

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Santa Fe Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 5053 Peck Rd. El Monte, CA 91732	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 145) was treated with dignity by failing to provide privacy and failing to cover Resident 145's right flank (the area on the side of the body between the ribs and the hip) while Resident 145 was in the shower chair.</p> <p>This deficient practice resulted in exposure of Resident 145's right flank to Resident 145's right thigh and had the potential to result in a psychosocial decline to Resident 145.</p> <p>Findings:</p> <p>During a review of Resident 145's Admission Record (AR), the AR indicated, Resident 145 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including anxiety disorder (mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life), unspecified and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety.</p> <p>During a review of Resident 145's Care Plan (CP), titled, Resident has self-care deficits ., revision date 2/24/2025, the CP indicated, one of the interventions was to maintain resident's privacy and respect Resident 145's rights.</p> <p>During a review of Resident 145's History and Physical (H&P), dated 3/2/2025, the H&P indicated, Resident 145 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 145's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/6/2025, the MDS indicated, Resident 145's cognition (ability to understand and process information) was severely impaired.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/18/2025 at 7:57 AM with Certified Nursing Assistant (CNA) 3 and the Registered Nurse Supervisor (RNS), Resident 145 was sitting up in a shower chair at Resident 145's bedside. Resident 145's right flank and right thigh were exposed, and the privacy curtains were partially drawn. The door of Resident 145's shared room was propped open while CNA 3 was donning (putting on) personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) outside of Resident 145's room. There were a few male residents (unidentified) walking in the hallways. The RNS stated, part of Resident 145's body was exposed and should have been covered for dignity [purposes]. CNA 3 stated, CNA 3 was going to take Resident 145 to the shower and CNA 3 should have closed the curtains for privacy.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Resident Rights Guidelines for All Nursing Procedures, revised date 10/2010, the P&P indicated, one of the steps to follow that involved direct resident care was to close the room entrance door and provide for the resident's privacy.</p> <p>During a review of the facility's P&P titled, Dignity, revised date 2/2021, the P&P indicated, patient rights included considerate and respectful care, and to be made comfortable and residents had the right to respect for their personal values and beliefs. The P&P indicated, residents were treated with dignity and respect at all times. The P&P indicated, for staff to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438</p> <p>Based on observation, interview, and record review, the facility failed to ensure informed consents were obtained for one of one sampled resident (Resident 94) as indicated in the facility's policy and procedure (P&P), titled, Informed Consent and Alarm Monitor, by failing to:</p> <p>a. Ensure an informed consent was completed prior to the use of the bed/wheelchair alarms (a safety device, often a sensor pad or clip, that alerts caregivers when a patient attempts to leave their bed or chair, helping to prevent falls and injuries)</p> <p>b. Ensure informed consents were completed prior to the use of Lexapro (anti-depressant, medication used to treat depression [serious illness that negatively affects how one feels, thinks and acts]) and Remeron (medication used to treat depression).</p> <p>These failures resulted in violation of Resident 94/responsible party's right to understand Resident 94's treatment, including the risks and benefits of the medications and the purpose of the use of the alarms. Additionally, the failures had the potential to result in distress to Resident 94 related to the sound of the alarms.</p> <p>Findings:</p> <p>a. During a review of Resident 94's Admission Records (AR), the AR indicated, Resident 94 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) and muscle weakness (decreased strength in the muscles).</p> <p>During a review of Resident 94's Minimum Data Sheet (MDS, a resident assessment tool), dated 3/19/2025, the MDS indicated, Resident 94 had severe impaired cognition (ability to understand and process information).</p> <p>During a concurrent observation and interview on 3/17/2025 at 10:31 AM with Certified Nurse Assistant 1 (CNA 1) inside Resident 94's room, Resident 94 was sitting on his wheelchair. CNA 1 stated, Resident 94's bed and wheelchair had pad alarms to alert staff when Resident 94 tried to get up from the bed or the wheelchair.</p> <p>b. During a review of Resident 94's Order Summary report (OSR), dated active as of 3/17/2025, the OSR included the following physician orders, all dated 3/13/2025,</p> <p>1. wheelchair pad alarm while out of bed and up in the wheelchair to alert staff of resident unassisted transfer. The order indicated an informed consent was to be obtained from the responsible party after explanation of risks and benefits and verification with the physician.</p> <p>2. Lexapro 10 milligrams (mg, a unit of measurement) by mouth daily for depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities).</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.Remeron 7.5 mg by mouth at bedtime for depression.</p> <p>During a concurrent interview and record review on 3/17/2025 at 1:51 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 94's medical records (chart) and PointClickCare (PCC, a healthcare software used for electronic health records) were reviewed. LVN 1 stated, Resident 94 did not have an informed consent signed for the use of the bed and wheelchair pad alarms or for the use of Lexapro and Remeron. LVN 1 stated bed and wheelchair alarm should not be applied; Lexapro and Remeron should not be started until informed consents were signed to make sure the resident and the resident's representative were informed of the risks and benefits for the use of the bed and wheelchair pad alarms and side effects of the medications.</p> <p>During an interview on 3/18/2025 at 3:32 PM with the Registered Nurse Supervisor (RNS), the RNS stated, an informed consent should be obtained before the application of bed and wheelchair pad alarms and before the use of anti-depressants to make sure the resident or her responsible party were informed of the purpose of the use of the alarms and the use of the anti-depressants.</p> <p>During a review of the facility's undated P&P titled, Alarm Monitor, the P&P indicated, The licensed nurse will obtain an informed consent for the alarm.</p> <p>During a review of the facility's P&P, titled, Informed Consent, revised 12/2024, the P&P indicated, To ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints . Informed consent may be obtained through the following means: In person, By phone, Via fax, and by email . The informed consent form shall be maintained in the resident's clinical record.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 14) call light (a device used by a resident to signal the need for assistance) was within reach.</p> <p>This failure had the potential to result in Resident 14's needs to not be met in a timely manner and/or the potential for Resident 14 to experience harm if Resident 14 was unable to alert staff during an emergency.</p> <p>Findings:</p> <p>During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety (a mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life).</p> <p>During a review of Resident 14's History and Physical (H&P), dated 11/23/2024, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/6/2025, the MDS indicated, Resident 14's cognition (ability to understand and process information) was severely impaired. The MDS indicated, Resident 14 required partial/moderate assistance (helper does less than half the effort), substantial/maximal assistance (helper does more than half the effort), and was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During a concurrent observation and interview on 3/17/2024 at 12:10 PM with Certified Nursing Assistant (CNA) 4, Resident 14 was sitting up in a wheelchair positioned in the middle of the room facing away from Resident 14's bed. Resident 14's call light was secured around the right-side grab bar of Resident 14's bed. CNA 4 stated, Resident 14's call light was not within Resident 14's reach. CNA 4 stated, the call light should be within reach in case Resident 14 needed CNA 4's help.</p> <p>During an interview on 3/18/2025 at 3:33 PM with the Registered Nurse Supervisor (RNS), the RNS stated, the call light had to be within reach for residents (in general) so residents, even the confused residents, can press the call light and for residents to call for help.</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, Call Lights, the P&P indicated, to assure residents receive prompt assistance, staff should know how to place the call light for a resident and insured that the call light was within the resident's reach when in his/her room or when on the toilet.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on interview and record review, the facility failed to provide and ensure Advance Directives (AD, a legal document indicating resident preference on end-of-life treatment decisions) were kept in 3 of 5 sampled resident's (Residents 14, 145, 38) medical records.</p> <p>This failure had the potential to cause confusion among the healthcare providers in the event Residents 14, 145 and 38 required immediate medical care and/treatment and had the potential for the residents to receive inadequate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment.</p> <p>Findings:</p> <p>a. During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety (a mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life).</p> <p>During a review of Resident 14's History and Physical (H&P), dated 11/23/2024, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/6/2025, the MDS indicated, Resident 14's cognition (ability to understand and process information) was severely impaired.</p> <p>During a review of Resident 14's Care Plan (CP,) titled, Advance Directives, date initiated 2/24/2025, the CP's interventions indicated to respect my/legal representative's/DPOA's (Durable Power of Attorney) wishes/decisions as specified in the AD.</p> <p>b. During a review of Resident 145's AR, the AR indicated, Resident 145 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including anxiety disorder (mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life), unspecified and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety.</p> <p>During a review of Resident 145's History and Physical (H&P), dated 3/2/2025, the H&P indicated, Resident 145 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 145's CP, titled, Advance directive initiated as follows ., revision date 2/24/2025, the CP indicated, one of the interventions was to respect resident's and/or family's wishes.</p> <p>During a review of Resident 145's H&P, dated 3/2/2025, the H&P indicated, Resident 145 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 145's MDS, dated [DATE], the MDS indicated, Resident 145's cognition (ability to understand and process information) was severely impaired.</p> <p>c. During a review of Resident 38's AR, the AR indicated, Resident 38 was admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), single episode, unspecified and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition.</p> <p>During a review of Resident 38's H&P, dated 1/2/2025, the H&P indicated, Resident 38 had the capacity to understand and make decisions.</p> <p>During a review of Resident 38's MDS, dated [DATE], the MDS indicated, Resident 38's cognition was intact.</p> <p>During a concurrent interview and record review on 3/19/2025 at 8:51 AM with the Social Services Assistant (SSA), Residents 14, 145, and 38's Advance Healthcare Directive Acknowledgement (AHDA), and the Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life), were reviewed as follows:</p> <p>a. Resident 14's AHDA dated 5/23/2017 indicated, Resident 14 had executed an AD. Resident 14's POLST dated 2/21/2018 indicated, Resident 14 did not have an AD.</p> <p>b. Resident 145's AHDA dated 8/8/2023 indicated, Resident 145 had executed an AD. Resident 145's POLST dated 8/8/2023 indicated, Resident 145 did not have an AD.</p> <p>c. Resident 38's AHDA dated 1/9/2025 indicated, Resident 38 had executed an AD. Resident 38's POLST dated 1/9/2025, did not indicate if Resident 38 had an AD.</p> <p>The POLST forms indicated, the POLST complemented an AD and was not intended to replace that document (AD). The SSA stated, the SSA was responsible for handling of the AHDA, for completion upon admission, and the facility should obtain a copy of the AD right away. The SSA stated, the SSA could not find an AD on file [in the medical records] for Residents 14, 145, and 38. The SSA stated, the facility should have followed thru and obtained a copy of Residents 14, 145, and 38's AD and the ADs needed to be filed in the residents' medical records so the facility could honor Residents 14, 145 and 38's wishes like their final decision for their treatment and respect their wishes.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P), titled, Advance Directives, revised date 9/2022, the P&P indicated, the resident has the right to formulate an AD, including the right to accept or refuse medical treatment. The P&P indicated, ADs are honored in accordance with state law and the facility's policy. The P&P indicated a POLST paradigm form was not an advance directive. The P&P indicated, if the resident or the resident's representative had executed one or more advance directive(s), or executed one upon admission, copies of these documents were obtained and maintained in the same section of the resident's medical record and were readily retrievable by any facility staff.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to complete an assessment after a significant change in condition for one of one sampled resident (Resident 41) to include a bipolar disorder (mental health condition that causes clear shifts in a person's mood, energy, activity levels, and concentration) diagnosis as indicated in Resident 41's physician order for Depakote (medication used to treat certain psychiatric conditions such as bipolar disorder).</p> <p>This deficient practice had the potential to result in unmet needs for Resident 41.</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record (AR), the AR indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted the resident on 12/10/2024 with multiple diagnosis including dementia (a gradual decline in mental ability usually caused by a brain disease) and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, significantly impacting daily functioning).</p> <p>During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool) dated 12/17/2024, the MDS indicated Resident 41 had severe impaired cognition (ability to understand and process information) and required maximal assistance (helper does more than half the effort) for bathing and toileting. The MDS did not indicate bipolar disorder as an active diagnosis for Resident 41.</p> <p>During a concurrent interview and record review on 3/20/2025 at 10:40 AM with the Minimum Data Set Coordinator (MDSC), Resident 41's AR and MDS section I: Active were reviewed. The MDSC stated Resident 41's AR and MDS did not indicate a diagnosis of bipolar disorder. The MDSC stated Resident 41 was last hospitalized from 11/20/2024 to 12/10/2024 and upon readmission to the facility, the nursing staff (in general) reviewed the resident's hospital records to find out what the resident was treated for and if the resident experienced a significant change such as a fracture or a new diagnosis. The MDSC stated when a resident returned from the hospital, the resident's MDS had to be updated to include any significant changes and completed within 14 days. The MDSC stated it was important to note any new diagnosis in the AR and MDS because, not doing so, could affect the resident's plan of care.</p> <p>During a concurrent interview and record review on 3/20/2025 at 11:00 AM with the MDSC, Resident 41's Order Summary Report (OSR) with active orders as of 3/19/2025 was reviewed. The OSR indicated Resident 41 had an order for Depakote Sprinkles oral capsule delayed release, 625 mg (milligrams, unit of measurement) taken by mouth two times a day for bipolar disorder manifested by uncontrollable extreme mood swings causing stress with order date of 12/10/2024 (date of readmission). The OSR indicated to monitor episodes of bipolar disorder manifested by uncontrollable extreme mood swings causing stress with order date of 12/10/2024. The MDSC stated the Depakote medication was likely added during Resident 41's hospitalization and Resident 41's AR and MDS should have included a bipolar disorder diagnosis based off the hospital records from where Resident 41 was treated.</p> <p>During a review of Resident 41's physician progress notes, (PPN) dated 1/15/2025. The PPN indicated to continue Depakote Sprinkles 625 mg by mouth twice a day for bipolar.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Record Content: Documentation Principles, dated 1/2004, the P&P indicated the Resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438</p> <p>Based on interview and record review, the facility failed to complete an evaluation for Level II Pre-Admission Screening and Resident Review (PASARR, a federal assessment requirement to help ensure individuals who have mental disorders or intellectual disabilities are placed in facilities that can provide the appropriate care) for one of one sampled resident (Residents 43).</p> <p>This failure had the potential to result in unmet individualized services to Resident 43.</p> <p>Findings:</p> <p>During a review of Resident 43's Admission Record (AR), the AR indicated, Resident 43 was initially admitted to the facility 11/12/2024 and readmitted on [DATE] with diagnoses that included traumatic subdural hemorrhage (a collection of blood that accumulates between the outer and middle layer of the brain's protective membranes after a head injury), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and hypertension (HTN, high blood pressure).</p> <p>During a review of Resident 43's PASSAR Level I (a screening process to identify individuals seeking admission to a Medicaid-certified nursing facility who may have a serious mental illness [SMI] or intellectual/developmental disability [ID/DD]) screening, dated 12/5/2025, the PASARR Level I screening indicated, Resident 43 had a positive result for SMI and required a Level II.</p> <p>During a concurrent interview and record review on 3/18/2025 at 11:03 am with the Registered Nurse Supervisor (RNS), Resident 43's medical records (chart) and PointClickRecord (PCC, a healthcare software used for electronic health records) were reviewed. The RNS stated, there were no documented records that Resident 43 was evaluated for PASARR Level II. PASARR Level II screening were completed on residents with positive result on the screening of PASARR Level I within a week of admission to make sure residents receive proper and appropriate care in the facility.</p> <p>During an interview on 3/20/2025 at 11:09 AM with the Director of Nursing (DON), the DON stated all residents with a positive Level I PASARR result should be evaluated for a PASARR Level II to determine if the resident needed specialized care services and referrals.</p> <p>During a review of facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), revised 6/2024, the P&P indicated, If the DHCS/DDS contractor deems a Level II evaluation is necessary, the facility will assist the DHCS contractor with additional information, face-to-face visit for further evaluation as indicated. The Facility's designated staff will review the available information from the PASARR Online System regularly, follow up with the DHCS/DDS' contractor on Level II determination/recommendation, and document and maintain the records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to develop a care plan related to bipolar disorder (mental health condition that causes clear shifts in a person's mood, energy, activity levels, and concentration) for one of one sampled resident (Resident 41).</p> <p>This deficient practice had the potential to result in Residents 41 not to receive the necessary care and services according to Resident 41's specific needs.</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record (AR), the AR indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted the resident on 12/10/2024 with multiple diagnosis including dementia (a gradual decline in mental ability usually caused by a brain disease) and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, significantly impacting daily functioning).</p> <p>During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool) dated 12/17/2024, the MDS indicated Resident 41 had severe impaired cognition (ability to understand and process information) and required maximal assistance (helper does more than half the effort) for bathing and toileting. The MDS did not indicate bipolar disorder as an active diagnosis for Resident 41.</p> <p>During an interview on 3/20/2025 at 11:00 AM with Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 41's current medical record should have included a new bipolar disorder diagnosis based off the hospital records obtained during Resident 41's hospitalization from [DATE] to 12/10/2024. The MDSC stated the MDSC was unsure if a CP needed to be completed for the new diagnosis.</p> <p>During an interview on 3/20/2025 at 11:23 AM with the MDSC, the MDSC stated a CP should have been developed for a new diagnosis like bipolar disorder on admission. The MDSC stated Resident 41 did not have a CP for bipolar disorder and the CP was needed so that all staff (in general) was aware of the diagnosis and relevant interventions.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2023, the P&P indicated the interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the resident has been readmitted to the facility from a hospital stay.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to obtain weekly weights for three of three sampled residents (Resident 34, 28, and 145) as indicated in the facility's policy and procedure (P&P) titled, Weight Change, as evidenced by:</p> <p>A. Resident 34's weight was not taken upon readmission to the facility on [DATE] and not taken on 3/18/2025 per the physician order.</p> <p>B. Resident 28 weight was not taken weekly as ordered by the physician.</p> <p>C. Resident 145's weight was not taken on 3/18/2025 as per the physician's order.</p> <p>This deficient practice had the potential to result in physical declines to Residents 34, 28, and 145 due to untreated weight loss.</p> <p>Findings:</p> <p>A. During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was initially admitted to the facility on [DATE] and the resident was readmitted on [DATE] with multiple diagnosis including heart failure (the inability of the heart to pump blood effectively) and dementia (a gradual decline in mental ability usually caused by a brain disease.)</p> <p>During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 34 had severe impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for bathing and toileting.</p> <p>During a review of Resident 34's Order Summary Report (OSR) with active orders as of 3/18/2025, the OSR indicated Resident 34 had a physician order to monitor weight every Tuesday for four weeks then monthly with a start date on 3/18/2025.</p> <p>During an interview on 3/19/2025 at 2:20 PM with the Restorative Nurse Assistant (RNA), the RNA stated the RNA was responsible for weighing the residents and the RNA was made aware, by the nursing staff, which residents to weigh. The RNA stated residents were weighed when they returned from the hospital because residents tended to lose weight during a hospitalization . The RNA stated the RNA did not have access to the facility's computer documentation system and typically wrote down resident weights and handed them to either the Director of Nursing (DON) or nursing staff and nursing would input the weights into the computer system right away. The RNA stated Resident 34 was weighed upon return to the facility and the RNA gave the weight to the Infection Preventionist nurse (IP). The RNA stated Resident 34 was not on the RNA's list of weekly weights and the RNA could not recall what Resident 34's weight was upon return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/19/2025 at 2:43 PM with the IP, the IP stated the most recent weight recorded for Resident 34 was on 3/3/2025 prior to Resident 34's hospitalization dated from 3/8/2025 to 3/14/2025. The IP stated the RNA may have given the IP Resident 34's weight on a scrap of paper but the IP did not input the weight into the computer system and did not have any documentation to support that Resident 34's weight was taken.</p> <p>40438</p> <p>B. During a review of Resident 28's AR, the AR indicated, Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), hypertension (HTN, high blood pressure), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood).</p> <p>During a review of Resident 28's MDS, dated [DATE], the MDS indicated, Resident 28 had severe impaired cognition (ability to understand and process information). The MDS indicated Resident 28 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting, upper and lower body dressing, and personal hygiene.</p> <p>During a review of Resident 28's Change of Condition (COC)/Interact Assessment Form, dated 3/5/2025, the form indicated, Resident 28 had a weight loss of 5.2 percent (%), a specified amount for every hundred).</p> <p>During a review of Resident 28's Weights and Vitals Summary (WVS), dated 3/18/2025, the WVS indicated the last weight recorded for Resident 28 was on 3/3/2025 for 147 pounds (lbs., unit of weight), Resident 28 had an 8-pound weight loss in thirty days.</p> <p>During a review of Resident 28's OSR, dated active as of 3/18/2025, the OSR included a physician's order, dated 3/5/2025, to monitor weight every Tuesday for 4 weeks.</p> <p>During a concurrent interview and record review on 3/18/2025 at 3:17 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 28's medical record (chart) and PointClickCare (PCC, electronic medical record) were reviewed. LVN 3 stated Resident 28 had no weights recorded on 3/11/2025 and 3/18/2025. LVN 3 stated weights should be monitored for residents [who were experiencing] weight loss to address the nutritional status of the resident appropriately.</p> <p>During an interview on 3/18/2025 at 3:32 PM with the Registered Nurse Supervisor (RNS), the RNS stated, residents [who were experiencing] weight loss should be weigh weekly to monitor weight changes for the detection of health issues and medication management.</p> <p>42307</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. During a review of Resident 145's AR, the AR indicated, Resident 145 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including anxiety disorder (mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life), unspecified and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety.</p> <p>During a review of Resident 145's MDS, dated [DATE], the MDS indicated, Resident 145's cognition (ability to understand and process information) was severely impaired. The MDS indicated, Resident 145's proportion of total calories (a unit of measurement that indicate the energy content of food and beverages) received was 25% or less while a resident at the facility.</p> <p>During a review of Resident 145's Care Plan (CP), titled, Resident has alteration in nutritional status ., revision date 2/24/2025, the CP's interventions indicated to monitor weight per policy.</p> <p>During a review of Resident 145's History and Physical (H&P), dated 3/2/2025, the H&P indicated, Resident 145 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 145's Nutritional Assessment DSS (NA), dated 3/2/2025, timed at 11:16 AM, the NA indicated, Resident 145 had a loss of 5% (percent, a number or ratio expressed as a fraction of 100) or more in the last month and Resident 145 was not on prescribed weight-loss regimen.</p> <p>During a review of Resident 145's COC, dated 3/5/2025 timed at 2:20 PM, the COC indicated, an RD (Registered Dietician) consultation and weekly weight for 4 weeks.</p> <p>During a review of Resident 145's OSR), active orders as of 3/20/2025, the OSR included, a physician's order, dated 3/5/2025, the order indicated to monitor weight every Tuesday for 4 weeks.</p> <p>During a review of Resident 145's CP, titled, Resident weight loss -5.0% change ., date initiated 3/5/2025, the CP indicated, one of the interventions was weekly weight for 4 weeks as per physician's order.</p> <p>During a review of Resident 145's undated WVS, the WVS indicated, Resident 145's last weight documented in PCC (PointClickCare, a healthcare software used for electronic health records) was dated 3/3/2025.</p> <p>During a concurrent interview and record review on 3/19/2024 at 2:45 PM with the RNA, the facility's undated Weekly Weights (WW), was reviewed. The WW indicated, the following weekly dates: Week 1 on 3/11/2025; Week 2 on 3/18/2025; Week 3 on 3/25/2025; Week 4 on 4/1/2025. The RNA stated, the RNA did not enter resident weights in PCC and the DON was the one who entered the weights in PCC. The WW did not indicate any weights for week 2 on 3/18/2025 (Tuesday) for Resident 145. The RNA stated, the RNA was responsible for weighing the residents. The RNA stated, the RNA did the weekly weights on Tuesday or Friday it depends, if [it is a] busy day.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's undated policy and procedure (P&P) titled, Weight Change, the P&P indicated, all residents were to be weighed and measured upon admission and once weekly for four weeks thereafter and a record should be kept in resident's chart.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40438</p> <p>Based on observation, interview, and record review, the facility failed ensure proper food storage, in one of one kitchen walk-in refrigerator (Refrigerator 1), consistent with the facility's policy and procedure (P&P), titled, Refrigerator/Freezer Storage, by failing to:</p> <ol style="list-style-type: none"> a. Ensure a transparent container with sliced cheese was labeled with an open date (date to indicate when it was opened). b. Ensure a halfway-filled pickle jar was labeled with an open date. c. Ensure two unopened plastics of whipping cream were labeled with a received date. <p>These failures had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) to the residents consuming the facility's food.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 3/17/2025 at 8:58 AM with the Certified Dietary Manager (CDM) inside Refrigerator 1, the following items were found,</p> <ol style="list-style-type: none"> 1. A transparent container that had sliced cheese and the container was not dated or labeled with the date when it was opened. 2. An undated halfway-filled bottle jar with hamburger pickles. 3. Two undated and unopened plastics of whipping cream. CDM stated food items inside the fridge should be labeled with open and receive dates to keep track of the quality and freshness of the food. <p>During an interview on 3/19/2025 at 12:55 PM with the Registered Dietitian (RD), the RD stated all items in Refrigerator 1 should be labeled with an open and receive dates to keep track when food items arrived, to know when to discard food items, and to make sure food served to the residents was at its highest quality.</p> <p>During a review of the facility's P&P titled, Refrigerator/Freezer Storage, revised 2019, the P&P indicated, Leftover food or unused portions of packaged foods should be covered, dated, and labeled to ensure they will be used first. The P&P indicated all items should be properly covered, dated, and labeled. The P&P indicated food items should have the following appropriate dates: Delivery date - upon receipt, Open date - opened containers of PHF and Thaw date - any frozen items.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438</p> <p>Based on interview and record review, the facility failed to ensure its binding arbitration agreements (AA, a contractual promise where parties agree to resolve disputes through arbitration instead of litigation) included a selection that allowed the residents or their responsible parties/resident representatives to communicate with federal, state, or local officials for two of two sampled residents (Residents 34 and 38).</p> <p>This failure had the potential to violate Resident 34 and Resident 38's rights and result in unjust arbitration.</p> <p>Findings:</p> <p>a. During a review of Resident 34's Admission Record (AR), the AR indicated, Resident 34 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>During a concurrent interview and record review on 3/19/2025 at 8:32 AM with the Admission Coordinator (AC), Resident 34's AA, dated 1/29/2025 was reviewed. The AC stated Resident 34's AA was signed by the resident's responsible party on 1/29/2025. The AC stated Resident 34's AA did not have a selection indicating the resident's responsible party could communicate with federal, state, or local officials.</p> <p>b. During a review of Resident 38's AR, the AR indicated, Resident 38 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic [long standing] lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 28's Minimum Data Sheet (MDS, a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 28 had intact cognition (ability to understand and process information). The MDS indicated Resident 28 required partial/moderate assistance (helper did less than half the effort) with oral and toileting hygiene, upper and lower body dressing, and with personal hygiene.</p> <p>During a concurrent interview and record review on 3/19/2025 at 8:45 AM with the AC, Resident 38's AA, dated 1/22/2025 was reviewed. The AC indicated Resident 34's AA was signed by the resident's responsible party on 1/22/2025. The AC stated Resident 38's AA did not have a selection indicating the resident's responsible party could communicate with federal, state, or local officials like the Surveyors and the Ombudsman. The AC stated it was important to allow residents and their representatives to communicate with federal, state, and local officials to honor the resident's rights to seek justice and not to discourage the residents to complain against the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to follow infection (the invasion and growth of germs in the body) prevention and control practices for 6 of 6 sampled residents (Residents 14, 16, 38, 40, 18 and 34) by failing to ensure:</p> <p>a. personal toiletries and resident care items were labeled and not stored inside the [NAME] and [NAME] restroom (a restroom that has two doors and is sandwiched between two bedrooms and is accessible by both bedrooms) of Residents 14, 16, 38 and 40.</p> <p>b. communal drinks were not accessible for Resident 18 to pour water by himself.</p> <p>c. the lint traps for 2 of 3 sampled dryers (Dryer 1 and Dryer 2) were kept clean and did not have a heavy thick accumulation of lint.</p> <p>d. Resident 34's bed sheets were clean from smeared stool.</p> <p>e. Proper storage/disposal of a used cup set on top of the handrail outside of room [ROOM NUMBER].</p> <p>These deficient practices had the potential to result in the spread of infection and physical declines to Residents 14, 16, 38, 40, 18, and 34, and amongst the residents residing at the facility.</p> <p>Findings:</p> <p>a. During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, leading to distorted perceptions, thoughts, and behaviors), mood disturbance (a significant change in a person's emotional state that persists for an extended period), and anxiety (a mental health condition characterized by persistent, excessive fear or worry that significantly interferes with daily life).</p> <p>During a review of Resident 14's History and Physical (H&P), dated 11/23/2024, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/6/2025, the MDS indicated, Resident 14's cognition (ability to understand and process information) was severely impaired.</p> <p>During a review of Resident 16's AR, the AR indicated, Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 16's H&P, dated 10/19/2024, the H&P indicated, Resident 16 was able to make decisions for activities of daily living.</p> <p>During a review of Resident 16's MDS, dated [DATE], the MDS indicated, Resident 16's cognitive skills for daily decision making were severely impaired.</p> <p>During a review of Resident 38's AR, the AR indicated, Resident 38 was admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), single episode, unspecified and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition.</p> <p>During a review of Resident 38's H&P, dated 1/2/2025, the H&P indicated, Resident 38 had the capacity to understand and make decisions.</p> <p>During a review of Resident 38's MDS, dated [DATE], the MDS indicated, Resident 38's cognition was intact.</p> <p>During a review of Resident 40's AR, the AR indicated, Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including encephalopathy (a medical condition that affects brain function, leading to changes in mental state and behavior), unspecified and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), unspecified.</p> <p>During a review of Resident 40's H&P, dated 2/28/2025, the H&P indicated, Resident 40 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 40's MDS, dated [DATE], the MDS indicated, Resident 40's cognition was severely impaired.</p> <p>During an observation on 3/17/2025 at 9:14 AM in the [NAME] and [NAME] restroom of Residents 14, 16, 38, and 40, there were an opened, unlabeled 8 Fl oz (fluid ounce, a unit of volume used to measure liquids) of Remedy (name brand) Cleanse Spray Cleanser, an uncapped, unlabeled 1.5 oz can of Midline (brand) Shaving Cream stored on top of the sink and an unlabeled grey colored wash basin stored on the floor under the sink.</p> <p>During a concurrent observation and interview on 3/17/2025 at 12:14 PM with Certified Nursing Assistant (CNA) 4 in the [NAME] and [NAME] restroom of Residents 14, 16, 38, and 40, there was an opened, unlabeled 8 Fl oz (fluid ounce, unit of volume) of Remedy Cleanse Spray Cleanser, an uncapped, unlabeled 1.5 oz can of Midline shaving cream stored on top of the sink, and an unlabeled grey colored wash basin stored on the floor under the sink. CNA 4 stated, the facility didn't usually store them (personal toiletries and resident care items) inside the restroom and [the items] should be locked up in the resident's closets. CNA 4 stated, it was important for personal toiletries and resident care items to be labeled with a resident's name for the safety of the residents. CNA 4 stated, Residents 38 and 40 get up and walked and could potentially use the personal care items that did not belong to Residents 38 and 40, it's contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/19/2025 at 1:08 PM with the Infection Preventionist (IP), the IP stated, residents should have their own toiletries and resident care items to prevent cross contamination (a process by which bacteria can be transferred from one area to another) and should be labeled with a resident's name and kept at the resident's bedside drawer. The IP stated, Residents 14, 16, 38, and 40 shared a restroom and Residents 38 and 40 were, up and about.</p> <p>During a review of the facility's policy and procedure (P&P), titled Accommodation of Needs, date revised 3/2021, the P&P indicated, to label toiletry items with large print so a visually impaired resident can distinguish one from another.</p> <p>b. During a review of Resident 18's AR, the AR indicated, Resident 18 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, ad behavior), unspecified and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 18's H&P, dated 9/13/2024, the H&P indicated, Resident 18 was able to make decisions for activities of daily living.</p> <p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated, Resident 18's cognition was severely impaired.</p> <p>During a concurrent observation and interview on 3/19/2025 at 8:33 AM with Licensed Vocational Nurse (LVN) 4, Med Cart 2 had a pitcher of water, a pitcher of cranberry juice and a pitcher of lemonade along with a supply of plastic drinking cups. Med Cart 2 was parked in the hallway and Resident 18 was ambulating (walking) in the hallway. Resident 18 stopped, grabbed a plastic cup, poured himself a cup of water from the pitcher of water, walked away, and came back to pour another drink of water from the pitcher on Med (medication) Cart 2. An unidentified staff was outside standing against the wall nearby in the hallway monitoring the activity room located across. LVN 4 stated, residents should not be allowed to pour water by themselves from the pitcher located on the medication cart for infection control [purposes], cross contamination from resident touching the pitcher.</p> <p>During an interview on 3/19/2025 at 1:08 PM with the IP, the IP stated, it was not ok for Resident 18 and residents to pour a cup of water by themselves from the pitcher that was on top of Med Cart 2, for infection control and safety reasons. The IP stated, the resident's hands could be dirty and if the resident did not like the drink, the resident could spit it out and/or put the remaining water back into the pitcher, most of these residents have dementia.</p> <p>During a review of the facility's P&P, titled Infection Prevention and Control Program, dated 2001, the P&P indicated, an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P indicated, one of the important facets of infection prevention included instituting measures to avoid complications or dissemination.</p> <p>c. During an interview on 3/20/2025 at 8:19 AM with the Laundry (LD) in the laundry room located inside a separate building of a sister facility, there were 3 commercial washers and 3 commercial dryers. The LD stated the laundry room was used by both the facility and the sister facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/20/2025 at 8:33 AM in the laundry room, Dryer 1 and Dryer 2 were not currently used. The lint trap of Dryer 1 and Dryer 2 had a heavy, thick accumulation of lint, including on the door and clumps of lint on the bottom of Dryer 1. The LD stated, the heavy accumulation of lint could cause a fire and that's very dangerous. The LD stated, the LD waited at the end of the LD's shift to clean up for the next shift and empty out the lint traps before the LD left at 2:30 PM. The LD stated, the LD should clean the lint traps more often.</p> <p>During a review of the facility's Lint Cleaning Schedule - Daily (LCS), dated 3/20/25, the LCS indicated, lint was to be removed from the lint traps every two hours and frequency of lint cleaning may increase, depending on the usage of the dryer and the presence of lint. The LCS indicated, initials of the individual that performed the lint cleaning task were to be noted. The LCS indicated, no initials on 3/19/2025 at 4:00 AM, 6:00 AM, 8:00 AM, and 10:00 AM and on 3/20/2025 at 4:00 AM, 6:00 AM, and 8:00 AM.</p> <p>During an interview on 3/20/2025 at 2:43 PM with the Maintenance Supervisor (MS), the MS stated, the thick accumulation of lint in the lint trap could affect the temperature of the dryer, it won't have the right temperature [to properly clean items] and could also be a fire hazard.</p> <p>During a review of the facility's undated P&P, titled, Maintenance of the Laundry Room and Laundry Equipment, the P&P indicated, to clean lint filters after each use of washer or dryer every three (3) hours.</p> <p>48729</p> <p>d. During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was initially admitted to the facility on [DATE] and the resident was readmitted on [DATE] with multiple diagnosis including heart failure (the inability of the heart to pump blood effectively) and dementia (a gradual decline in mental ability usually caused by a brain disease.)</p> <p>During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 34 had severe impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for bathing and toileting.</p> <p>During a concurrent observation and interview on 3/17/2025 at 10:20 AM with Certified Nursing Assistant (CNA) 2, Resident 34's bedsheets and room wall were observed with brown streaks. CNA 2 stated Resident 34 had been putting Resident 34's hands in Resident 34's soiled diaper earlier and CNA 2 hoped the brown streaks was not stool.</p> <p>During a concurrent observation and interview on 3/17/2025 at 10:30 AM with CNA 3, CNA 3 stated Resident 34's sheets needed to be changed because Resident 34 likely got the bedsheets dirty with stool from placing his hands in Resident 34's soiled diaper and handling his own feces. CNA 3 stated Resident 34's sheets needed to be changed because Resident 34 could touch the sheets and get other things dirty like the bedrails and staff could get dirty as well.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/2025 at 11:17 AM with the Infection Preventionist nurse (IP), the IP stated if a resident's bedsheets had feces on them, it could become an infection control issue. The IP stated, the resident could touch other sheets, bed rails, and spread the feces potentially contaminating the staff as well. The IP stated Resident 34 could not independently clean Resident 34's hands.</p> <p>e. During a concurrent observation and interview on 3/18/2025 at 10:30 AM with CNA 1, a hard plastic reusable cup was observed set on top of the handrail outside of room [ROOM NUMBER]. The cup had leftover white liquid inside. CNA 1 stated the cup was not supposed to be there and sometimes the residents (in general) left their cups wherever. CNA 1 stated staff looked through the hallways after meals to look for any cups left behind, but this cup was missed.</p> <p>During an interview on 3/20/2025 at 11:17 AM with the Infection IP, the IP stated staff (in general) tried to monitor the hallways during meals and cups should not be left on the handrails. The IP stated if a cup was left unattended on the handrails another resident could potentially grab the cup and use it causing a potential for infection control issues because a resident could get sick depending on what is in the cup or how it was used.</p> <p>During a review of the facility's P&P, titled Infection Prevention and Control Program, dated 2001, the P&P indicated, an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P indicated, one of the important facets of infection prevention included instituting measures to avoid complications or dissemination.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on observation, interview, and record review, the facility failed to ensure 20 out of 23 resident rooms (Rooms 1, 2, 3, 4, 5, 6,7, 8, 9, 10, 11, 12 ,16, 17, 18, 19, 20, 21, 22, and 24) met the minimum requirement of 80 square feet (sq. ft. - unit of measure) per resident in bedrooms with more than one resident.</p> <p>This deficient practice had the potential to result in the residents not to have enough room or inability to move freely throughout their rooms and limit the space for facility staff to provide necessary services and treatments.</p> <p>Findings:</p> <p>During a review of the facility's Resident Listing Report, (RLR) dated 3/17/2025, the RLR indicated room [ROOM NUMBER] had four residents in one room.</p> <p>During a review of the facility's Client Accommodation Analysis, (CAA), dated 3/17/2025, the CAA indicated the following rooms were less than 80 sq. ft. per resident:</p> <p>Room No. No. of beds: Room Size: Floor Area:</p> <p>1 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>2 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>3 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>4 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>5 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>6 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>7 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>8 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>9 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>10 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>11 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>12 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>16 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>17 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>18 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>19 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>20 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>21 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>22 2 14 ft. x 10 ft. 140 sq. ft.</p> <p>24 4 22 ft. x 14 ft. 308 sq. ft.</p> <p>During a review of the facility's room waiver request letter, dated 3/17/2025 the room waiver request letter indicated the facility could provide reasonable privacy, closet, storage space, and had sufficient room to provide nursing care and resident equipment. The letter indicated the rooms were in accordance with the special needs of all the residents [occupying the rooms] as necessary.</p> <p>During a concurrent observation and interview on 3/20/2025 at 10:28 AM, with Certified Nursing Assistant (CNA) 7. There were two wheelchairs inside the room [ROOM NUMBER]. CNA 7 entered room [ROOM NUMBER] and was observed attending to a bed alarm (safety device that contains a sensor to trigger an alarm when change in pressure is detected). CNA 7 was able to move freely throughout the room. CNA 7 stated CNA 7 was able to provide care to the residents without issue from the available space in the resident rooms.</p>