RN 1 stated it was important to document so staff could see how much urine the resident was producing, if the resident was retaining urine, and if the resident was experiencing any signs or symptoms of infection. RN 1 stated the licensed nurse and the MDS Nurse should implement care plan interventions. During a review of the facility's Policy and Procedure (P&P), tilted Intake and Output Recording, revised 4/15/2021, the P&P indicated residents intake and output of residents who have an indwelling catheter would be monitored and recorded for 30 days.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 15 and Resident 148) received respiratory care consistent with professional standards of practice by failing to: 1. Ensure Resident 15 received oxygen as ordered. 2. Ensure the nasal cannula (a device used to deliver supplemental oxygen through the nose) tubing, oral suction device (a small plastic tube attached to a suction machine to remove saliva or mucus from the mouth), nebulizer (a device that turns the liquid medicine into a mist which is then inhaled) mask, and respiratory set-up bags (plastic bags used to store oxygen supplies) were changed after seven days. 3. Ensure there was signage indicating oxygen was in use outside of Resident 15 and 148's room. These deficient practices had the potential to result in unsafe use or storage of oxygen equipment, respiratory infection, inability to breathe comfortably, and/or hospitalization , and place Resident 15 and Resident 148 at risk of injury due to a fire hazard. Findings: a. During an observation on 9/30/2024 at 10:56 a.m., in Resident 15's room, Resident 15 was observed lying in bed. The nasal cannula was not dated. Resident 15 nasal cannula was hooked up to an oxygen cylinder (a medical device that produces a higher concentration of oxygen from the surrounding air) and the resident was receiving 2.5 liters per minute (LPM) of oxygen. Outside of Resident 15's room, there was no sign indicating oxygen was in use. During an observation on 10/2/2024 at 2:01 p.m., in Resident 15's room, Resident 15 was observed asleep in bed. Resident 15 was receiving 3 LPM of oxygen. Outside of Resident 15's room, there was no sign indicating oxygen was in use. During a review of Resident 15's Admission Record, the admission record indicated Resident 15 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 15's diagnoses included respiratory failure (serious condition that makes it difficult to breath, lungs can't get enough oxygen into the blood) and chronic obstructive pulmonary disease (COPD- group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs). During a review of Resident 15's History and Physical (H&P) dated 9/24/2024, the H&P indicated Resident 15 could make needs known but could not make medical decisions. During a review of Resident 15's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/7/2024, the MDS indicated Resident 15's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 15 required moderate assistance (helper does less than half the effort) for personal hygiene and toileting hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 15's Order Summary Report, dated 9/24/2024, the Order report indicted to administer oxygen at 2 LPM via nasal cannula. During an interview on 10/3/2024 at 1:48 a.m. with Licensed Vocational Nurse (LVN 6), LVN 6 stated before oxygen administration, the nurse must review the physician's order to know how much oxygen to administer to the resident. LVN 6 stated it was important to follow the physician's order to prevent the mistake of giving too little or too much oxygen. LVN 6 stated if Resident 15 did not receive enough oxygen she would not receive any therapeutic effect and if Resident 15 received too much oxygen it could create complications with her breathing. LVN 6 stated she was supposed to assess Resident 15's oxygen settings and oxygen equipment. LVN 6 stated she did not know Resident 15's nasal cannula was not dated and she did not know Resident 15 received more oxygen than what the physician ordered. LVN 6 stated the person that opened the oxygen equipment should have dated it with an open date and should have set up the oxygen concentrator to deliver oxygen at 2 LPM. LVN 6 stated when a resident received oxygen therapy, staff must place an oxygen in use sign outside of the resident's door for the resident's safety. During an interview on 10/4/2024 at 12:06 p.m. with Registered Nurse (RN 6), RN 6 stated nurses must check the physician orders before administering oxygen to a resident. RN 6 stated nurses must always check how many liters of oxygen a resident was receiving because oxygen was a medication and must be set according to the physician's order. RN 6 stated it was important for the nasal cannula to be dated for infection control purposes, staff must know how old the cannula was and replace it when needed. RN 6 stated a sign indicating the use of oxygen must be displayed outside of a resident's room for safety measures and remind to others not to smoke near the resident. b. During a review of Resident 148's Admission Record, dated 10/2/2024, the admission record indicated Resident 148 was admitted to the facility on [DATE]. Resident 148's diagnoses which included schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), acute kidney failure (the sudden and rapid loss of kidney's ability to filter waste and balance fluid in blood), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long-term poor airflow), anemia (a condition in which the body does not have enough healthy red blood cells), hypertension (high blood pressure), and atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure). During a review of Resident 148's H&P, dated 1/18/2024, the H&P indicated Resident 148 was able to make decisions for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 148's MDS, dated [DATE], the MDS indicated Resident 148's cognitive skills were severely impaired. The MDS indicated Resident 148 required setup and clean up assistance from a helper for eating and partial assistance (helper does less than half the effort) for toileting and personal hygiene. During a review of Resident 148's Order Summary Report, dated 6/13/2024, the order summary report indicated Resident 148 had an active order to be suctioned for excessive secretions (fluids produced by the lungs and airways, such as mucus and phlegm) as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 148's Order Summary Report, dated 6/13/2024, the order summary report indicated Resident 148 had an active order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 3 milligrams MG)/3 milliliter (ML), inhale 3 ML every 4 hours as needed for shortness of breath and wheezing (a high-pitched, whistling sound that can occur during breathing when the airways become narrowed or blocked) via nebulizer. During a review of Resident 148's Order Summary Report, dated 9/1/2024, the order summary report indicated Resident 148 had an active order for Oxygen at 2 LPM via nasal cannula to keep oxygen saturation (the percentage of oxygen you have circulating in your blood) above 92 percent (%) for COPD. During a review of Resident 148's Nursing Progress Notes, dated 10/2/2024, the progress note indicated Resident 148 verbalized wanting suction available at bedside as needed for increased secretions. During a review of Resident 148's medical record on 10/1/2024, the medical record indicated there were no care plans initiated for oxygen administration, respiratory therapy, or the use of a suction device. During a concurrent observation and interview on 9/30/2024 at 10:55 a.m., in Resident 148's room, observed Resident 148 sitting on a wheelchair next to her bed. Resident 148 was not receiving any oxygen. Resident 148 stated she only needed oxygen when she felt short of breath. There was an oxygen tank (a metal container that stores compressed used to provide supplemental oxygen) observed next to Resident 148's bed. There were two respiratory set-up bags hanging from the oxygen tank that were dated 9/8/2024. Inside of the respiratory bags was a nasal cannula, oral suction device and a nebulizer mask with oxygen tubing that were also dated 9/8/2024. During an observation on 10/1/2024 at 11:05 a.m., outside of Resident 148's room, observed there was no Oxygen in Use or No Smoking signage on Resident 148's door. During a concurrent observation and interview on 10/2/2024 at 3:53 p.m., with Licensed Vocational Nurse (LVN) 7, in Resident 148's room, Resident 148's oxygen equipment was observed. LVN 7 stated the nasal cannula tubing, oral suction device, nebulizer mask and respiratory set-up bags should be changed every Sunday. LVN 7 stated that the oxygen equipment had not been changed since 9/8/2024. LVN 7 stated the oxygen equipment should have last been changed on 9/29/2024. LVN 7 stated that it was important to change the oxygen equipment weekly because of infection control issues. LVN 7 stated Resident 148 could develop a respiratory infection if the oxygen equipment was not changed regularly. During a concurrent observation and interview on 10/2/2024 at 4:02 p.m. with the Infection Preventionist Nurse (IP), outside of Resident 148's room, the IP confirmed there was no oxygen signage posted at the doorway entrance. The IP stated that Resident 148 was receiving oxygen and there should be signage posted outside of the door. The IP stated oxygen was helpful to the resident but also could be hazardous. The IP stated the signage on the door let the staff know there was oxygen in the room. The IP entered the room and observed Resident 148's respiratory equipment. The IP stated the equipment needed to be changed and it was the licensed nurse's responsibility to change the respiratory equipment every Sunday. The IP stated Resident 148 ran a risk of infection if the tubing was not changed. The IP stated oxygen tubing should be changed to ensure it was not damaged and working properly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/2024 at 4:23 p.m., with the Director of Nursing (DON), the DON stated all respiratory equipment should be changed weekly to ensure residents were receiving clean devices. The DON stated the oxygen signage should be on the doors of the residents receiving oxygen to alert people not to smoke because it could cause an explosion. The DON stated he was considering posting oxygen signage on all doors since all residents could potentially be placed on oxygen. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy effective date November 2017, the P&P indicated, Oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff would administer oxygen as prescribed. The P&P indicated No smoking signs would be prominently displayed wherever oxygen was being stored or administered and oxygen tubing, masks and cannulas would be changed no more than every seven days and as needed. The P&P indicated the oxygen supplies would be labeled and dated each time they are changed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to ensure one out of eight sampled resident's (Resident 117) blood sugar level was checked prior to administering Glipizide (blood sugar lowering medication). This deficient practice resulted had the potential for adverse reactions for Resident 117, including blood sugar levels that were too high or too low, and could possibly lead to complications including nerve damage, eye disease, kidney disease, heart and blood vessel disease, coma, and hypoglycemia (low blood sugar). Findings: During a review of Resident 117's Admission Record, the admission record indicated Resident 117 was admitted to the facility on [DATE]. Resident 117's diagnoses included diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) and chronic kidney disease (gradual loss of kidney function. Kidneys are unable to filter wastes and excess fluids from blood). A review of Resident 117's History and Physical (H&P) dated 5/9/2024, the H&P indicated Resident 117 could make needs known but could not make medical decisions. During a review of Resident 117's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/9/2024, the MDS indicated Resident 117's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 117 was dependent on staff for toileting hygiene, shower/bathing, dressing, and personal hygiene. The MDS indicated Resident 117 required supervision (staff provides verbal cues and touching as resident completes activity) for eating and oral hygiene. During a review of Resident 117's Order Summary Report, dated 5/9/2024, the order summary report indicated Resident 117 had an order for Glipizide 10 milligrams (mg, unit of measurement), two times a day for diabetes. The order summary report indicated to give 30 minutes before breakfast and to hold if blood sugar level was less than 90. During a review of Resident 117's Medication Administration Record (MAR), dated 9/1/2024 to 9/30/2024, the MAR indicated Resident 117's blood sugar level was not checked on 9/1/2024 to 9/9/2024, 9/11/2024 to 9/20/2024, and from 9/22/2024 to 9/30/2024 at 6:30 a.m.; and was not checked on 9/12/2024, 9/22/2024, 9/23/2024, 9/28/2024, and 9/29/2024 at 4:30 p.m. The MAR indicated Resident 117 was administered Glipizide. During a review of Resident 117's Weights and Vital Signs Report, dated 9/1/2024 to 9/30/2024, the report indicated Resident 117's morning blood sugar was checked only on 9/10/2024, 9/21/2024, and 9/24/2024. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 7:15 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated it was important to check Resident 117's blood sugar before administering Glipizide to prevent hypoglycemia (low blood sugar). LVN 2 stated Glipizide medication could further decrease blood sugar levels and result in a diabetic coma (a life-threatening condition that occurs when a person with diabetes experiences dangerously high or low blood sugar levels). LVN 2 stated when a medication indicated parameters, a licensed nurse must follow them when administering a medication. LVN 2 stated she knew she was supposed to check Resident 117's blood sugar before administering Glipizide but Resident 117 always refused to have his blood sugar checked. LVN 2 stated for the month of September 2024 she did not check Resident 117's blood sugar but still administered Glipizide to Resident 117. LVN 2 stated she did not follow the doctor's order because she administered Glipizide to Resident 117 and did not check his blood sugar. LVN 2 stated her practice was not safe and could have harmed Resident 117. During an interview on 10/4/2024 at 11:30 a.m. with Registered Nurse (RN) 6, RN 6 stated he expected all nurses to check the doctors' orders before administering a medication. RN 6 stated all nurses must follow the medication parameters. RN 6 stated if the blood sugar level was not checked before giving medication it could have caused Resident 117 to go into a coma. During a concurrent interview and record review on 10/4/2024 at 11:52 a.m. with RN 6, Resident 117's MAR, dated September 2024, was reviewed. The MAR indicated Resident 117's blood sugar was not checked on multiple days and Glipizide medication was given to Resident 117. RN 6 stated Glipizide should not have been given to Resident 117 if the blood sugar level was not checked. During a review of the facility's Policy and Procedure (P&P) titled Medication-Administration, dated 1/1/2012, the P&P indicated, when administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record i. e. blood pressure (pressure of circulating blood against the walls of blood vessels), pulse (heart rate), and finger stick blood glucose monitoring (a method for measuring blood sugar levels by pricking the fingertip with a lancet to obtain a drop of blood).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 50) was administered medications in accordance with physician orders to meet the medical needs of the resident by failing to administer Resident 50's medications scheduled for 8 AM administration with a meal as ordered or too close to the next scheduled dose for: (cross reference F759) Metformin (used for diabetes to lower blood glucose/sugar) was documented administered over 60 minutes after the scheduled administration time on 9/28/2024, 9/29/20224, 9/30/2024, and 10/1/2024, and Naproxen (a nonsteroidal anti-inflammatory medication used for pain relief) was documented administered over 60 minutes after the scheduled administration time and within two and one-half hours of the next scheduled dose on 9/27/2024, 9/28/2024, 9/29/20224, 9/30/2024, and 10/1/2024 The deficient practice of failing to administer medications in accordance with the physician orders increased the risk that Resident 50 may experience adverse reactions, pain or discomfort, potential for medication errors, gastrointestinal (GI - stomach) upset, uncontrolled blood glucose (a type of sugar) levels, that could lead to a decline in the resident's condition, harm, or hospitalization . Findings: During a review of Resident 50's Admission Record (a document containing diagnostic and demographic information), the admission record indicated Resident 50 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 50's diagnoses included Type 2 Diabetes Mellitus ((DM-a disorder characterized by difficulty in blood sugar control), hypertension (high blood pressure), low back pain, and osteoarthritis (a progressive disorder of the joints). During a review of Resident 50's Minimum Data Set (MDS), a federally mandated resident assessment tool) dated 8/16/2024, the MDS indicated the resident's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making was severely impaired. The MDS indicated Resident 50 was independent for eating and oral hygiene, and required set up or clean-up assistance for dressing, bathing, and personal hygiene. During a review of Resident 50's October 2024 Physician's Orders, the orders indicated Resident 50 orders included: 1. Metformin 500 milligrams (mg - unit of measurement), instructions to give one tablet by mouth two times a day for DM. Give with food, order dated 9/23/2024. 2. Naproxen 500 mg, instructions to give one tablet by mouth three times a day for back pain. Take with food, order dated 9/18/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a MedPass observation on 10/1/2024 at 9:35 AM, with a Licensed Vocational Nurse (LVN) 13, at [NAME] Nursing Station, Medication Cart (MedCart) 1, LVN 13 prepared and administered three medications for Resident 50 that included, one tablet of metformin 500 mg. Resident 50 was not observed having or being provided food during the medication administration on 10/1/2024 during morning MedPass. During an interview on 10/1/2024 at 9:44 AM, with LVN 13, LVN 13 stated Resident 50 was administered the three medications which was scheduled for 8 AM administration. During an interview on 10/1/2024 at 9:54 AM, with Resident 50, in the presence of LVN 13, Resident 50 stated, My stomach hurts so bad. During a concurrent interview and record review on 10/1/2024 at 10:14 AM, with LVN 13, Resident 50's metformin order dated 9/23/2024 was reviewed. LVN 13 stated, the resident was required to be given metformin with meals. LVN 13 stated Resident 50's breakfast comes around 7 AM and did not know if the resident ate breakfast. LVN 13 stated that Resident 50's metformin was supposed to be given with food to avoid stomach upset and manage the resident's diabetes. During a review of the facility provided Mealtime schedule, the Mealtime schedule indicated for the [NAME] Nursing Station, breakfast was served at 7:45 AM, lunch was served at 12:45 PM, and Dinner was served at 5:45 PM. During an interview on 10/1/2024 at 10:23 AM with the Director of Staff Development (DSD) 1, in the presence of LVN 13, DSD 1 stated the licensed nurse should verify the food consumption of the resident to ensure the resident did eat. DSD 1 stated with metformin there should not be a prolonged amount of time after the resident eats to when the medication was administered. DSD 1 stated the purpose of metformin was to control the resident's blood sugar levels, and if the resident has not eaten could cause hypoglycemia (low blood sugar) and could be dangerous to the resident that could lead to dizziness, risk of falling, hospitalization , coma, or death. During a medication reconciliation review of Resident 50's physician orders and October 2024 Medication Administration Record (MAR), Resident 50's physician order and MAR for 10/1/2024 indicated the resident was administered naproxen that was scheduled for 8 AM administration which was not observed prepared or administered to the resident on 10/1/2024 during the morning medication pass observation. During a concurrent interview and record review on 10/1/2024 at 3:07 PM, with LVN 13, on the [NAME] Nursing Station, Resident 50's MAR for October 2024 and actual medication was reviewed. LVN 13 reviewed Resident 50's MAR that was initialed to indicate on 10/1/2024 Resident 50 was administered naproxen at 8 AM. LVN 13 stated she was not sure how the naproxen was missed and stated the naproxen was not administered to Resident 50 and should have been administered to the resident on 10/1/2024 at 8 AM with food but was not. Review of the MAR dated 10/1/2024 documentation indicated Resident 50 was administered naproxen 500 mg at 9:52 AM and at 12:26 PM (almost two and a half hours later). LVN 13 stated Resident 50's physician was not notified the resident's medications scheduled for 8 AM was administered late and that the naproxen was not administered to Resident 50 as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/2/2024 at 11:20 AM, with the Director of Nursing (DON), Resident 50's October 2024 MAR and Administration Detail Report was reviewed, and the Administration Detail Report documentation indicated Resident 50 was administered metformin and naproxen scheduled for 8 AM was administered not in accordance with the physician's order as follows: Metformin Administration History indicated on: 9/28/2024 scheduled for 8:00 AM, administration documented at 9:07 AM. 9/29/2024 scheduled for 8:00 AM, administration documented at 10:29 AM. 9/30/2024 scheduled for 8:00 AM, administration documented at 9:57 AM. 10/1/2024 scheduled for 8:00 AM, administration documented at 9:52 AM. Naproxen Administration History indicated on: 9/27/2024 scheduled for 8:00 AM, administration documented at 11:44 AM. 9/27/2024 scheduled for 12:00 PM, administration documented at 11:44 AM. 9/28/2024 scheduled for 8:00 AM, administration documented at 9:07 AM. 9/28/2024 scheduled for 12:00 PM, administration documented at 12:10 PM. 9/29/2024 scheduled for 8:00 AM, administration documented at 10:30 AM. 9/29/2024 scheduled for 12:00 PM, administration documented at 12:37 PM. 9/30/2024 scheduled for 8:00 AM, administration documented at 10:00 AM. 9/30/2024 scheduled for 12:00 PM, administration documented at 12:40 PM. 10/1/2024 scheduled for 8:00 AM, administration documented at 9:52 AM, medication not administered. 10/1/2024 scheduled for 12:00 PM, administration documented at 12:40 PM. The DON stated Resident 50's metformin and naproxen should be given with food as ordered to prevent gastrointestinal (GI - stomach) side effects. The DON stated the licensed nurse should have assessed the resident for any other issues and notified the physician and react or respond to the resident based on the physician's instructions. The DON stated the licensed nurse must inform the physician before giving the next dose of a medication when the doses may be too close together. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 10/2017, the P&P indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meal orders, which are administered based on mealtimes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Errors, dated 7/2018, the P&P indicated, To ensure the prompt reporting of errors in the administration of medications and treatments to residents. All errors related to the administration of medications or treatments will be reported to the Director of Nursing Services, the attending physician, and the Administrator immediately. Medication error means the administration of medication .at the wrong time . During a review of the facility's P&P titled, Pain Management, dated 6/2023, the P&P indicated, The Licensed Nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR) .Residents who have nonsteroidal anti-inflammatory medication ordered will be observed for bleeding tendencies or gastrointestinal upset.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure an order for Ativan (a medication used for anxiety- a feeling of fear, dread, or uneasiness) was limited to a 14-day duration for one of 11 sampled residents (Resident 140). This deficient practice had the potential to result in unnecessary or prolonged use of Ativan that could lead to Residents 140 experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to the medication therapy and may cause impairment or decline in mental, physical condition, functional, and/or psychosocial status of the resident. Findings: During a review of Resident 140's Admission Record, the admission record indicated Resident 140 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 140's diagnoses included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood that affected the brain's normal functioning), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that was characterized by disturbances in thought). During a review of Resident 140's History and Physical (H&P) dated 2/7/2024, the H&P indicated Resident 140 was able to make decisions for activities of daily living. During a review of Resident 140's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/25/2024, the MDS indicated Resident 140 had serious mental illness. The MDS indicated Resident 140's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 140 had no impairments to the extremities and required supervision in mobility. During a review of Resident 140's informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), dated 4/24/2024, the consent indicated Ativan PRN (as needed) was ordered for 30 days. During a review of Resident 140's informed consent, dated 7/9/2024, the consent indicated Ativan PRN was ordered for 30 days. During a review of Resident 140's informed consent, dated 9/18/2024, the consent indicated Ativan PRN was ordered for 30 days. (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 concurrent interview and record review on 10/2/2024, at 1:53 p.m., with Registered Nurse (RN) 1, Resident 140's order summary report, as of 10/1/2024, was reviewed. The report indicated the physician ordered Ativan 0.5 milligrams (mg - a unit of measure for mass) by mouth every six hours PRN for anxiety for 30 days on 9/18/2024. RN 1 stated the Ativan PRN order was ordered for 30 days and it should be limited to a 14-day duration. During a concurrent interview and record review on 10/2/2024, at 1:54 p.m., with RN 1, Resident 140's psychiatric notes, dated 5/26/2024, was reviewed. The notes indicated there was no documentation on the reason for ordering Ativan PRN for 30 days. RN 1 stated she was unable to see the documented reason to use Ativan PRN for 30 days. During a concurrent interview and record review on 10/2/2024, at 1:55 p.m., with RN 1, Resident 140's psychiatric notes, dated 8/25/2024, was reviewed. The notes indicated there was no documentation on the reason for ordering Ativan PRN for 30 days. RN 1 stated she was unable to see the documentation on the reason to use Ativan PRN for 30 days. During a concurrent interview and record review on 10/2/2024, at 1:56 p.m., with RN 1, Resident 140's psychiatric notes, dated 9/22/2024, was reviewed. The notes indicated no documentation on the reason for ordering Ativan PRN for 30 days. RN 1 stated if the physician did not specify the reason for ordering Ativan PRN for 30 days, the Ativan PRN should be ordered for 14-days only. RN 1 stated the nurse should document in progress note that they communicated with the physician regarding the reason for ordering Ativan PRN for 30 days. RN 1 stated the purpose of limiting PRN to a 14-day duration was to allow nurses to reassess the resident's behavior and adjust the medication. During a review of the facility's policy and procedure (P&P) titled, Behavior /Psychoactive Medication Management, effective on 3/24/2024, the P&P indicated Any psychoactive medication ordered on a PRN basic, must be ordered not to exceed14 days. The P&P indicated if the physician feels the medication needs to be continued, he/she must document the reason(s) for the continued usage, and write the order for the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%). Four medication errors out of 27 total opportunities contributed to an overall medication error rate of 14.81 % for one of five residents (Resident 50) observed during medication administration (MedPass). The facility failed to ensure Resident 50 was administered medications as order with meals, for metformin (used for diabetes [high blood sugar] to lower blood glucose/sugar) and naproxen (used for pain) and within an hour of the prescribed administration time for lactulose (prevent or relieve constipation) and lidocaine patch (for pain relief). The deficient practice of failing to administer medications in accordance with the physician orders increased the risk that Resident 50 may experience adverse reactions, complications, that could lead to a decline in the resident's condition, harm, or hospitalization . Findings: During a review of Resident 50's Admission Record (a document containing diagnostic and demographic information), the admission record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 50's diagnoses included Type 2 Diabetes Mellitus ((DM-a disorder characterized by difficulty in blood sugar control), hypertension (high blood pressure), low back pain, and osteoarthritis (a progressive disorder of the joints). During a review of Resident 50's Minimum Data Set (MDS), a federally mandated resident assessment tool, dated 8/16/2024, the MDS indicated the resident's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making was severely impaired. Resident 50's MDS indicated the resident was independent for eating and oral hygiene, and required set up or clean-up assistance for dressing, bathing, and personal hygiene. During a review of Resident 50's October 2024 Physician's Orders, the physician orders indicated Resident 50 orders included: 1. Metformin 500 milligrams (mg - unit of measurement) instructions to give one tablet by mouth two times a day for DM. Give with food, order dated 9/23/2024. 2. Naproxen 500 mg, instructions to give one tablet by mouth three times a day for back pain. Take with food, order dated 9/18/2024. 3. Lactulose Oral Solution 10 grams (gm - unit of measure of weight) per 15 milliliters (ml - unit of measure of volume), give 45 ml (30 gm) by mouth two times a day for elevated ammonia level, order dated 9/6/2024. 4. Lidocaine External Patch 5 percent (%), apply to the back neck topically one time a day for neck pain and remove per schedule, order date 9/18/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a MedPass observation on 10/1/2024 at 9:35 AM, with Licensed Vocational Nurse (LVN) 13, at [NAME] Nursing Station, Medication Cart (MedCart) 1, LVN 13 prepared and administered three medications for Resident 50 that included, one tablet of metformin 500 mg, 45 ml of lactulose, and applied one lidocaine patch 5 % to the back of the resident's neck. Resident 50 was not observed having or being provided food during the medication administration on 10/1/2024 during the morning MedPass. During an interview on 10/1/2024 at 9:44 AM, with LVN 13, LVN 13 stated Resident 50 was administered the three medications scheduled for 8 AM administration, because the resident was not in the room earlier. During an interview on 10/1/2024 at 9:54 AM, with Resident 50, in the presence of LVN 13, Resident 50 stated, My stomach hurts so bad. Resident 50 asked LVN 13 if the lactulose would help with the stomach discomfort. LVN 13 stated, Yes, the lactulose helps with the stomach and to prevent constipation. During an interview on 10/1/2024 at 10:14 AM, with LVN 13, Resident 50's metformin order dated 9/23/2024 was reviewed. LVN 13 stated, Resident 50 was required to be given metformin with meals. LVN 13 stated Resident 50's breakfast comes around 7 AM and did not know if the resident ate breakfast. LVN 13 stated Resident 50's metformin was supposed to be given with food to avoid stomach upset and manage the resident's diabetes. During a review of the facility provided Mealtime schedule, the Mealtime schedule indicated for the [NAME] Nursing Station, breakfast was served at 7:45 AM, lunch was served at 12:45 PM, and Dinner was served at 5:45 PM. During an interview on 10/1/2024 at 10:23 AM with the Director of Staff Development (DSD) 1, in the presence of LVN 13, DSD 1 stated the licensed nurse should verify the food consumption of the resident to ensure the resident did eat. DSD 1 stated with metformin should not be a prolonged amount of time after the resident eats to when the medication was administered. DSD 1 stated the purpose of metformin was to control the resident's blood sugar levels, and if the resident has not eaten metformin could cause hypoglycemia (low blood sugar) and could be dangerous to the resident that could lead to dizziness, risk of falling, hospitalization , coma, or death. During a medication reconciliation review of Resident 50's physician orders and October 2024 Medication Administration Record (MAR), Resident 50's physician orders and MAR for October 2024 indicated the resident was administered naproxen that was scheduled for 8 AM administration which was not observed prepared or administered to the resident on 10/1/2024 during the morning medication pass observation. During a concurrent interview and record review on 10/1/2024 at 3:07 PM, with LVN 13, on the [NAME] Nursing Station, Resident 50's MAR for October 2024 and actual medication was reviewed. LVN 13 reviewed Resident 50's MAR that was initialed to indicate resident 50 was administered naproxen at 8 AM. LVN 13 was not sure how the naproxen was missed and stated the naproxen was not administered to Resident 50 and should have been administered to the resident on 10/1/2024 at 8 AM with food but was not. Review of the MAR for 10/1/2024 indicated Resident 50 was administered naproxen 500 mg at 9:52 AM and at 12:26 PM (almost two and a half hours later). LVN 13 stated that Resident 50's physician was not notified the resident's medications scheduled for 8 AM was administered late and that the naproxen was not administered to Resident 50 as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/2/2024 at 11:20 AM with the Director of Nursing (DON), the DON stated Resident 50's metformin and naproxen should be given with food as ordered to prevent gastrointestinal (GI - stomach) side effects. The DON stated the licensed nurse should have assessed the resident for any other issues and notified the physician and react or respond to the resident based on the physician's instructions. The DON stated the licensed nurse must inform the physician before giving the next dose of a medication when the doses may be too close together. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 10/2017, the P&P indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meal orders, which are administered based on mealtimes .If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time .), the space provided on the front of the MAR for that dosage administration is initialed and circled .Documentation procedures may be revised based on electronic MAR protocol.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure a resident was free from significant medication error by administering carvedilol (medicine to treat high blood pressure) outside the parameter (specific instructions that you could measure) as ordered by the physician for one of 11 sampled residents (Resident 30). This deficient practice had the potential to cause complications of hypotension (low blood pressure, dizziness and fainting leading to falls) and low heart rate (leading to lose consciousness). Findings: During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE]. Resident 30's diagnoses included hypertension (HTN -high blood pressure), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs). During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/25/2024, the MDS indicated Resident 30's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 30 had no impairment to all extremities and required supervision in walking. During a review of Resident 30's History and Physical (H&P), dated 2/9/2024, the H&P indicated Resident 30 had intact sensation without focal (specific) neuro weakness. During a review of Resident 30's Order Summary Report as of 10/1/2024, the report indicated an order dated 12/17/2021 to hold carvedilol if systolic blood pressure (SBP- the maximum blood pressure during contraction of the ventricles) was less than 110 millimeters of mercury (mmHg, unit of measurement). During a review of Resident 30's September 2024 Medication Administration Record (MAR), the MAR indicated carvedilol was administered to Resident 30 with a SBP less than 110 mmHg on the following dates and times: 1. 9/2/2024 at 5:00 p.m. - SBP was 102 mmHg. 2. 9/10/2024 at 5:00 p.m. - SBP was 108 mmHg. 3. 9/19/2024 at 5:00 p.m. - SBP was 85 mmHg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent of interview and record review on 10/4/2024 at 10:21 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 30's September 2024 MAR was reviewed. LVN 3 stated carvedilol should not have been given on 9/19/2024 with a SBP of 85 mmHg. LVN 3 stated the risk of administering carvedilol with a SBP of 85 mmHg would cause the resident's blood pressure to drop even more. LVN 3 stated Resident 30 may experience side effects of the medication such as dizziness, lightheaded, nausea, vomiting, and loss of consciousness. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines, effective date 10/2017, the P&P indicated medications were administered in accordance with written orders of the attending physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31333 Based on observation, interview, and record review, the facility failed to ensure one of three medication storage rooms, Advance Care (AC) Unit had a medication room thermometer, and failed to ensure THE refrigerator and room temperatures was properly monitored and maintained as indicated in the facility's policy and procedures (P&P), titled, Medication Storage in the Facility: Storage of Medications. This deficient practice had the potential to result in the loss of strength and integrity of stored medications, and the potential for residents on the AC Unit, requiring medications from the one of three medication storage rooms observed to receive deteriorated or ineffective medications. Findings: During a concurrent interview and observation, on 10/1/2024 at 10:40 AM, in the AC Unit Nursing Station with Licensed Vocational Nurse (LVN) 12 in the presence of LVN 14, and Director of Staff Development (DSD) 1, LVN 12 opened the medication storage refrigerator and stated the temperature was 41 degrees Fahrenheit (F, temperature scale used to measure temperature). Observed inside of the refrigerator was drops of water on packages of medication and at the bottom of a container that held Ziplock bags labeled for individual residents and contain insulins (a hormone that lowers the level of glucose (a type of sugar) in the blood) and another container labeled Refrigerated Ekit (an injectable emergency medication kit, Ekit). The medications inside of the AC Unit refrigerator included: - Eight Novolog (insulin) Flexpen (a pre-filled device for injecting insulin). - One vial of Insulin Aspart. - Two vials of Humulin R (Regular). - Two Trulicity insulin pens. - One Lantus Solostar insulin pen. - Two boxes of Ozempic (one unopened and unused and one opened and partially used). One injectable Ekit with a package date of 8/8/2024, and was labeled to contain: - One vial of Novolin R. - One vial of Humalog (lispro) KwikPen (a pre-filled device for injecting insulin). - One vial of Lorazepam 2 milligram ([mg] - unit of measure of weight) per milliliter ([ml] - a unit of measure for volume). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/1/2024 at 10:46 AM, with LVN 12, the medication temperature log was reviewed. The temperature log indicated the refrigerator temperature on 10/1/2024 for the 7 AM - 3 PM and 3 PM - 11 PM nursing shifts were each documented and initialed to be 36 F. LVN 12 stated the licensed nurses were not supposed to write the medication refrigerator temperature in advance for the 3 PM - 11 PM shift on 10/1/2024. LVN 12 stated the medication refrigerator temperature should only be documented at the actual time the refrigerator temperature was monitored and not before the start of the nursing shift. LVN 12 stated could not determine when the refrigerator temperature moved out of range and would not know if the medications were stored correctly or were still safe and effective to use for the residents. During concurrent observation and interview on 10/1/2024 at 11:00 AM with Registered Nurse (RN) 1, on the AC Unit Nursing Station, no room thermometer was observed. RN 1 stated the licensed nurses should monitor the room temperature on the AC Unit Nursing Station where medication carts containing medications were stored. RN 1 stated the licensed nurses have not monitored the AC Unit Nursing Station room temperature where medications were stored for a few years. During a concurrent interview and observation on 10/1/2024 at 11:29 AM, Maintenance Staff (MAINT) 1, in the presence of LVN 12, LVN 14, and DSD 1, MAINT 1 brought an Infrared Thermometer and checked the medication refrigerator temperature on the AC Unit and the reading indicated a temperature of 53.4 F when pointed toward the back of the freezer section and 56.4 F when pointed toward the bottom section of the refrigerator where the medications was stored. MAINT 1 stated the refrigerator temperature needed to be adjusted. DSD 1 stated, the facility must maintain the medication at an appropriate temperature level to maintain the integrity and potency of the medications. During an interview on 10/1/2024 at 11:43 AM with the Director of Nursing (DON), at the AC Unit Nursing Station, the DON stated the medication refrigerator temperature was out of range. The DON stated the medication may not be effective for the residents since the medications were not maintained at the right temperature. The DON stated the AC Unit Nursing Station should be monitoring the room temperature in areas where medications were stored. During an interview on 10/2/2024 at 8:50 AM, with MAINT 1, MAINT 1 stated the thermometer that was inside of the AC Unit medication refrigerator was faulty and the facility thought the temperature readings was correct. MAINT 1 stated when the Infrared Thermometer gun was used the temperature registered over 53 F which was out of range. MAINT 1 stated the refrigerator temperature range should be between 36 F to 46 F. During a review of the facility's policy and procedures (P&P), titled, Medication Storage in the Facility: Storage of Medications, dated 4/2008, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Medications requiring storage at room temperature are kept at temperatures ranging from 15 degrees Celsius (C temperature scale used to measure temperature) (59 F) to 30 C (86 F). Medications requiring refrigeration or temperatures between 2 C (36 F) to 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring . Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when staff: a. Failed to follow puree diet recipes (texture-modified diet where all the foods have a soft pudding-like consistency). b. Failed to demonstrate and verbalized the process of testing Quaternary ammonium compounds ([Quat], group of chemicals used to disinfect and sanitize) sanitizer concentration. These deficient practices had a potential to result in inaccurate food texture, ineffective therapeutic diets, difficulty swallowing, chewing, eating and foodborne illnesses (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 281 of 284 facility residents receiving food from the kitchen. Findings: a. During a review of the facilities' daily spreadsheet titled, Fall Menus, dated 9/30/2024), the Fall Menus indicated residents who received puree diets would receive the following food items for lunch: 1. Puree Kung [NAME] pork 3.25 ounces ([oz] a unit of measurement). 2. Puree Seasoned brown rice 3.25 oz. 3. Puree Sesame broccoli 1/2 cup ([c] a unit of household measurement). 4. Puree Orange slice garnish. 5. Puree Wheat roll 1 piece (pc.). 6. Fesh fruit cup 3.25 oz. 7. Milk 4 oz. During an interview on 9/30/2024 at 11:55 a.m. with [NAME] 1, [NAME] 1 stated the process of making the puree food were as follows: 1. Scoop 20 portions of rice using the green scoop. 2. Puree the rice with hot water using a blender. 3. Thicken with mashed potatoes. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cook 1 stated she prepared the broccoli, Kung [NAME] chicken and fruit cup the same way she prepared the rice. [NAME] 1 stated she did not follow the recipe as she did not know the facility had a recipe for puree diets. [NAME] 1 stated it was important to follow the recipe to make sure residents would get the same number of calories and nutrients. [NAME] 1 stated if the recipe was not followed the taste and consistency of the food would change. [NAME] 1 stated choking would be the potential outcome to residents and the residents might not eat the food and would not get the nourishments they were supposed to get. [NAME] 1 stated she did not received any training on how to make the puree diet because she came from a different facility. During concurrent observation and interview on 9/30/2024 at 12:20 p.m., of the test tray (a process for evaluating, testing, taking temperature of the food) of a puree diet with the Registered Dietitian (RD) and Food Service Director (FSD), the RD stated the puree seasoned brown rice was a little runny and it was going into the other food items on the plate. The RD stated the puree seasoned brown rice should maintain its shape, but it did not. The RD stated the fruit cup were watery and it changed its taste and did not look good. The FSD stated the staff did not follow the recipe as the food did not achieve its consistency. The FSD stated she did not remember what training she provided [NAME] 1 as she came from a different facility already with experience. The FSD stated the potential outcome for puree food not achieving the right consistency was choking. The RD stated he agreed with the FSD that staff did not follow the recipes as the food did not reach its right consistency. The RD stated residents could choke and be unsatisfied with the puree texture resulting in residents not eating the food that could cause weight loss as a potential outcome. During a review of the facility's Policies and Procedures (P&P) titled, Dietary Department-General, dated 6/1/2014, the Dietary Department-General P&P indicated Procedure: (I) The primary objective of the dietary department include: A. Preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent to the physician's orders; B. Maintenance of standards for quality of food. During a review of the facility's P&P titled Standardized Recipe, dated 7/1/2014, the Standardized Recipe P&P indicated, Policy: Food products prepared and served by the dietary department will utilize standardized recipes. Procedures: (I) Standardized recipes are provided with the menu cycle. (II) Standardized recipes have adjustment yields needed. (III) Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. (IV) Recipes will have modifications noted. During a review of the facility's diet manual titled Regular Pureed Diet, dated 2020, indicated Description: The Pureed Diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of food should be smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified on the spreadsheet. Detailed procedure for pureeing foods in Binder #1, misc. section. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's standardized recipe titled Recipe: Pureed Starch (Rice, Pasta, Potatoes), undated, the Puree Starch standardized recipe indicated Directions: (1) Complete regular recipe. Measure out the total number of portions needed for puree diets. (2) Puree on low speed to a paste consistency before adding any liquid. (3) Gradually add warm milk (4) Puree should reach a consistency slightly softer than whipped topping. May add more liquid if needed to reach this consistency. Taste and adjust seasoning (without salt), as needed. (5) Add stabilizer to increase the density of puree food if needed. During a review of the facility's standardized recipe titled Recipe: Pureed Fruit, undated, the Puree Fruit standardized recipe indicated Directions: (1) Complete regular recipe. Measure out the total number of portions needed for puree diets. Drain completely. (2) Puree on low speed adding stabilizer where needed. (3) Puree should reach a consistency of applesauce. During a review of the facility's Job Description titled [NAME] Job Description, dated and signed by [NAME] 1 on 4/1/2024, the [NAME] Job Description indicated Principal Responsibilities: Prepares in a timely manner, nutritious and attractive meals, and supplements for all residents according to Federal, State and Corporate requirements. The [NAME] Job Description indicated [NAME] 1 was oriented about recipe file, food standards and food production. During a review of the facility's Competency checklist titled Competency Test for Cooks and FNS staff, dated 3/24/2021, the Competency Test for Cooks and FNS staff indicated, [NAME] 1 passed the competency test, however there was no question for recipes and puree diets. During a review of the facility's Training Records titled In-service Meetings, dated 10/2023 to 9/2024, the In-service meeting records indicated there was no in-service for puree recipes. b. During an interview on 10/2/2024 at 2:16 p.m. with Dietary Aide 1 (DA 1), DA 1 stated he checked the Quat sanitizer concentration and it had to be 50-100 parts per million ([ppm], strength and concentration of the solution). During a concurrent observation and interview on 10/2/2024 at 2:19 p.m. with DA 2, DA 2 got a red bucket and dipped the test strip to check for the Quat sanitizer concentration. DA 2 stated, the test strips should be dipped for 10 seconds, and it should be at 100 ppm. DA 2 dipped the test strips in the red bucket with Quat sanitizer for 15 seconds and agitated the test strip. DA 2 stated the test strip was at 0 ppm. DA 2 stated something was wrong with the test strips and he needed to tell the supervisor as it did not reach 100-200ppm which was the acceptable range for Quat sanitizer concentration. During a concurrent observation and interview on 10/2/2024 at 2:31 p.m. with DA 3, DA 3 demonstrated the process of testing the concentration of the Quat sanitizer. DA 3 dipped and agitated the test strips in the newly replenished red bucket with sanitizer. DA 3 stated the Quat sanitizer concentration was at 100 ppm. DA 3 sated he needed to redo the checking of the sanitizer concentration until the reading gets to 200 ppm. DA 3 retested the Quat sanitizer. DA 3 sated the test strips was at 100ppm and needed to retest it again until it reached the proper concentration. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/2/2024 at 2:38 p.m. with the Assistant Dietary Supervisor (ADS), the ADS filled up the bucket with Quat sanitizer then dipped the test strips for 25 seconds (timed by using a cellphone clock). The ADS stated the test strips was at 100 ppm and he dipped the test strips for 20 seconds by counting 1, 2, 3, 4, 5, 6,7,8,9,10,11,12,13, 14,15, 16, 17, 18, 19, 20. The ADS stated the test strip should be at 200-400ppm to make sure the surfaces were cleaned and sanitized. During an interview on 10/2/2024 at 2:47 p.m. with the RD, the RD stated the sanitizer should be in the proper concentration to ensure it would clean the food preparation and contact areas properly. The RD stated if the sanitizer was not in its proper concentration, then there could still be some bacteria that were not terminated and could cause the residents to get sick with stomach issues. During a review of the facility's manufacturer's guidelines titled Oasis 146 Multi-Quat Sanitizer undated, the Oasis 146 Multi-Quat Sanitizer manufacturer's guidelines indicated 150-400 ppm Quat range, EPA-registered sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and ware is effective against foodborne organisms as listed on product label. During a review of the facility's test strip label titled J512 Test Paper Lot 227723 expiration date 10/1/2025, the J512 Test Paper label indicated dip test paper for 10 seconds, compare color at once, pH solution no higher than pH 8.0., temperature between 65-85 F, and protect paper from moisture. During a review of the facility's Job Description titled, Dietary Assistant/Dishwasher Job Description, dated and signed by DA 2 on 1/3/2024, the Dietary Assistant/Dishwasher Job Description indicated Principal Responsibilities: Maintains a safe and sanitary work environment. During a review of the facility's Job Specific Orientation Checklist titled ,Dietary Aide Orientation, dated 9/9/2024, the Dietary Aide Orientation checklist indicated DA 2 completed proper kitchen sanitation. During a review of the facility's Job Specific Competency titled Dietary Aide Competency dated 1/4/2024, the Dietary Aide Competency indicated DA 2 demonstrated partial competency in demonstrating knowledge of chemicals and knows which ones to use and when. During a review of the facility's Job Description titled Dietary Assistant/Dishwasher Job Description, dated and signed by DA 3 on 2/22/2023, the Dietary Assistant/Dishwasher Job Description indicated Principal Responsibilities: Maintains a safe and sanitary work environment. During a review of the facility's Job Specific Orientation Checklist titled Dietary Aide Orientation, dated 2/2/2023, the Dietary Aide Orientation checklist indicated DA 3 completed proper kitchen sanitation. During a review of the facility's Job Specific Competency titled Dietary Aide Competency dated 2/2/2023, the Dietary Aide Competency indicated DA 3 demonstrated competency in demonstrating knowledge of chemicals and knows which ones to use and when. During a review of the facility's Job Description titled, Dietary Assistant/Dishwasher Job Description, dated and signed by the ADS on 8/21/2019, the Dietary Assistant/Dishwasher Job Description indicated Principal Responsibilities: Maintains a safe and sanitary work environment. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Job Specific Orientation Checklist titled, Dietary Aide Orientation, dated 8/19/2019, the Dietary Aide Orientation checklist indicated DA 3 completed orientation for cleaning supplies. During a review of the facility's Training Records titled In-service Meetings, dated 10/2023 to 9/2024, the In-service meeting records indicated there was no in-service for Quat sanitizer concentration testing.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to follow the menu and did not the meet nutritional needs of residents receiving puree diets (diet consisting with soft, pudding like consistency foods) when the seasoned brown rice was runny and the fruit cup was watery. This deficient practice placed 23 of 284 facility residents receiving a puree diet at risk of difficulty in eating, chewing, swallowing and decrease food and nutrient intake resulting to unplanned weight loss. Findings: During a review of the facilities' daily spreadsheet titled, Fall Menus, dated 9/30/2024), the Fall Menus indicated residents receiving puree diets would receive the following food items for lunch: 1. Puree Kung [NAME] pork 3.25 ounces ([oz] a unit of measurement). 2. Puree Seasoned brown rice 3.25 oz. 3. Puree Sesame broccoli 1/2 cup ([c] a unit of household measurement). 4. Puree Orange slice garnish. 5. Puree Wheat roll 1 piece (pc.). 6. Fresh fruit cup 3.25 oz. 7. Milk 4 oz. During an interview on 9/30/2024 at 11:55 a.m. with [NAME] 1, [NAME] 1 stated the process of making the puree foods were as follows: 1. Scoop 20 portions of rice using the green scoop. 2. Puree the rice with hot water using a blender. 3. Thicken with mashed potatoes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cook 1 stated she prepared the broccoli, Kung [NAME] chicken and fruit cup the same way she prepared the rice. [NAME] 1 stated she did not follow the recipe as she did not know the facility had a recipe for pureed diets. [NAME] 1 stated it was important to follow the recipe to make sure residents would receive the same number of calories and nutrients. [NAME] 1 stated if recipes were not followed, the taste and consistency of the food would change. [NAME] 1 stated choking would be the potential outcome to residents and the residents might not eat the food and would not get the nourishments they were supposed to get. [NAME] 1 stated she did not get any training on how to make the pureed diet because she came from a different facility. During concurrent observation and interview on 9/30/2024 at 12:20 p.m., of the test tray (a process for evaluating, testing, taking temperature of the food) of a puree diet with the Registered Dietitian (RD) and the Food Service Director (FSD), the RD stated the puree seasoned brown rice was a little runny and it was going into the other food items on the plate. The RD stated the puree seasoned brown rice should maintain its shape, but it did not. The RD stated the fruit cup was watery and it changed its taste and did not look good. The FSD stated the staff did not follow the recipe as the food did not achieve its consistency. The FSD stated she did not remember what training she provided [NAME] 1 as she came from a different facility already with experience. The FSD stated the potential outcome for puree food not achieving the right consistency was choking. The RD stated he agreed with the FSD that staff did not follow the recipes as the food did not reach its right consistency. The RD stated residents could choke and be unsatisfied with the puree texture resulting in residents not eating the food that could cause weight loss as a potential outcome. During a review of the facility's Policies and Procedures (P&P) titled, Dietary Department-General, revised 6/1/2014, the Dietary Department-General P&P indicated Procedure: (I) The primary objective of the dietary department include: A. Preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent to the physician's orders; B. Maintenance of standards for quality of food. During a review of the facility's P&P titled, Standardized Recipe, dated 7/1/2014, the Standardized Recipe P&P indicated, Policy: Food products prepared and served by the dietary department will utilize standardized recipes. Procedures: (I) Standardized recipes are provided with the menu cycle. (II) Standardized recipes have adjustment yields needed. (III) Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. (IV) Recipes will have modifications noted. During a review of the facility's diet manual titled, Regular Pureed Diet, dated 2020, the manual indicated Description: The Pureed Diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of food should be smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified on the spreadsheet. Detailed procedure for pureeing foods in Binder #1, misc. section. (continued on next page)

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	555099	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's standardized recipe titled, Recipe: Pureed Starch (Rice, Pasta, Potatoes), undated, the Puree Starch standardized recipe indicated Directions: (1) Complete regular recipe. Measure out the total number of portions needed for puree diets. (2) Puree on low speed to a paste consistency before adding any liquid. (3) Gradually add warm milk (4) Puree should reach a consistency slightly softer than whipped topping. May add more liquid if needed to reach this consistency. [NAME] and adjust seasoning (without salt), as needed. (5) Add stabilizer to increase the density of puree food if needed. During a review of the facility's standardized recipe titled, Recipe: Pureed Fruit, undated, the Puree Fruit standardized recipe indicated Directions: (1) Complete regular recipe. Measure out the total number of portions needed for puree diets. Drain completely. (2) Puree on low speed adding stabilizer where needed. (3) Puree should reach a consistency of applesauce.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and appearance when, the seasoned brown rice was too sticky, the rice grains were not separated, and the broccoli tasted bland without the sesame taste. This deficient practice placed 260 of 284 facility residents at risk of unplanned weight loss, a consequence of poor food intake, from food the kitchen. Findings: During a review of the facilities' daily spreadsheet titled, Fall Menus, dated 9/30/2024), the Fall Menus indicated residents would the following food items for lunch: 1. Kung [NAME] pork 3.25 ounces ([oz] a unit of measurement). 2. Seasoned brown rice 3.25 oz. 3. Sesame broccoli 1/2 cup ([c] a unit of household measurement). 4. Orange slice garnish. 5. Wheat roll 1 piece (pc.). 6. Fresh fruit cup 1/2 c. 7. Milk 4 oz. During an observation on 9/30/2024 at 11:38 a.m., of the tray line (an area where foods are assembled), the seasoned brown rice was observed sticky. During a concurrent observation and interview on 9/30/2024 at 12:20 a.m., of the regular diet test tray (a process for evaluating, testing, taking temperature of the food), with the Registered Dietitian (RD) and Food Service Director (FSD), the RD stated the seasoned brown rice should not be sticky and should not be stuck together. The RD stated the rice grains should be separated on the plate. The RD stated the broccoli did not have the taste of a sesame flavor. The RD stated residents might not eat the food and could lead to unplanned weight loss as a potential outcome. During a review of the facility's Policies and Procedures (P&P) titled, Dietary Department-General, revised 6/1/2014, the Dietary Department-General P&P indicated Procedure: (I) The primary objective of the dietary department include: A. Preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent to the physician's orders; B. Maintenance of standards for quality of food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Standardized Recipe, dated 7/1/2014, the Standardized Recipe P&P indicated, Policy: Food products prepared and served by the dietary department will utilize standardized recipes. During a review of the facility's diet manual titled, Regular Diet, dated 2020, indicated Description: The regular diet is designed to meet the nutritional needs of residents who do not need dietary modifications or restrictions. During a review of the facility's standardized recipe titled, Seasoned [NAME] Rice, undated, the Seasoned [NAME] Rice standardized recipe indicated Ingredients: uncooked brown rice, boiling wate4r, salt, onion powder, margarine, parsley flakes. Directions: (3) Keep an eye on the rice, it may need a little more or little less cooking time. During a review of the facility's standardized recipe titled, Sesame Broccoli, dated 2024, the Sesame Broccoli standardized recipe indicated Ingredients: fresh broccoli or frozen, margarine, garlic powder, salt, toasted or blended sesame oil. Directions: (4) Just before serving, add sesame oil and stir well. Pour over broccoli and gently mix to combine.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. Four (4) of seven (7) racks in the walk-in refrigerator had cracks, chips, and rust. b. Walk-in freezer floor had dried ice cream drippings, two (2) axes on the floor, a bowl, and the walk-in freezer had ice buildup and torn door gaskets. c. Baking pans had burnt particles. d. Clear storage containers had blue tapes and tape residues and was not air dried prior to stacking. e. Chopping boards in the clean area had scratches and were sticky to touch. f. Three (3) dented cans were stored with non-dented cans. g. Internal parts of the ice machine in the kitchen had black dirt particles. h. Low temperature dishmachine by the preparation area was at 110 degrees Fahrenheit ([F] a degree of temperature). i. Quaternary ammonium compounds ([Quat], group of chemicals used to disinfect and sanitize) sanitizer was not within an acceptable concentration. j. Resident's refrigerator and freezer temperatures were not following acceptable temperature standards. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 281 of 284 medically compromised residents who received food and ice from the kitchen. Findings: a. During an observation on 9/30/2024 at 8:42 a.m., inside the walk-in refrigerator, 4 green racks were observed chipped and the paint was coming off. During an interview on 9/30/2024 at 9:31 a.m. with the Food Service Director (FSD), the FSD stated the kitchen staff were cleaning the racks as it had rusts and chips. The FSD stated it was important to maintain the racks in good condition to prevent cross-contamination. The FSD stated residents could get foodborne illness as a potential outcome. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policies and Procedures (P&P) titled, Food Storage and Handling, dated 6/4/2024, the Food Storage and handling P&P indicated, To properly store, thaw, and prepare food to avoid foodborne illnesses. (d) Shelving should be sturdy with a surface which is smooth, and easily cleaned. During a review of Food Code 2022, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. b. During an observation on 9/30/2024 at 9:02 a.m., inside the walk-in freezer, the walk-in freezer floor was observed with dried ice cream drippings. There were 2 axes were observed on the floor. The walk-in freezer had ice build-up on the pipes and door. The walk-in freezer gasket was torn. During an interview on 9/30/2024 at 9:36 a.m. with the FSD, the FSD stated the walk-in freezer was cleaned last week. The FSD stated the walk-in freezer had ice buildup, torn gaskets and axes were on the floor. The FSD stated the walk-in freezer had ice cream drippings. The FSD stated she needed to work with the maintenance staff to have the gasket fixed and cleaned to prevent food contamination as it could lead to food borne illness to the residents. During a review of the facility's P&P titled, Freezer Operation and Cleaning, dated 10/1/2014, the Freezer Operation and Cleaning P&P indicated, Policy: The dietary staff will use the freezer accordingly to manufacturer's guidelines. The freezer will be cleaned periodically, as necessary. During a review of Food Code 2022, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. c. During an observation on 9/30/2024 at 9:10 a.m., in the storage area, pans were observed with burnt buildup. During an interview on 9/30/2024 at 9:41 a.m. with the FSD, the FSD stated the pans in the clean area were old and were burnt. The FSD stated these pans were not okay to use as it would cause cross-contamination. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (B) The Food-contact surfaces of cooking equipment and pans shall be kept free from encrusted grease deposits and other soil accumulation. d. During an observation on 9/30/2024 at 9:10 a.m., in the pots and pans storage area, the clear containers were observed with blue stickers and sticker sticky residues. The clear containers were stacked wet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/2024 at 9:43 a.m. with the FSD, the FSD stated the kitchen staff used the clear containers for storage of food and ice. The FSD stated the clean containers were washed through the dish machine however the stickers should have been taken off to prevent cross-contamination of dirt to food. During an interview on 9/30/2024 at 9:49 a.m. with the FSD, the FSD stated the dishwashing process included the use of the dish machine and staff would let the clean dishes sit in the clean area without using towels to dry them as the dishes were needed to be air dried. The FSD stated the clean containers were not air dried and were staked wet. The FSD stated it needed to be air dried and he was not sure why air drying was needed. The FSD stated contamination would be the potential outcome to the residents for not air drying the dishes. During a review of Food Code 2022, the Food Code 2022 indicated,4-601.11 Equipment, Food Contact Surfaces, Nonfood-Contact Surfaces and utensils. (C) NonFood Contact Surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During a review of Food Code 2022, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. e. During an observation on 9/30/2024 at 9:10 a.m., in the kitchen's clean area, the chopping boards were observed with scratches and were sticky to touch. During an interview on 9/30/2024 at 9:45 a.m. with the FSD, in the utensil's storage area, the FSD stated the chopping boards were clean and had gone through the dish machine. The FSD stated the chopping board were scratched and were sticky to touch. The FSD stated the chopping board needed replacement to prevent contamination of food. During a review of facility's P&P titled, Discarding of Chipped/Cracked Dishes and Single Service Items, dated 10/1/2014, the Discarding of Chipped/Cracked Dishes and Single Service Items P&P indicated, Policy: The dietary staff will maintain a sanitary environment in the dietary department by discarding compromised service ware and single service items. (I) The dietary staff will discard chipped or cracked dish or glass ware. During a review of Food Code 2022, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. f. During an observation on 9/30/2024 at 9:51 a.m., in the dry storage area, observed 3 dented cans stored along with non-dented cans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/2024 at 9:53 a.m. with the FSD, the FSD stated the designated area for dented cans was in the preparation room. The FSD stated the kitchen staff separated the dented cans from the non-dented cans so staff would not use it because of botulism (a rare but serious illness caused by toxins that attack the body's nerves). The FSD stated there were 3 dented cans that were not separated from the non-dented cans. The FSD stated she needed to retrain her staff to separate the dented cans and place them in the designated area. During a review of the facility's P&P titled, Food Storage and Handling, dated 6/4/2024, the Food Storage and Handling P&P indicated, Purpose: To properly store, thaw, and prepare food to avoid foodborne illnesses. 8. Canned fruit storage (c) Place dented or bulging cans in a separate storage area and return for credit. 11. Canned vegetable storage (d) Place dented or bulging cans in a separate area and returned for credit. During a review of Food Code 2022, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. g. During concurrent observation and interview on 9/30/2024 at 9:56 a.m. with the FSD, the ice machine was observed with black dirt residue when wiped with a paper towel. The FSD stated the ice machine was cleaned and sanitized once a month. The FSD stated the last time the ice machine was cleaned was on 9/26/2024. The FSD stated there were black particles coming out from the ice machine and it was not supposed to be there as they used ice for the residents. The FSD stated the residents could get sick, but she did not know what kind of sickness. During an observation on 9/30/2024 at 10:52 a.m., Dietary Aide 5 (DA 5) was observed cleaning the ice machine in the kitchen using his personal cellphone camera to see the internal parts. During an interview on 9/30/2024 at 10:55 a.m. with DA 5, DA 5 stated he cleaned the ice machine on 9/26/2024. DA 5 sated it was hard to get inside the little compartments as he could not see what he was cleaning. DA 5 stated he used his personal cellphone camera to see but his hands were not small enough to get to the internal parts of the ice machine and it was not visible to him. During an interview on 9/30/2024 at 11:00 a.m. with the FSD, the FSD stated if DA 5 could not see the internal parts of the ice machine, it would not be cleaned properly, and he would not be able to perform a detailed cleaning. The FSD stated cross-contamination would be the potential outcome for those residents consuming ice. During a review of the facility's P&P titled Dietary Department- General, dated 6/1/2014, the Dietary Department- General P&P indicated The primary objectives of the dietary department include: (b) maintenance of standards for sanitation and safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Ice Machine-Operation and Cleaning, dated 10/1/2014, the Ice Machine-Operation and Cleaning P&P indicated The dietary staff will operate the ice machine according to the manufacturer's guidelines. The ice machine will be cleaned routinely. (J.) Maintenance staff will clean the ice making mechanism according to manufacturer's guidelines. During a review of the facility's Installation, Operation and Maintenance Manual titled Indigo NXT Ice Machines dated 11/2018, the Indigo NXT Ice Machine indicated Cleaning and Sanitizing Procedures: This procedure must be performed a minimum of once every six months. The ice machine and bin must be disassembled cleaned and sanitized. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. h. During a concurrent observation and interview on 9/30/2024 at 11:40 a.m. with Dietary Aide 6 (DA 6), DA 6 stated the dish machine temperature acceptable ranges were between 120 to 140 degrees ( ) Fahrenheit (F, measure of temperature). DA 6 stated the temperature of the dish machine was 110 F and was not the acceptable temperature. During a concurrent observation and interview on 9/30/2024 at 11:46 a.m. with the Assistant Dietary Supervisor (ADS), the ADS stated the dish machine temperature was 110 F which was not acceptable. The ADS stated the kitchen staff would have to use the compartment sinks and do manual washing. During an interview on 9/30/2024 at 11:56 a.m., with the FSD, the FSD stated the dish machine should have a temperature of 120 F for the wash, and temperature of 140 F for the rinse. The FSD stated the dish machine was not in proper temperatures and would not properly clean the dishes and could get the residents sick due to cross-contamination. During a review of the facility's P&P titled, Dish Machine Operation and Cleaning, dated 10/1/2014, the Dish Machine Operation P&P indicated, Operation of Equipment (A) Check water temperature gauges (Wash must be between 120 F and 160 F). To reach proper temperatures upon startup. Several empty racks should be sent through the machine. If the machine fails to reach the proper temperature, turn off the machine and report the incident to the supervisor. During a review of the facility's P&P titled, Dish Machine Temperature Recording, dated 10/1/2014, the Dish Machine Temperature Recording P&P indicated Record temperature daily on DS-33-Form A-Dishmachine Temperature Log. Low Temperature Dishmachine- Wash temperature: 120-150 F, Rinse Temperature 120-150 F. (V) Any temperatures that are below the required levels, outlined in the chart above, must be brought to the attention of the dietary manager promptly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.110 Mechanical Warewashing Equipment Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F. i. During a concurrent observation and interview on 10/2/2024 at 2:19 p.m. with DA 2, DA 2 got a red bucket and dipped the test strip to check for the Quat sanitizer concentration. DA 2 stated, the test strips should be dipped for 10 seconds, and it should be at 100 parts per million ([ppm], strength and concentration of the solution). DA 2 dipped the test strips in the red bucket with Quat sanitizer for 15 seconds and agitated the test strip. DA 2 stated the test strip was at 0 ppm. DA 2 stated something was wrong with the test strips as it did not reach 100-200ppm which was the acceptable range for Quat sanitizer concentration. During a concurrent observation and interview on 10/2/2024 at 2:31 p.m. with DA 3, DA 3 demonstrated the process of testing the concentration of the Quat sanitizer. DA 3 dipped and agitated the test strips in the newly replenished red bucket with sanitizer. DA 3 stated the Quat sanitizer concentration was at 100 ppm. DA 3 stated he needed to redo the checking of the sanitizer concentration until the reading gets to 200 ppm. During a concurrent observation and interview on 10/2/2024 at 2:38 p.m. with the ADS, the ADS filled up the bucket with Quat sanitized then dipped the test strips for 25 seconds. The ADS stated the test strips was at 100 ppm. The ADS stated the test strip should be at 200-400ppm to make sure the kitchen surfaces were cleaned and sanitized. During an interview on 10/2/2024 at 2:47 p.m. with the RD, the RD stated the sanitizer should be in the proper concentration to ensure it would clean the food preparation and contact areas properly. The RD stated if the sanitizer was not in its proper concentration, then there could still be some bacteria that were not terminated and could cause the residents to get sick with stomach issues. During a review of the facility's manufacturer's guidelines titled, Oasis 146 Multi-Quat Sanitizer undated, the Oasis 146 Multi-Quat Sanitizer manufacturer's guidelines indicated 150-400 ppm Quat range, EPA-registered sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and ware is effective against foodborne organisms as listed on product label. j. During a concurrent observation and interview on 10/2/2024 at 3:35 p.m. with Registered Nurse 3 (RN 3) and the RD, RN 3 stated the resident's freezer was 18 F and it was an acceptable temperature. The RD stated the freezer temperature should 0 F. The RD stated the food would not be completely frozen and it could spoil if it was above 0 F. The RD stated the refrigerator temperature range of 32-45 F on the form was not an acceptable temperature and it should be at 32-40 F otherwise it would be on a danger zone where bacteria flourished more and would grow. The RD stated it could cause spoilage of food and residents could get sick with stomach issues. During a review of the facility's P&P titled, Receiving Food and Supplies, dated 7/30/2023, the Receiving Food and Supplies P&P indicated, Food and Supply items will be received and handled in accordance with recommended sanitary practices. Purpose: To prevent foodborne illnesses. (9)(a) Do not allow cold foods to rise above 40 F and frozen foods to rise above 0 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Refrigerator/Freezer Temperature Records, dated 11/1/2014, the Refrigerator/Freezer Temperature Records P&P indicated To establish guidelines to record the temperatures of refrigerated and frozen storage areas. A daily temperature record is to be kept for refrigerated and frozen storage areas. II. The freezer temperature must be at 0 F or below. III. The refrigerator temperature must be 41 F or below. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not maintaining the trash area free from trash, plastic, plastic cups, black garbage bags with trash on the floor and completely covering the dumpster (a large trash metal container designed to be emptied into a truck). This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to all 284 facility residents. Findings: During an observation on 9/30/2024 at 3:26 p.m., in the dumpster area, observed that the dumpster was not completely covered. During an observation on 10/1/2024 at 1:57 p.m., in the dumpster area, observed that the dumpster was not completely covered. A black trash bag with trash, used plastic cups, plastic, and other dirt debris were on the surrounding floor. During a concurrent observation and interview on 10/1/2024 at 2:22 p.m. with the Food Service Director (FSD), the FDS stated the kitchen staff took the trash out all day in the dumpster area. The FSD stated the dumpster was not completely covered. During a concurrent observation and interview on 10/1/2024 at 2:25 p.m. with Housekeeping Staff 1 (HKS 1), Housekeeping Staff 2 (HKS 2) and the FSD, HKS 1 stated the dumpster was not fully covered and it was not okay. HKS 1 stated the dumpster needed to be completely covered to prevent contamination. The FSD sated the dumpster needed to be covered because trash could fall and could attract flies and other pests could go to the kitchen where they served food. HKS 2 stated the dumpster needed to be completely closed to prevent the spread of germs and the area had plastic, plastic cups on the floor and it was not okay. HKS 2 stated the dumpster area needed to be clean and there should not be trash on the floor to prevent the spread of germs to the residents. During an interview on 9/30/2024 at 2:36 p.m. with the Environmental Services Supervisor (EVSS), the EVSS stated the dumpster cover was a compactor to press the garbage down. The EVSS stated the dumpster was not completely covered and needed to be covered to prevent mice, flies, and anything else that it could attract. The EVSS stated he was not aware of any potential outcome for residents of this practice. The EVSS stated his staff cleaned the dumpster surroundings every morning and evening. The EVSS stated the kitchen staff made sure it was free from small spills, boxes on the floor and trash should be inside the dumpster to prevent any accidents. During a review of the facility's Policies and Procedures (P&P) titled, Waste Management, reviewed 4/21/2022, the Waste Management P&P indicated, Purpose: To reduce risk of contamination from regulated waste and maintain appropriate handling and disposable of all waste. IV. Food waste will be placed in covered garbage and trash cans. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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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** 48343 Based on observation, interview, and record review, the facility failed to ensure standard infection control practices were followed for four of eight sampled residents (Residents 62, 246, 132 and 155) by failing to: 1. Ensure Resident 62's oxygen nasal cannula (device used to deliver supplemental oxygen placed directly on the resident's nostrils) and nebulizer mask (nebulizer a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) were properly stored in plastic bag and dated as indicated in the facility's policy and procedure (P&P). 2. Ensure Resident 246's indwelling catheter (a tube that allows urine to drain from the bladder into a bag) drainage bag was not touching the floor. 3. Ensure Resident 155's oxygen tubing, nasal cannula, and humidifier were changed every seven (7) days and dated. 4. Ensure an Enhanced Barrier Precautions ([EBP]-the use of gown and gloves for specific care activities that involve a high change of the spread of infection) sign was posted in front of Residents 246's, and 132's room. These deficient practices placed Residents 62, 246, 132, and 155 at risk for respiratory infection and had the potential to cause the avoidable spread of harmful pathogens (bacteria, viruses, or other microorganisms that can cause disease) and infection to all residents and staff in the facility. Findings: a. During a review of Resident 62's Admission Record (Face Sheet), the Face Sheet indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included acute respiratory failure (a serious condition when the lungs can not get enough oxygen into the blood), heart failure (a condition when your heart would not pump enough blood for your body needs), major depression (loss of interest in activities), and hypertension (high blood pressure). During a review of Resident 62's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 9/6/2024, the MDS indicated Resident 62 had the ability to express ideas and wants, and had clear comprehension. The MDS indicated Resident 62 was dependent (helper does all the effort) from staff for toileting hygiene, showering, and personal hygiene. During a review of Resident 62's physician order, dated 8/19/2024, indicated Albuterol Sulfate (medication used to treat shortness of breath [SOB]) Inhalation Nebulization Solution (2.5 milligram [mg, unit of measurement]/0.5-millimeter [ml, unit of measurement], one (1) vial (a small container) inhale orally via nebulizer every six (6) hours as needed for SOB. The physician order also indicated to administer oxygen (O2) at three (3) liters (L, a unit for measuring the volume of liquid) per minute (LPM) via nasal cannula as needed for SOB. (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 concurrent observation and interview on 9/30/2024 at 11:16 a.m., in Resident 62's room, Resident 62's undated nebulizer tubbing and mask was observed on Resident 62's bedside table and not stored in a bag. Resident 62's undated nasal cannula was observed on the floor next to Resident 62's bed. Resident 62 stated she was having SOB earlier and had a breathing treatment via the nebulizer mask. Resident 62 stated when the breathing treatment was done, she placed the nebulizer mask on the bedside table. Resident 62 stated she was not aware the nebulizer mask should have been placed in the bag. Resident 62 stated she did not have a bag for the nebulizer mask. Resident 62 stated the nasal cannula was undated, and she was not aware when the last time nasal cannula was changed. During an interview on 10/1/2024 at 8:45 a.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated the nebulizer mask should be changed weekly, dated, and placed in a plastic bag next to the residents' bed when not in use. LVN 1 stated the mask and tubbing touching the floor was unsanitary and an infection control issue. LVN 1 stated the nebulizer mask not stored properly in the bag placed a risk for possible contamination (making something dirty, containing unwanted substances). LVN 1 stated it would produce respiratory problems and would place Resident 62 at risk for infection. During an interview on 10/3/2024 at 2:15 p.m., with the Infection Preventionist (IP) Nurse, the IP Nurse stated it was important the resident's respiratory treatment tubing and masks should be changed weekly, dated, and labeled so staff would know when it was last changed. The IP Nurse stated the nasal cannula and nebulizer mask must be stored in a bag to prevent contamination and respiratory infection. b. During a review of Resident 246's Face Sheet, the Face Sheet indicated Resident 246 was admitted to the facility on [DATE]. Resident 246's diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), major depression, schizophrenia (a serious mental illness that affects how a person thinks feels, and behaves), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). During a review of Resident 246's MDS, dated [DATE], the MDS indicated Resident 246 had severely impaired (never/rarely made decisions) cognitive skills for daily decision making (ability to think and process information). The MDS indicated Resident 246 was dependent from staff for toileting hygiene, showering, and personal hygiene. During a review of Resident 246's physician order, dated 9/29/2024, indicated for an indwelling catheter related to urinary retention (difficulty urinating). During an observation on 9/30/2024 at 10:20 a.m., 12:30 p.m., and 4:30 p.m., in front of Resident 246's room, there was no EBP sign posted, and there was no proper personal protective equipment ([PPE] -a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) upon entrance to Resident 246's room. During an observation on 9/30/2024 at 12:31 p.m., and 4:30 p.m., in Resident 246's room, Resident 246 was observed lying in bed. The indwelling catheter bag was observed touching the floor. During an observation on 10/1/2024 at 8:25 a.m., in front of Resident 246's room, there was no EBP sign posted and there was no PPE upon entrance to Resident 246's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/2024 at 8:30 a.m., in Resident 246's room, Resident 246's indwelling foley catheter urine collection bag was observed touching the floor. During a concurrent observation and interview on 10/1/2024 at 8:40 a.m., in Resident 246's room, with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 246's indwelling foley catheter urine collection bag was touching the floor. CNA 1 stated indwelling catheter urine collection bag should not be touching the floor for infection control reasons, and that it placed Resident 246 at risk for acquiring infections. CNA 1 stated the urine collection bag should be attached to Resident 246's bed and should not be touching the floor. During a concurrent observation and interview on 10/1/2024 at 8:45 a.m., in front of Resident 246's room, with LVN 1, LVN 1 stated there was no EBP sign posted in front of Resident 246's room, and there was no PPE upon entrance in Resident 246's room. LVN 1 stated Resident 246's indwelling catheter was inserted on 9/29/2024 and the EBP sign should have been posted immediately for staff to know and use the PPE during Resident 246's care. LVN 1 stated there was a potential for the development of infection amongst other residents in the facility due to lack of the implementation of EBP. During an interview on 10/3/2024 at 2:30 p.m., with IP Nurse, the IP Nurse stated the implementation of EBP could help the spread and prevention of in-house acquired infections amongst residents and staff within the facility. c. During a review of Resident 132's Admission Record, the Admission Record indicated Resident 132 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 132's diagnoses included Parkinson's disease (a chronic, progressive brain disorder that affects the nervous system and causes movement problems), gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), severe protein-calorie malnutrition, and lack of coordination. During a review of Resident 132's MDS, dated [DATE], the MDS indicated Resident 132's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 132 was dependent on staff when activities of daily living (ADLs, daily self-care activities such as dressing, personal hygiene, dressing, and toileting hygiene) were performed. During an observation on 9/30/2024, at 11:02 a.m., Resident 132's doorway was observed. There was no EBP sign posted in front of Resident 132's room. During a concurrent observation and interview, on 10/1/2024, at 8:59 a.m., with the IP Nurse, Resident 132's doorway was observed. No EBP sign was posted near Resident 132's doorway. The IP Nurse stated that a sign should have been placed closer to the doorway of Resident 132's room so that staff were reminded to use PPE especially because Resident 132 had a G-tube. The IP Nurse stated that EBP signs should be posted outside of the doorway to remind the staff to don (put on) PPE during high-contact resident care activities for residents that had wounds or indwelling (inside the body) devices. The IP Nurse stated if there was no signage posted in front of the room, then there was potential for staff to forget to don PPE and cause cross contamination or the spread of infection to occur [during high-contact resident care activities]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During an observation on 9/30/2024, at 11:10 a.m., in Resident 155's room, Resident 155's humidifier for the oxygen was dated 9/23/2024. Resident 155's oxygen tubing and nasal cannula were observed on top of the resident's oxygen concentrator without dates by the bedside. During a review of Resident 155's Admission Record, the record indicated Resident 155 was originally admitted to facility on 7/23/2019 and readmitted on [DATE]. Resident 155's diagnoses included respiratory failure with hypoxia (a condition when body didn't have enough oxygen in the tissues), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), obesity (having too much body fat), and dementia. During a review of Resident 155's H&P dated 8/18/2024, the H&P indicated Resident 155 had the capacity to understand and make decisions. During a review of Resident 155's MDS, dated [DATE], the MDS indicated Resident 155 had serious mental illness. The MDS indicated Resident 155's cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 155 had impairment on one side of the lower extremities and required moderate assistance in toileting hygiene, personal hygiene, and rolling left and right. During a review of Resident 155's order summary report as of 10/2/2024, the order summary report, dated 8/17/2024, indicated to administer oxygen via nasal cannula as needed for SOB. During a concurrent observation and interview on 10/2/2024, at 10:45 a.m., with Licensed Vocational Nurse (LVN) 5, in Resident 155's room, the humidifier on Resident 155's oxygen concentrator was dated 9/23/2024. The oxygen tubing and nasal cannula were placed on top of the oxygen concentrator by Resident 155's bedside without dates. LVN 5 stated the humidifier was changed on 9/23/2024. LVN 5 stated it was not appropriate to have the oxygen tubing and nasal cannula placed on top of the oxygen concentrator and they should be placed inside the storage bag. LVN 5 stated the oxygen tubing, nasal cannula, and humidifier should be dated and changed every Sunday or seven days. LVN 5 stated the charge nurses were responsible for changing the oxygen tubing, nasal cannula, and humidifier. LVN 5 stated the oxygen supplies might accumulate dirt and not work properly if not changed timely. LVN 5 stated the purpose of changing the oxygen supplies every seven days was for infection control and it was the standard of nursing practice. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, revised 11/2017, the P&P indicated oxygen would be administered under safe and sanitary conditions. The P&P indicated oxygen tubbing, masks, and cannulas would be changed every seven (7) days and as needed and would be dated each time when changed. During a review of the facility's P&P tilted, Nebulizer (small volume), revised 10/15/2020, the P&P indicated the following: 1. Assemble nebulizer equipment, label the set-up bag with resident's name and date. 2. Place set-up bag at the resident's bedside. 3. Nebulizer set-up should be changed every 7 days and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P tilted, Catheter-Care, revised 6/10/2021, the P&P indicated indwelling catheter collection bag would be kept below the level of the bladder and would be anchored (stay in one position) to not touch the floor. During a review of the facility's P&P titled, Enhanced Barrier Precaution, revised 7/5/2024, the P&P indicated the following: 1. Facility would implement EBP to reduce the risk of multidrug-resistant organism transmission. 2. Facility would determine residents for whom EBP are to be utilized. 3. Post EBP sign on the resident's room door to inform facility staff of the appropriate tasks requiring the use of PPE. 4. EBP utilized when performing high contact resident care activities: a. Bathing/showering b. Providing hygiene. c. Changing linens. d. Device care or use: urinary catheter. 5. Make PPE, including gowns and gloves, available immediately outside of the resident room.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 47858 Based on observation, interview, and record review, the facility failed to ensure that resident bedrooms accommodated no more than four residents in one out of 88 rooms (Room A). This deficient practice could adversely affect the adequacy of space, nursing care, comfort, and privacy to the residents and their visitors residing in Room A. Findings: During a review of the Facility Census, dated 9/30/2024, the Facility Census indicated Room A had the capacity to accommodate eight residents. During a review of the facility's Client Accommodation Analysis (undated), the Client Accommodation Analysis indicated Room A measured 655 square feet ([sq. ft.]- unit of measurement). During the initial tour of the facility, on 9/30/2024, at 10:07 a.m., it was observed Room A was occupied by eight residents. During observations made throughout the course of the survey, from 9/30/2024 to 10/4/2024, there were no adverse effects that pertained to the adequacy of space, nursing care, comfort, and privacy of the residents in Room A. Room A had enough space for the resident's beds and dressers. During a concurrent record review and interview, on 10/4/2024, at 10:40 a.m., with the Administrator (ADM), the facility's Room Waiver Request, dated 8/15/2024, was reviewed. The Room Waiver Request indicated the facility normally admitted residents for behavior and psychological problems. The ADM stated that Room A had eight residents in the room. The ADM stated the facility would request for a room waiver and ensure that the residents' health and safety were not adversely affected. The Department will recommend the request for a waiver/variance.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 45009 During an observation, interview, and record review the facility failed to meet the required room size measurement of 80 square feet ([sq. ft.]- a unit of measurement) of room space per resident in rooms with multiple residents. This deficient practice could potentially not provide residents privacy and could potentially affect residents' health and safety. Findings: During a review of the facility's Client accommodations Analysis form, dated 9/30/2024, the form indicated 9 rooms did not meet the 80 sq. ft. per resident requirement. During a review of the facility's Room Waiver Request Letter, dated 8/15/2024, the Room Waiver Request Letter indicated the following rooms did not meet the 80 sq. ft. of space per resident requirement: Room location # of beds Sq. Ft. Required Sq. Ft. 1. ACU-1 A 4 310 320 2. ACU-3 A 4 310 320 3. ACU- 4 A 4 310 320 4. ACU- 4 B 2 154 160 5. ACU-5 B 2 152 160 6. ACU-6 A 4 310 320 7. ACU-7 A 4 310 320 8. ACU-8 A 4 310 320 9. SW-7 2 141 160 During observations made throughout the course of the survey from 9/30/2024 to 10/4/2024, there were no adverse effects that pertained to the residents' care provided by facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. (continued on next page)

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Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview, on 10/4/2024, at 10:40 a.m., with the Administrator (ADM), the facility's Room Waiver Request, dated 8/15/2024, was reviewed. The request indicated the facility normally admitted residents for behavior and psychological problems. The ADM stated the facility would ensure the residents' health and safety were not adversely affected. The Department will recommend the request for a waiver/variance. During a review of the facility's Policy and Procedure (P&P) titled, Room Waiver dated 12/1/2015, the P&P indicated management team consisting of Administrator, Director of Nurses, and Social Services Director will observe rooms to ensure they are in accordance with the special needs of the residents, and will not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest wellbeing.