

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Downey Community Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8425 Iowa Street Downey, CA 90241	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of seven sampled residents (Resident 100).</p> <p>This deficient practice had the potential to result in a delay in meeting the residents' needs for assistance and could lead to falls and accidents.</p> <p>Findings:</p> <p>During an observation on 4/8/2025 at 8:46 a.m., in Resident 100's room, Resident 100 was awake and lying on her bed. The call light cord was observed hanging around the left-upper side rail with the touch pad touching the floor.</p> <p>During an observation on 4/8/2025 at 2:10 p.m., in Resident 100's room, Resident 100 was awake and lying on her bed. The call light touch pad was touching the floor.</p> <p>During a review of Resident 100's Admission Record, the Admission Record indicated Resident 100 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of generalized muscle weakness, dementia (a progressive state of decline in mental abilities), and history of falling.</p> <p>During a review of Resident 100's Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 100's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 100 was dependent (helper did all the effort) with self-care (eating, oral hygiene, toileting hygiene, showering/ bathing self, and personal hygiene) and mobility (rolling left and right, chair/bed-to-chair transfer, and tub/shower transfer).</p> <p>During a review of Resident 100's History and Physical (H&amp;P), dated 2/10/2025, the H&amp;P indicated Resident 100 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 100's care plan for fall risk, undated, the care plan indicated to ensure the resident's call light is within reach.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and picture review of Resident 100's call light, on 4/9/2025 at 2:20 p.m. with Certified Nursing Assistant (CNA) 5, the pictures dated 4/8/2025 at 8:46 a.m. and 2:10 p.m. were reviewed. The pictures showed Resident 100's call light touching the floor and not within reach. CNA 5 stated it was not acceptable that Resident 100's call light was not within reach because it was on the floor. CNA 5 stated the call light should be within the resident's reach. CNA 5 stated the purpose of the call light was for emergencies to call for help when needed. CNA 5 stated the call light was for resident safety. CNA 5 stated she checked call light placement visually during rounds every 20 to 30 minutes. CNA 5 stated all staff were responsive to ensure the call light was within reach.</p> <p>During a concurrent interview and picture review on 4/9/2025 at 2:38 p.m., with Licensed Vocational Nurse (LVN) 7, the pictures dated 4/8/2025 at 8:46 a.m. and 2:10 p.m. were reviewed. The pictures showed Resident 100's call light was touching the floor and not within reach. LVN 7 stated the call light touch pad was not reachable to the resident because it was on the floor. LVN 7 stated the purpose of the call light was safety and to address the resident's needs. LVN 7 stated if Resident 100 was not able to press the call light, the call light touch pad needed to be placed on the resident's chest when in bed for easy access. LVN 7 stated she checked the call light placement in the morning, during the medication pass and every time she attended to the residents. LVN 7 stated everyone was responsible for ensuring the call light was within reach.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Call Light, dated 1/2024, the P&amp;P indicated Check the placement of call light during rounds. Make sure it is within reach.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48343</p> <p>Based on observation, interview, and record review, the facility failed to promptly notify the physician and the resident's representative (RR 1) of a change in condition (COC) of skin tears (separation of the skin) and bleeding on both forearms for one of four sampled residents (Resident 89).</p> <p>This deficient practice resulted in a delay in medical assessment and treatment for Resident 89 and placed the resident at risk of harm.</p> <p>Findings:</p> <p>During a review of Resident 89's Admission Record, the Admission Record indicated Resident 89 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), cerebrovascular accident ([CVA]- stroke, loss of blood flow to a part of the brain), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN]- high blood pressure).</p> <p>During a review of Resident 89's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 89's cognitive (the ability to think and process information) skills for daily decision making was severely impaired.</p> <p>During a review of Resident 89's History and Physical (H&amp;P), dated 3/10/2025, the H&amp;P indicated Resident 89 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 89's care plan with a focus of Resident was at risk for skin breakdown related to stroke, dated 3/20/2025, the care plan indicated the facility would monitor Resident 89 for skin breakdown and report injuries to the physician.</p> <p>During an observation on 4/10/2025 at 10:05 a.m., in Resident 89's room, Resident 89 was observed with dressings (materials applied to wounds to promote healing) on her right and left forearms.</p> <p>During a telephone interview on 4/10/2025 at 11:39 a.m., with Resident 89's RR 1, RR 1 stated she has visited Resident 89 daily since the resident's admission to the facility. RR 1 stated on the morning of 4/7/2025 at approximately 12:00 p.m., Resident 89 was observed with dressings on both of her forearms which were not present during her previous visits. RR 1 stated staff were not able to explain what happened. RR 1 stated on 4/7/2025 around 3:00 p.m., upon an assessment by Treatment Nurse (TX 1), Resident 89 was observed with two skin tears on her left forearm, one skin tear on her right forearm with bleeding, and new bruises on both forearms. RR 1 stated TXN 1 was not able to explain how Resident 89 developed skin tears and bruises on her forearms. RR 1 stated she was not made aware of Resident 89's skin tears and new bruises. RR 1 stated she was upset and disappointed the facility failed to notify her of Resident 89's change of condition.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 11:55 a.m., with TXN 1, TXN 1 stated on 4/7/2025 around 2:30 p.m., she (TXN 1) was notified by Licensed Vocational Nurse (LVN 6) that Resident 89 had dressings to her forearms and needed a skin assessment. TXN 1 stated upon removal of the old dressings she observed Resident 89 with skin tears to the left and right forearms with bleeding and bruises. TXN 1 stated she did not know how Resident 89 developed skin tears on her forearms and who originally applied the dressings. TXN 1 stated she notified the Director of Nursing (DON) regarding Resident 89's change of condition.</p> <p>During a concurrent interview and record review on 4/10/2025 at 1:10 p.m., with LVN 6, Resident 89's Electronic Medical Record (EMR) dated 4/6/2025 to 4/7/2025 was reviewed. LVN 6 stated Resident 89's EMR indicated there was no documented evidence how Resident 89 sustained the skin tears, bleeding, and bruises, and who applied the dressings. LVN 6 stated there was no documentation Resident 89's assigned 11 p.m. to 7 a.m. Certified Nursing Assistant (CNA 2) reported to the licensed nurses regarding the change of condition. LVN 6 stated the physician was not notified until after the concern was brought to the licensed nurses' attention by RR 1 on 4/7/2025 around 2:30 p.m. LVN 6 stated Resident 89's skin tears, bleeding, and bruises was a significant change of condition and staff should have notified the physician and RR 1 immediately to prevent delayed medical assessment, care, and treatment.</p> <p>During a telephone interview on 4/14/2025 at 9:32 a.m., with CNA 2, CNA 2 stated on the morning of 4/7/2025 around 4:00 a.m., while she was providing personal hygiene care to Resident 89, Resident 89 was moving her arms and struck the bed siderails. CNA 2 stated this resulted in skin tears and bleeding to both forearms. CNA 2 stated she applied the dressings to Resident 89's forearms but did not report the incident to the licensed nurse because she was scared and afraid that she would be suspended. CNA 2 stated she should have notified the charge nurse immediately so the resident could receive timely evaluation and treatment.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Condition Change of Resident, dated 1/2024, the P&amp;P indicated the facility would observe, record, and report changes in condition to the physician and resident's representative.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47286</p> <p>Based on interview and record review, facility staff failed to report an allegation of resident-to-resident physical abuse to the State Agency within two (2) hours, for two of four sampled residents (Resident 44 and Resident 42).</p> <p>This failure resulted in delayed notification to the State Agency and increased the potential for additional resident-to-resident abuse incidents to occur.</p> <p>Cross reference F-tag F943.</p> <p>Findings:</p> <p>During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 44's admitting diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), 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 44's History and Physical (H&amp;P), dated 10/20/2024, the H&amp;P indicated Resident 44 did not have the capacity to understand or make decisions.</p> <p>During a review of Resident 44's Minimum Data Assessment (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 44 did not have cognitive impairments (problems with thinking and memory). The MDS indicated Resident 44 required supervision and/or touch assistance from staff for mobility while in and out of bed.</p> <p>During a review of Resident 42's Admission Record, the record indicated Resident 42 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 42's admitting diagnoses included schizoaffective disorder, paranoid schizophrenia, anxiety disorder (mental health conditions characterized by excessive fear or worry that interferes with daily life), and psychosis.</p> <p>During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 did not have cognitive impairments. The MDS indicated Resident 42 exhibited verbal behavioral symptoms one to three days out of seven days observed. The MDS indicated Resident 44 did not have impairments to her upper extremities (shoulder, elbow, wrist, hand) or lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 42 was independent to reposition herself while in bed and required set-up or clean-up assistance from staff (staff set up or clean up, but resident completes the activity) to get out of bed and to walk.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/7/2025 at 9:50 a.m., with Resident 44, Resident 44 stated her previous roommate (Resident 42) threw a chair at her. Resident 44 could not state the date that the altercation occurred. When asked where the alleged incident occurred, Resident 44 stated it occurred in Room A, and stated she was moved to her current room (Room B) after the alleged incident occurred. Resident 44 stated this was her first and only altercation with Resident 42.</p> <p>During a concurrent interview and record review, on 4/8/2025 at 10:05 a.m., with Social Worker (SW) 1, Resident 44's progress note, dated 3/10/2025 at 10:45 a.m., was reviewed. SW 1 stated the progress note indicated Resident 44 was moved to another room on 3/10/2025 due to incompatibility with her roommate. SW 1 stated that on 3/10/2025, Resident 44 did not report Resident 42 threw a chair at her. The State Agency Surveyor informed SW 1 of Resident 44's allegation that Resident 42 threw a chair at her.</p> <p>During an interview on 4/8/2025 at 4:04 p.m., with the facility's Program Director (PD), the PD stated she was made aware on 4/8/2024 of the alleged resident-to-resident altercation between Resident 44 and Resident 42, that occurred on an unspecified date. The PD stated she was responsible for reporting the allegation to the State Agency. The PD stated the allegation was not yet reported to the State Agency District Office because they had 24 hours to report.</p> <p>During a review of the document titled Fax Transmission Details, dated 4/8/2025, the document indicated the SOC-341 (a mandated reporting form used when someone suspects elder or dependent adult abuse or neglect) was sent to the State Agency District Office on 4/8/2025 at 4:52 p.m.</p> <p>During a review of the document titled Report of Suspected Dependent Adult/Elder Abuse (SOC-341), dated 4/8/2025, the SOC-341 indicated it was completed by the PD, and indicated social services staff were made aware of Resident 44's abuse allegation on 4/8/2025 around 10am.</p> <p>During an interview on 4/10/2025 at 11:57 a.m., with the Director of Nursing (DON), the DON stated timely reporting of alleged abuse was important for the safety of the facility residents and stated that failing to report timely could negatively impact the safety of the residents.</p> <p>During an interview, on 4/10/2025 at 12:41 p.m., with the Administrator (ADM), the ADM stated it was the facility's policy and process to report resident-to-resident altercations to the State Agency within two (2) hours.</p> <p>During a review of the facility P&amp;P titled Prevention, Reporting and Correction of Inappropriate Conduct Including Abuse, Neglect and Mistreatment of Residents and Investigations of Injuries of Unknown Origin, reviewed 2018, the P&amp;P indicated all allegations of abuse were to be reported in accordance with state and federal regulations.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47679</p> <p>Based on interview and record review, the facility failed to ensure one of six sampled residents' (Resident 129) assessment entry on the Minimum Data Set ([MDS], a resident assessment tool) was accurate and included the depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) diagnosis.</p> <p>This deficient practice had the potential to negatively affect Resident 129's plan of care and delivery of necessary care and services related to depression.</p> <p>Findings:</p> <p>During a review of Resident 129's Admission Record, the Admission Record indicated Resident 129 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included psychosis (a state where a person loses touch with reality by experiencing things that are not real), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 129's MDS, dated [DATE], the MDS indicated Resident 129's cognition (process of thinking) was moderately impaired). The MDS indicated Resident 129 required moderate assistance (helper does less than half the effort) with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 129 received antidepressant medication (medication used to treat depression).</p> <p>During a review of Resident 129's History and Physical (H&amp;P), dated 3/14/2025, the H&amp;P indicated Resident 129 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 129's Orders, start date 3/14/2025, the Orders indicated to give bupropion (an antidepressant medication) 150 milligrams (mg, a unit of measurement), by mouth, in the morning, for depression as manifested by lack of interest in participating in daily activities.</p> <p>During a review of Resident 129's General Acute Care Hospital (GACH) Psychiatric Evaluation Note (a note recording the findings from a psychiatrist's periodic assessment), dated 2/25/2025, the Note indicated Resident 129 had psychiatric diagnoses that include major depressive disorder and schizophrenia.</p> <p>During a concurrent interview and record review on 4/9/2025 at 1:45 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 129's MDS, dated [DATE], was reviewed. The MDSC stated Resident 129's MDS did not indicate Resident 129 had depression as an active diagnosis. The MDSC stated Resident 129's diagnosis of depression should have been coded in the MDS, dated [DATE], due to Resident 129's use of antidepressant medication and depression diagnosis from the GACH. The MDSC stated an accurate MDS assessment was necessary to capture the needs of the resident and to develop the best patient-centered plan of care for the resident. The MDSC stated Resident 129's inaccurate MDS assessment could negatively impact care planning, which could increase the risk of Resident 129's needs not being fully met.</p> <p>(continued on next page)</p>		

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<p>F 0641</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&amp;P) titled, Resident Assessment, undated, the P&amp;P indicated, It is this facility's policy to provide appropriate care and services to residents by conducting initial and periodical comprehensive assessment of each resident's functional capacity . Each resident assessment must be conducted and coordinated with the appropriate participation of health professionals knowledgeable about the resident's status and needs.</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>51684</p> <p>Based on interview, and record review, the facility failed to ensure a care plan (a document that outlines a resident's care needs, diagnosis, and treatment goals) for Pregabalin (medication to treat nerve pain by calming overactive nerves in the body) was developed and implemented for one of four sampled residents (Resident 479).</p> <p>This deficient practice placed Resident 479 at risk for delayed monitoring and implementing interventions.</p> <p>Findings:</p> <p>During a review of Resident 479's Admission Record [(Face Sheet) front page of the chart that contains a summary of basic information about the resident], the Admission Record indicated the facility admitted Resident 479 on 3/25/2025, with diagnoses including arthritis (a condition that causes inflammation and pain in the joints), muscle weakness (a reduced ability to contract or exert force with muscle), polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) and acute pulmonary edema (a medical emergency characterized by a rapid buildup of fluid in the lungs, making it difficult to breath).</p> <p>During a review of Resident 479's Minimum Data Set (MDS - a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 479's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 479 required maximal (helper does more than half the effort) assistance from staff for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 479's History and Physical (H&amp;P), dated 3/27/2025, the H&amp;P indicated Resident 479 had the capacity to understand and make decisions.</p> <p>During a review of Resident 479's physician order dated 3/26/2025, the physician order indicated an order for Pregabalin oral capsule 75 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for neuropathic pain (pain that caused by nerve damage).</p> <p>During a concurrent interview and record review on 4/9/2025 at 12:04 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 479's care plans were reviewed. LVN 1 stated a care plan for Resident 479's pregabalin medication could not be found. LVN 1 stated having a care plan for pregabalin was important to monitor parameters, potential side effects and have the appropriate interventions in place.</p> <p>During an interview on 4/10/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated care plans were the nurse's bible and are initiated upon admission, during any change of condition and be revised as needed. The DON stated care plans were in place for proper delivery of resident care and needs.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47679</p> <p>Based on interview and record review, the facility failed to revise the person-centered care plan (document that helps nurses and other team care members organize aspect of resident care) for one of seven sampled residents (Resident 328) who was on dual (two) antiplatelet medication (medication to prevent blood clots from forming).</p> <p>This deficient practice had the potential to result in confusion between licensed nurses regarding Resident 328's appropriate use of dual antiplatelet medication and navigation of Resident 328's plan of care.</p> <p>Findings:</p> <p>During a review of Resident 328's Admission Record, the Admission Record indicated Resident 328 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the right dominant side following a cerebral infarct (also known as stroke, a loss of blood flow to a part of the brain) and nontraumatic intracerebral hemorrhage (a collection of blood that accumulates between the brain the inner lining of the skull without any prior head trauma).</p> <p>During a review of Resident 328's Minimum Data Set ([MDS], a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 328's cognition (process of thinking) was intact. The MDS indicated Resident 328 required maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. The MDS indicated Resident 328 received antiplatelet medication.</p> <p>During a review of Resident 328's History and Physical (H&amp;P), dated 3/30/2025, the H&amp;P indicated Resident 328 did not have the capacity to understand and make decisions</p> <p>During a review of Resident 328's Orders, start date 6/17/2024, the Orders indicated to give:</p> <ol style="list-style-type: none"> <li>1. Aspirin (an antiplatelet medication) 81 milligrams (mg, a unit of measurement), by mouth, in the morning for stroke prophylaxis (prevention).</li> <li>2. Clopidogrel (an antiplatelet medication) 75mg, by mouth, in the morning for stroke prophylaxis.</li> </ol> <p>During an interview on 4/9/2025 at 12:25 p.m., with Physician 1, Physician 1 stated Resident 328 had a previous stroke and was on dual antiplatelet medication to help prevent future strokes. Physician 1 stated although there is an increased risk for bleeding, the concurrent use of aspirin and clopidogrel was beneficial for Resident 328's health.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Downey Community Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8425 Iowa Street Downey, CA 90241	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/9/2025 at 1:49 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 328's Care Plan, initiated 6/17/2025 and revised on 9/19/2024, was reviewed. The MDSC stated the Care Plan indicated Resident 328 was on dual antiplatelet therapy with aspirin and clopidogrel. The MDSC stated the Care Plan's staff interventions indicated to review the medication list for adverse interactions and to avoid the use of aspirin. The MDSC stated when a care plan was initiated, standardized interventions were available to include, the author of the care plan was responsible for revising the interventions to ensure the care plan was patient-centered and specific to the resident's current plan of care. The MDSC stated Resident 328 was on the dual antiplatelet therapy since his admission to the facility and his care plan should have been revised to indicate the allowed the concurrent use of aspirin and clopidogrel. The MDSC stated due to the inaccurate information on Resident 328's Care Plan, the information could cause confusion to the licensed nurses on how to proceed with Resident 328's antiplatelet therapy.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Care Plans, undated, the P&amp;P indicated the facility was to develop of a plan of care for residents to manage and promote improvement. The P&amp;P indicated care plans could be updated of new risk factors, new goals, or new interventions, as necessary.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48343</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services to maintain good grooming and personal hygiene for two of four sampled residents (Residents 112, and 75) by failing to keep the residents' fingernails clean and neat.</p> <p>This failure had the potential to result in negative impact on Residents 112 and 75's quality of life and self-esteem, and had the potential for development of infection.</p> <p>Findings:</p> <p>a. During a concurrent observation and interview on 4/7/2025 at 9:47 a.m., with Resident 112, in Resident 112's room, observed Resident 112's fingernails long with black substance underneath. Resident 112 stated her fingernails looked long and that she would like to have her fingernails cut and cleaned.</p> <p>During a review of Resident 112's Admission Record, the Admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension ([HTN]- high blood pressure), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 112's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 112's cognitive (the ability to think and process information) skills for daily living was severely impaired. The MDS indicated Resident 112 required maximal (helper does more than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 112's care plan with a focus of Resident has an ADL self-care deficit related to impaired cognitive skills, date initiated 2/19/2025, the care plan indicated the facility would assist Resident 112 with ADLs daily and as needed.</p> <p>During a concurrent observation and interview on 4/8/2025 at 12:45 p.m., with Certified Nursing Assistant (CNA 4), in Resident 112's room, Resident 112 had black substance underneath her fingernails. CNA 4 stated Resident 112's fingernails were dirty. CNA 4 stated CNAs were responsible for cleaning the residents' fingernails daily and trimming as needed. CNA 4 stated ensuring the residents' fingernails were clean was essential to prevent infection.</p> <p>b. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and DM.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily living was severely impaired. The MDS indicated Resident 75 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) assistance from staff for ADLs.</p> <p>During a review of Resident 75's History and Physical (H&amp;P), dated 1/24/2025, the H&amp;P indicated Resident 75 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 75's care plan with a focus of Resident has an ADL self-care deficit related to impaired cognitive skills, date initiated 2/6/2025, the care plan indicated the facility would assist Resident 75 with ADLs daily and nail care trimmings as needed.</p> <p>During a concurrent observation and interview on 4/7/2025 at 11:00 a.m., with CNA 3, in Resident 75's room, Resident 75 was observed with long fingernails with a brown substance underneath. CNA 3 stated Resident 75's fingernails were long and dirty. CNA 3 stated it was important to keep Resident 75's fingernails clean and trimmed to prevent the growth of bacteria (infection). CNA 3 stated long, dirty fingernails had the potential for the resident to scratch his skin and if Resident 75 scratched himself hard enough, it could create an open wound and increased risk of infection. CNA 3 stated having dirty fingernails was not sanitary because the resident will use her hands to hold utensils when eating and any bacteria could transfer into the body.</p> <p>During an interview on 4/10/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated residents should be provided with care and services necessary to maintain good personal hygiene.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Activities of Daily Living (ADLs), dated 1/2024, the P&amp;P indicated the facility would provide assistance to residents in meeting their ADLs needs and nail care.</p> <p>During a review of the facility's P&amp;P titled Job Description Certified Nursing Assistant (CNA), undated, the P&amp;P indicated the CNAs would assist residents with personal grooming, e.g., trimming fingernails.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47679</p> <p>Based on observation, interview, and record review, the facility failed to ensure the accurate and complete documentation on the Controlled Record for two of two sampled residents (Residents 155 and 178).</p> <p>This deficient practice resulted in the inaccurate count of medications left in the medications bubble packs (a card used to store medications for the resident) and had the potential to result in an additional dose administered, for drug diversion (the act of health care providers stealing prescription medicine for their own use), and/or the potential for medication error to occur.</p> <p>Findings:</p> <p>a. During a review of Resident 178's Admission Record, the Admission Record indicated Resident 178 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (also known as pinched nerve where the nerve root in the spine is compressed or irritated), cervicalgia (neck pain), and low back pain.</p> <p>During a review of Resident 178's History and Physical (H&amp;P), dated 4/9/2025, the H&amp;P indicated Resident 178 had fluctuation capacity to understand and make decisions.</p> <p>During a review of Resident 178's Orders, dated 4/10/2025, the Orders indicated to give pregabalin (medication used to treat nerve pain) 25 milligrams (mg, unit of measurement) by mouth, three times a day for pain management.</p> <p>During a review of Resident 178's electronic Medication Administration Record ([eMAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/10/2025, the eMAR indicated pregabalin 25mg was administered to Resident 178 on 4/10/2025 at 8:46 a.m.</p> <p>During an observation on 4/10/2025 at 9:26 a.m., at Station 1 Cart 3, with Licensed Vocational Nurse (LVN) 1 present, Resident 178's bubble pack for pregabalin was observed with seven capsules left in the bubble pack.</p> <p>During a concurrent interview and record review on 4/10/2025 at 9:28 a.m., with LVN 1, Resident 178's Controlled Drug Record, undated, was reviewed. LVN 1 stated the last documentation on the record was 4/9/2025 at 9 a.m. and the Record indicated there should be eight doses left in the bubble pack. LVN 1 stated she administered Resident 178 the morning dose of pregabalin 25mg and she did not document on the Controlled Drug Record. LVN 1 stated the facility's procedure for administering controlled medication (medications highly regulated by the government due to the high potential of abuse and misuse) was to document the date and time the medication was removed from the bubble pack onto the Controlled Drug Record. LVN 1 stated the purpose of the Controlled Drug Record was to keep the licensed nurses accountable for the number of doses of the controlled medication was left in the bubble pack. LVN 1 stated keeping an accurate count helped to prevent confusion whether the resident received the medication and to prevent drug diversion.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a review of Resident 155's Admission Record (Face Sheet), the Face Sheet indicated Resident 155 was admitted to the facility on [DATE] with diagnoses that included surgical amputation (removal of a limb or part of a limb) and stage three pressure ulcer (full-thickness loss where the fatty tissue beneath the skin is visible) of the sacral region (bottom part of the spine).</p> <p>During a review of Resident 155's Minimum Data Set (MDS, a resident assessment tool), dated 3/1/2025, the MDS indicated Resident 155's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 155 required supervision with eating and personal hygiene. The MDS indicated Resident 155 received scheduled pain medication regimen.</p> <p>During a review of Resident 155's H&amp;P, dated 2/28/2025, the H&amp;P indicated Resident 155 had the capacity to understand and make decisions.</p> <p>During a review of Resident 155's Orders, order date 2/26/2025, the Orders indicated to give tapentadol (medication used to treat pain) 100mg, by mouth, two times a day for pain management.</p> <p>During a review of Resident 155's eMAR, dated 4/10/2025, the eMAR indicated tapentadol 100mg was administered to Resident 155 on 4/10/2025 at 7:29 a.m.</p> <p>During an observation on 4/10/2025 at 9:45 a.m., at Station 3 Cart 1, with LVN 2 present, Resident 155's bubble pack for tapentadol was observed with four tablets left in the bubble pack.</p> <p>During a concurrent interview and record review on 4/10/2025 at 9:47 a.m., with LVN 2, Resident 155's Controlled Drug Record, undated, was reviewed. LVN 2 stated the last documentation on the record was 4/9/2025 at 7:25 a.m. and the Record indicated there should be five doses of tapentadol left in the bubble pack. LVN 2 stated she administered Resident 155 tapentadol earlier in the morning and she thought she documented on the Controlled Drug Record but did not. LVN 2 stated after removing the tablet from the bubble pack, she was responsible for documenting on the Controlled Drug Record to indicate the number of remaining doses. LVN 2 stated having an inaccurate count of remaining doses of Resident 155's tapentadol could cause confusion whether Resident 155 received the medication.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Controlled Drug Handling, undated, the P&amp;P indicated, Licensed nurses must record the controlled medication administered on the resident on the MAR and narcotic count sheet.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>51684</p> <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on observation, interview, and record review, the facility failed to monitor Resident 479 for signs of being over medicated while on Pregabalin (medication to treat nerve pain by calming overactive nerves in the body) for one of four sampled residents (Resident 479).</p> <p>This deficient practice placed Resident 479 at risk for adverse medication side effects.</p> <p>Findings:</p> <p>During an observation on 4/7/2025 at 10:21 a.m. in Resident 479's room, Resident 479 was observed lying in bed with eyes closed.</p> <p>During an observation on 4/7/2025 at 11:53 a.m., in Resident 479's room, Resident 479 was observed lying in bed with eyes closed.</p> <p>During an observation on 4/9/2025 at 10:00 a.m., in Resident 479's room, Resident 479 was observed lying in bed with eyes closed.</p> <p>During an observation on 4/10/2025 at 11:18 a.m. in Resident 479's room, Resident 479 was observed lying in bed with eyes closed.</p> <p>During a review of Resident 479's Admission Record [(Face Sheet) front page of the chart that contains a summary of basic information about the resident], the Admission Record indicated the facility admitted Resident 479 on 3/25/2025, with diagnoses including arthritis (a condition that causes inflammation and pain in the joints), muscle weakness (a reduced ability to contract or exert force with muscle), polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) and acute pulmonary edema (a medical emergency characterized by a rapid buildup of fluid in the lungs, making it difficult to breath).</p> <p>During a review of Resident 479's Minimum Data Set (MDS - a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 479's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 479 required maximal (helper does more than half the effort) assistance from staff for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 479's History and Physical (H&amp;P), dated 3/27/3025, the H&amp;P indicated Resident 479 had the capacity to understand and make decisions</p> <p>During a review of Resident 479's physician order dated 3/26/2025, the physician order indicated an order for Pregabalin oral capsule 75 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for neuropathic pain (pain that's caused by nerve damage) with parameters to hold medication for sedation.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/9/2025 at 12:04 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 479's medication administration record (MAR) from 3/2025 to 4/2025 were reviewed. LVN 1 stated monitoring for sedation was important and to hold medication if needed. LVN 1 was unable to locate any documentation on monitoring for sedation on Resident 479 MAR.</p> <p>During an interview on 4/10/2025 at 11:00 a.m., with the Director of Nursing (DON), the DON stated following the parameters listed on the order was important to avoid potential side effects. The DON stated the doctor should be notified if Resident 479 was constantly observed lying in bed sleeping.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication Side Effects, dated 1/2024, the P&amp;P indicated Residents of the facility receiving medications are monitored for potential side effects and adverse drug reactions (ADRs), with documentation, communication, and response to safeguard resident health.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45009</p> <p>Based on interview and record review, the facility failed to ensure one of eight sampled resident (Resident 230) was free from significant medication error (one which causes the resident discomfort or jeopardizes his or her health and safety) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Resident 230 received glipizide (lowers blood sugar) 30 minutes before breakfast.</li> <li>2. Ensure licensed nurses followed the physician's orders.</li> </ol> <p>These deficient practices placed Resident 230 at a higher risk to experience extremely lower blood sugar levels.</p> <p>Findings:</p> <p>During a review of Resident 230's Admission Record, the Admission Record indicated Resident 230 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and long-term use of insulin (a hormone that helps regulate blood sugar levels).</p> <p>During a review of Resident 230's History and Physical (H&amp;P) dated 4/3/2025, the H&amp;P indicated Resident 230 had the capacity to understand and make decisions.</p> <p>During a review of Resident 230's electronic medical record, unable to locate Minimum Data Set ([MDS] a required resident assessment tool) due to Resident 230's recent admission to the facility.</p> <p>During a review of Resident 230's Order Summary Report, dated 4/2/2025, the order summary report indicated Resident 230 was to receive glipizide 10 milligrams (mg, unit of measurement), two tablets by mouth, two times a day for DM, 30 minutes before breakfast and dinner.</p> <p>During a review of Resident 230's Medication Administration Record (MAR), dated 4/3/2025 - 4/9/2025, the MAR indicated Resident 230 received glipizide 10 mg, two tablets twice a day. The MAR indicated Resident 230 was ordered to receive glipizide 10 mg at 6:30 a.m. and 4:30 p.m. The MAR indicated from 4/3/2025 - 4/9/2025, Resident 230 received glipizide 10 mg at 6:30 a.m. and 4:30 p.m.</p> <p>During a review of Resident 230's Medication Administration Audit report, dated 4/1/2025 - 4/9/2025, the medication administration audit report indicated Resident 230 was to receive glipizide 10mg, two times a day for DM 30 minutes before breakfast. The Medication administration audit report indicated Resident 230 received glipizide on the following dates and times:</p> <ol style="list-style-type: none"> <li>1. 4/3/2025 at 7:18 a.m.</li> <li>2. 4/5/2025 at 7:12 a.m.</li> <li>3. 4/7/2025 at 6:33 a.m.</li> </ol> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. 4/8/2025 at 7:04 a.m.</p> <p>5. 4/9/2025 at 6:50 a.m.</p> <p>During an interview on 4/8/2025 at 1:46 p.m. with Resident 230, in Resident 230's room, Resident 230 stated nurses insisted on administering glipizide medication at 6:30 a.m. but did not want to take it at that time. Resident 230 stated she was instructed by her physician to take the medication within 30 minutes before having breakfast. Resident 230 stated the earliest she had breakfast was 8:00 a.m. Resident 230 stated she did not understand why the nurses wanted to administer glipizide one and half hours before she eats. Resident 230 stated this was an unsafe practice that jeopardized her health.</p> <p>During an interview on 4/10/2025 at 8:39 a.m. with Resident 230, Resident 230 stated she did not refuse glipizide. Resident 230 stated she asked the nurse if glipizide could be administered closer to the time that she ate breakfast. Resident 230 stated the nurse said no because the medication administration time was at 6:30 a.m. Resident 230 stated no one came to her and offered her the medication after 6:30 a.m. Resident 230 stated the facility should change the time of the medication administration or offer her a snack when they want to administer the medication. Resident 230 stated it was in her best interest to refuse the medication if the licensed nurses did not follow the physician's directions of administering glipizide 30 minutes before breakfast. Resident 230 stated if she took glipizide on an empty stomach her blood sugar will get very low and she will get hypoglycemic (a condition where the blood sugar (glucose) levels drop below normal). Resident 230 stated her blood sugar level was high and were not under control.</p> <p>During an interview on 4/10/2024 at 11:39 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the night shift charge nurse informed her that Resident 230 did not want to take her glipizide. LVN 1 stated this was the first time she heard that Resident 230 refused to take the glipizide. LVN 1 stated when a resident refused a medication the nurse was to go back and offer the resident the medication again. LVN 1 stated when she did morning medication pass, she did not offer the glipizide to Resident 230. LVN 1 stated medications that required to be administered close to breakfast must be held until breakfast was available or given with a snack if breakfast was not ready. LVN 1 stated breakfast trays were served at 8:00 a.m. LVN 1 stated she did not know why medication was schedule to be administered early and not close to breakfast time.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 1:43 p.m. with Registered Nurse (RN) 1, RN 1 stated she was not aware Resident 230 refused the glipizide. RN 1 stated this type of information should have been endorsed to her but it was not. RN 1 stated she expected the licensed nurses to offer residents the medication two times after the initial refusal. RN 1 stated she did not know why medication was scheduled to be administered at 6:30 a. m. if it was supposed to be given 30 minutes before breakfast. RN 1 stated she would expect the licensed nurses to find out why residents refused a medication and for them to call the physician to ask if the medication administration time could be adjusted. RN 1 stated licensed nurses could recommend giving medication with the meal or provide a supplement at 6:30 a.m. RN 1 stated it was important to administer glipizide 30 minutes before a meal because the medication affects a person's blood sugar. RN 1 stated if medication was administered and a resident had not eaten it will lower the residents blood sugar and potentially cause the resident to become hypoglycemic. RN 1 stated not administering glipizide within 30 min of breakfast was not following the physician's orders. RN 1 stated physician's provide directions to indicate the appropriate time is to administer medication and the licensed nurses must follow the directions. RN 1 stated it was important to follow the physician's orders because the physicians know their residents' medical condition and the orders are what benefit the residents' health.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Medication Refusal, dated 1/2024, the P&amp;P indicated a licensed nurse would determine why the resident refused medication in order to try to address his/her concerns and explain the consequences. The P&amp;P indicated a licensed nurse will assess the resident's needs and would re-offer the medication.</p> <p>During a review of facility's P&amp;P titled Medication Administration, dated 1/2024, the P&amp;P indicated medications are prepared and administered by a licensed nurse in accordance with written orders of the attending physician. The P&amp;P indicated medications are administered within 60 minutes of scheduled time, except before and after meal order, which are administered based on mealtimes.</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>48343</p> <p>Based on observation, interview, and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. Kitchen staff wore a hair covering in the food service or preparation areas of the kitchen.</li> <li>2. All food items in the storeroom were labeled and dated.</li> </ol> <p>These deficient practices had the potential to result in improper food safety practice and could lead to food contamination, and possible food borne illness in residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 4/7/2025 at 8:35 a.m., in the kitchen, with Dishwasher 1, observed Dishwasher 1 without the required hair covering while working in the dishwashing area, near the food preparation station. Dishwasher 1 stated he did not realize that his hair netting had fallen, and he believed his hair was still covered.</li> </ol> <p>During an interview on 4/7/2025 at 8:45 a.m., in the kitchen, with Dietary Supervisor (DS 1), DS 1 stated a hair covering not properly secured could result in hair falling into the food, clean dishes, or food preparation area, and increased risk of food contamination.</p> <ol style="list-style-type: none"> <li>2. During a concurrent observation and interview on 4/7/2025 at 9:00 a.m., in the dry food storage room, with DS 1, observed one large plastic container filled with a powdered substance unlabeled and undated. DS 1 stated the container held powdered nutritional supplement and should have been labeled and dated according to facility protocol. DS 1 stated all items in the storage room should be labeled with both the delivery and expiration dates to ensure safe usage.</li> </ol> <p>During a review of the facility's policy and procedure (P&amp;P) titled Infection Control- Dietary, dated 1/2024, the P&amp;P indicated personnel would wear a hair covering in food preparation, food service, and food storage areas.</p> <p>During a review of the facility's P&amp;P titled Labeling and Dating of Foods, undated, the P&amp;P indicated all food items in the storeroom would be labeled and dated. The P&amp;P indicated food delivered to the facility would be marked with a received date.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to remove outside food from the bedside after two hours for one out of seven residents (Resident 79) in accordance with the facility's Policy and Procedure (P&amp;P) titled, Foods brought by family or visitors.</p> <p>This deficient practice had the potential to result in food-borne illnesses (food poisoning) for Resident 79, with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever. It could lead to other serious medical complications (a medical problem that occurred during a disease) and hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 79's Admission Record, the Admission Record indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of metabolic encephalopathy (a brain dysfunction caused by imbalances in the body's chemistry, like electrolyte or blood chemical problems, due to other health issues) and gastroesophageal reflux disease (GERD, a condition where stomach acid frequently flows back up into the esophagus [food pipe]).</p> <p>During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 79's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 79 required supervision with eating; substantial assistance (helper did more than half the effort) with oral hygiene and personal hygiene; and was dependent (helper did all the effort) with toileting hygiene and showering/ bathing self.</p> <p>During a review of Resident 79's History and Physical (H&amp;P), dated 2/13/2025, the H&amp;P indicated Resident 79 had the capacity to understand and make decisions.</p> <p>During a review of Resident 79's Order Summary Report, dated 4/9/2025, the report indicated Resident 79 had an active order for a regular diet.</p> <p>During a concurrent observation and interview on 4/8/2025 at 11:07 a.m. with Resident 79, in Resident 79's room, observed Resident 79 receive outside food. Resident 79 stated he ordered outside food because it was good, and he did not eat the food the facility provided. Resident 79 stated staff did not check his food.</p> <p>During an observation on 4/8/2025 at 2:55 p.m., in Resident 79's room, observed the ordered food items on the resident's bedside table (approximately 4 hours later).</p> <p>During an interview on 4/9/2025 at 2:33 p.m. with Licensed Vocational Nurse (LVN) 2, left-over outside food items should not be stored at the bedside for more than an hour because the food could spoil and cause an upset stomach. LVN 2 stated staff should prevent foodborne illness by not keeping outside food items at the bedside for more than an hour. LVN 2 stated staff should encourage residents to discard the left-over food to prevent sickness. LVN 2 stated staff should educate residents on food safety.</p> <p>(continued on next page)</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and picture review of Resident 79's outside food items on 4/9/2025 at 3:21 p. m. with the Dietary Supervisor (DS), the pictures dated on 4/8/2025 at 11:07 a.m., 1:07 p.m., and 2:55 p.m., were reviewed. The pictures showed Resident 79's outside food items left at the bedside for more than two hours. The DS stated it was not acceptable to have chili with cheese at the bedside for more than two hours because bacteria would grow. The DS stated the nurse should throw away the food. The DS stated the chili with cheese was perishable. The DS stated the left-over chili with cheese should be put in the refrigerator, and staff should label with a use-by date, receive date, resident's name and room number on the food container. The DS stated the facility labeled the food so staff would know when it was received. The DS stated the food should not be kept for a long time because of bacteria. The DS stated staff should make sure the resident did not eat the left-over food. The DS stated if the resident still wanted the food, the staff needed to keep the food in the refrigerator. The DS stated the nurse was responsible for the outside food storage.</p> <p>During a review of the facility's P&amp;P titled, Foods brought by family or visitors, undated, the P&amp;P indicated Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours will be discarded.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48343</p> <p>Based on interview and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and accurately complete the Advance Directives Acknowledgement ([ADA]- a form gives you the right to give instructions about your own health care) for one of four sampled residents (Resident 132).</p> <p>This deficient practice resulted in inaccurate and incomplete medical records and had the potential to result in confusion in the resident's care and services. This also placed Resident 132 at risk of not receiving necessary care or not receiving care based on the resident's wishes due to inaccurate and incomplete information.</p> <p>Findings:</p> <p>During a review of Resident 132's Admission Record, the Admission Record indicated Resident 132 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 132's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/29/2025, the MDS indicated Resident 132's cognitive (the ability to think and process information) skills for daily living was intact. The MDS indicated Resident 132 was dependent (helper does all the effort) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a concurrent interview and record review on 4/9/2025 at 8:15 a.m., with the Admission Coordinator, Resident 132's ADA form was reviewed. The Admission Coordinator stated she was responsible for completing the ADA form for residents upon admission to the facility. The Admission Coordinator stated Resident 132's ADA form was incomplete and was missing Resident 132's initials. The Admission Coordinator stated the ADA form was a legal document included in the resident's medical record which reflected the resident's medical needs and wishes. The Admission Coordinator stated the form should have been completed accurately per the facility's policy to ensure the resident would receive treatment, and services needed. The Admission Coordinator stated inaccuracies could lead to actions that could harm the resident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Documentation, dated 1/2024, the P&amp;P indicated the medical record will be complete and accurate.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 142) fully understood the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court) in a language Resident 142 understood.</p> <p>This deficient practice resulted in Resident 142 not fully understanding what entering a binding Arbitration Agreement meant.</p> <p>Findings:</p> <p>During a review of Resident 142's Admission Record, the Admission Record indicated Resident 142 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest) and dementia (a progressive state of decline in mental abilities). The Admission Record indicated Resident 142's primary language was Spanish.</p> <p>During a review of Resident 142's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 142's preferred language was Spanish and needed an interpreter to communicate with a doctor or health care staff. The MDS indicated Resident 142's cognition (process of thinking) was moderately impaired. The</p> <p>MDS indicated Resident 142 required supervision with eating, oral hygiene, toileting hygiene, and transferring in-and-out of bed/ chair. The MDS indicated Resident 142 required partial assistance (helper did less than half the effort) with showering/ bathing self and personal hygiene.</p> <p>During a review of Resident 142's History and Physical (H&amp;P), dated 3/11/2025, the H&amp;P indicated Resident 142 had the capacity to understand and make decisions.</p> <p>During a review of Resident 142's Arbitration Agreement, dated 1/22/2024, the Arbitration Agreement indicated Resident 142 signed and entered the binding agreement. The Arbitration Agreement was in English.</p> <p>During an interview on 4/9/2025 at 8:52 a.m. with Resident 142, Resident 142 stated she did not remember the arbitration agreement, and she needed an explanation for what an arbitration was. Resident 142 stated she was unable to read English. Resident 142 stated she would like to have the Arbitration Agreement in Spanish because it was easier for her to understand.</p> <p>(continued on next page)</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>During an interview on 4/10/2025 at 9:05 a.m. with the Admission Coordinator, the Admission Coordinator stated the Arbitration Agreement was only available in English. The Admission Coordinator stated she would speak with the resident in Spanish if the resident's preferred language was Spanish. The Admission Coordinator stated she would explain the Arbitration Agreement word by word upon requests. The Admission Coordinator stated the facility should have the Arbitration Agreement in Spanish available for residents, whose primary language was Spanish, because it was resident's right to know what they were signing.</p> <p>During a review of the facility Policy and Procedure (P&amp;P) titled Resident Arbitration, dated 1/2024, the P&amp;P indicated the facility must ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>47679</p> <p>Based on interview and record review, the facility failed to ensure the Infection Preventionist Nurse (IPN) completed ten hours of continuing education in the field of Infection Prevention and Control on an annual basis.</p> <p>This deficient practice had the potential to result in the IPN being unaware and be unable to educate the facility's staff of updated information regarding Infection Prevention and Control.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 4/8/2025 at 10:18 a.m., with the IPN, the IPN's Nursing Home Infection Preventionist Training Court Certification, dated 11/14/2023, was reviewed. The IPN stated he completed his certification to become the facility's IPN on 11/14/2023 but did not complete any documented continuing education in the field of Infection Prevention and Control since then. The IPN stated he was responsible for completing at least ten hours of continuing education in Infection Control on an annual basis to keep up to date with all guidelines and protocols. The IIPN stated without the completion of continuing education, he may not be educating the facility's staff on the best way to treat infections in the facility.</p> <p>During a review of the California Department of Public Health (CDPH) All Facilities Letter (AFL, official letter from the CDPH to facilities to keep them informed about changes in regulations, enforcement actions, new technologies, and other important updates), dated 11/4/2020, the AFL indicated, The IP should complete 10 hours of continuing education in the field of [Infection Prevention and Control] on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.</p> <p>During a review of the facility's Infection Control Coordinator Job Description, undated, the Job Description indicated the Infection Control Coordinator was responsible for promoting professional growth and development by educational activities and participating in educational trainings.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45009</p> <p>Based on observation, interview, and record review, the facility failed to provide a touch pad (button activated by light touch) call light for one out of eight residents (Resident 86).</p> <p>This deficient practice had the potential to cause a delay or an inability in Resident 86 obtaining necessary care and services.</p> <p>Findings:</p> <p>During an observation on 4/9/2025 at 2:19 p.m., in Resident 86's room, the call light was observed near Resident 86's left hand. Resident 86 unsuccessfully attempted to press the call light button.</p> <p>During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of left body hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiplegia and hemiparesis (weakness) of the right dominant side.</p> <p>During a review of Resident 86's History and Physical (H&amp;P) dated 11/30/2024, the H&amp;P indicated Resident 86 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 86's Minimum Data Set ([MDS] a required resident assessment tool), dated 1/16/2025, the MDS indicated Resident 86's cognitive skills for daily decision making was impaired (ability to think and reason). The MDS indicated Resident 86 was dependent on staff for oral hygiene, toileting hygiene, and showering/bathing. The MDS indicated Resident 86 required maximal assistance (helper does more than half the effort) for dressing and personal hygiene.</p> <p>During an interview on 4/9/2025 at 2:21 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 86's room, CNA 1 stated Resident 86 could not move his right hand. CNA 1 stated Resident 86 could move his left hand but could not easily move his fingers.</p> <p>During a concurrent observation and interview on 4/9/2025 at 2:25 p.m. with CNA 1, in Resident 86's room, Resident 86 attempted to push the call light button with his left hand. Resident 86 attempted to place his thumb over the call light button but was unable to the press the button. CNA 1 asked Resident 86 to use his call light but Resident 86 was not able to push the button. CNA 1 stated Resident 86 could not use the call light and would not be able to call for help when needed. CNA 1 stated the call light system was not beneficial for Resident 86 because the resident was not physically able to use the call light. CNA 1 stated Resident 86 would benefit from a pad call light system because it did not require the resident to push any buttons.</p> <p>During an interview on 4/10/2025 at 10:51 a.m. with CNA 1, CNA 1 stated she did not notify anyone Resident 86 was not able to use his call light. CNA 1 stated she was supposed to notify her charge nurse or maintenance personnel to get another call light system for Resident 86 but she did not. CNA 1 stated Resident 86 could not call for help. CNA 1 stated Resident 86 needed a pad call light system because Resident 86 could not use the call light with a button.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 11:17 a.m. with the Director of Staff Development (DSD), the DSD stated it was important to make sure call lights were in working condition and residents were able to use the call light and ensure their needs are met.</p> <p>During an interview on 4/10/2025 at 2:04 p.m. with Registered Nurse (RN) 1, RN 1 stated it was every staff's responsibility to check on all resident call lights. RN 1 stated staff must check if the call lights work, if it was accessible and if the resident was able to use their call light. RN 1 stated the purpose of the call lights was to allow residents to ask for help when staff are not nearby. RN 1 stated it was important for residents to be able to use a working call light to meet their needs and assist them if there was an emergency.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Call Light, dated 1/2024, the P&amp;P indicated staff would assess residents' ability to use the facility call system, and alternative ways of calling for assistance would be accommodated as needed. The P&amp;P indicated if the call light is not functional for the resident, the facility must provide an alternative way to call for help.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Downey Community Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8425 Iowa Street Downey, CA 90241	
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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>47286</p> <p>Based on interview and record review, the facility failed to ensure the training provided to all facility staff, specifically related to abuse reporting, was consistent with federal reporting guidelines.</p> <p>This failure had the potential to affect all facility residents due to late reporting of abuse, and delayed investigations by the State Agency.</p> <p>Findings:</p> <p>During a concurrent interview and record review, on 4/10/2025 at 11:27 a.m., with the Director of Staff Development (DSD), the facility's lesson plan titled Abuse Definition, Prevention, Reporting, and Investigation, dated 3/30/2025 to 4/6/2025, was reviewed. The DSD stated the lesson plan indicated allegations of abuse were to be reported to the State Agency within 24 hours, unless the allegation involved injury. The DSD stated he was not sure what the federal requirements were for reporting abuse. The DSD stated this lesson plan was approved by the Director of Nursing (DON) prior to being taught to facility staff. The DSD stated timely reporting of allegations of abuse was to ensure the safety of the facility's residents, and stated delayed reporting could result in repeat incidents of abuse and/or negatively impact the safety of the facility's residents.</p> <p>During an interview on 4/10/2025 at 11:54 a.m., with the DON, the DON stated the DSD was the primary individual responsible for providing abuse training to all facility staff. The DON stated she reviewed the abuse lesson plans created by the DSD to ensure the lesson plan teachings were accurate. The DON stated the lesson plans were based on guidance provided in the All Facilities Letters (AFLs, letters sent from the Center for Health Care Quality (CHCQ), Licensing and Certification (L&amp;C) Program to health facilities, including changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) and the facility's policies and procedures (P&amp;P) for abuse.</p> <p>During a concurrent interview and record review, on 4/10/2025 at 11:57 a.m., with the DON, the facility's lesson plan titled Abuse Definition, Prevention, Reporting, and Investigation, dated 3/30/2025 to 4/6/2025, was reviewed. The DON stated the lesson plan indicated abuse allegations were to be reported within 24 hours if the allegation did not include bodily injury. The DON stated the lesson plan was based on AFL 21-26, dated 7/26/2021, and stated she reviewed it and approved for it to be taught to all facility staff. The DON stated the importance of timely reporting of abuse was to keep the facility residents safe.</p> <p>During an interview, on 4/10/2025 at 12:41 p.m., with the Administrator (ADM), the ADM stated it was the facility's policy and process to report resident-to-resident altercations to the State Agency within two (2) hours.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Downey Community Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8425 Iowa Street Downey, CA 90241	
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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review, on 4/10/2025 at 12:44 p.m., with the ADM, the facility's P&amp;P titled Prevention, Reporting and Correction of Inappropriate Conduct Including Abuse, Neglect and Mistreatment of Residents and Investigations of Injuries of Unknown Origin, reviewed 2018, was reviewed. The ADM stated the P&amp;P indicated staff were to follow the state and federal guidance for reporting abuse, and stated the federal guidance required abuse to be reported within two (2) hours.</p> <p>During a review of the facility P&amp;P titled Prevention, Reporting and Correction of Inappropriate Conduct Including Abuse, Neglect and Mistreatment of Residents and Investigations of Injuries of Unknown Origin, reviewed 2018, the P&amp;P indicated all allegations of abuse were to be reported in accordance with state and federal regulations.</p> <p>During a review of AFL 21-26, dated 7/26/2021, the AFL indicated the purpose of the letter was to remind facilities of the federally mandated reporting requirements of potential abuse, neglect, exploitation, or mistreatment of elders or dependent adults. AFL 21-26 indicated incidents involving abuse were to be reported to the State Agency, in writing or by electronic report, within two (2) hours.</p>		