STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555137	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grancell Village of the Jewish Homes for the Aging	7150 Tampa Ave Reseda, CA 91335

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 38469 Based on observation, interview and record review, the facility failed to ensure the call light (a device used by a resident to signal his/her need for assistance from staff) was within the resident`s reach while in bed for one out of one sampled resident (Resident 171) during review of the environment task.  This deficient practice had the potential to delay the provision of services and resident`s needs not being met. Findings: During review of Resident 171's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/30/2024 with diagnoses including dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (prevents airflow to the lungs, causing breathing problems). During a review of Resident 171's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 01/05/2025, the MDS indicated Resident 171's cognition (a mental process of acquitting knowledge and understanding) is intact. The MDS indicated Resident 171 required substantial assistance with toileting hygiene, shower, dressing and moderate assistance with personal hygiene. During a review of Resident 171's care plan (a written document that summarizes a resident's needs, goals, and care/treatment) titled, At Risk for Self-Care Deficits and Impaired Mobility, created on 12/31/2024, the care plan indicated an intervention to provide appropriate level of care to meet resident`s needs such as: daily personal care and assist with transfers, bed mobility and locomotion until able to perform independently. During a concurrent observation and interview on 01/13/2025 at 11:20 a.m., observed Resident 171's call light cord hanging on the bed siderail with the call button at the bottom of the bed. Resident 171 stated she needs her nurse and does not know where the call light is. During a concurrent observation and interview on 01/13/2025 at 11:20, Registered Nurse 1 (RN 1) came to Resident 171's room to check on the resident after she (RN 1) was informed that Resident 171 needs assistance. RN 1 confirmed the observation that resident`s call light button was positioned below the bed. RN 1 stated that call light should be within the resident's reach so the resident can use it to call for assistance. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/2025 at 4:21 p.m., with the Director of Nursing (DON), the DON stated that residents are provided with a call light so they can call staff for assistance and the call light should be placed within reach of the residents. The DON stated that if the call light is not within reach, the residents needs may not be met and they may get frustrated and attempt to get out of the bed unassisted, resulting to falls and injuries. During a review of the facility`s policy and procedure, titled Answering Call Lights, last reviewed and approved on 10/2024, the policy and procedure indicated that it is the policy of this facility that all residents/patients utilizing call lights have their needs and requests responded to and met . when the resident/patient is in bed or confined to a chair be sure the call light is within easy reach of the resident/patient .

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NAME OF PROVIDER OR SUPPLIER: Grancell Village of the Jewish Homes for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE: 7150 Tampa Ave Reseda, CA 91335	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and screening tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for one out of one sampled residents (Resident 22). This deficient practice had the potential to result in delayed services for Resident 22. Findings: During a review of the Face Sheet, the Face Sheet indicated Resident 22 was admitted to the facility on [DATE] with diagnosis including hydronephrosis (a condition that occurs when a kidney swells and urine cannot drain out from kidney), acute kidney failure (a condition in which the kidneys are damaged and cannot filter blood well), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living)). During a review of Resident 22's History and Physical (H&P), dated 8/28/2024, the H&P indicated Resident 22 had the capacity to understand and make decisions. During a review of the Minimum Data Set Assessment (MDS, a standardized assessment and care screening tool), dated 8/25/2024, the MDS indicated Resident 22 had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). During a concurrent interview and record review on 1/16/2025 at 8:35 a.m., with the Minimum Data Set Nurse (MDSN), Resident 22`s MDS assessments were reviewed. The MDSN stated when a resident is discharged from the facility, the facility has 14 days to complete the discharge MDS. The MDSN stated Resident 22 was discharged from the facility on 9/7/2024, however, the MDS Discharge assessment was not completed and not submitted to the Center for Medicaid Services (CMS). During an interview on 1/16/2025 at 1:51 p.m., with the Director of Nursing (DON), the DON stated the discharge assessment has to be done by the Minimum Data Set Nurse and submitted to CMS in 14 days. The DON stated the potential outcome of not completing MDS discharge assessment on time is the delay in care and payment for Resident 22. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 3.0 dated October 2023, indicated all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS completion date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 38469 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission addressing the resident's pain for one of two residents (Resident 170) investigated under the pain management care area. This deficient practice had the potential for Resident 170 to not receive the appropriate care and treatment interventions for pain management. Findings: During a review of Resident 170's Face Sheet (Admission Record), the Face Sheet indicated that the facility admitted the resident on 01/07/2025, with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe) and gastro-esophageal reflux disease (a common condition in which the stomach contents move up into the esophagus [food pipe]). During a review of Resident 170's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 01/14/2025, the MDS indicated that Resident 170's cognition (a mental process of acquitting knowledge and understanding) was intact. The MDS indicated Resident 170 required substantial assistance with toileting hygiene, shower, dressing and moderate assistance with personal hygiene. During a review of Resident 170's Physician`s Orders, it indicated the following: 1. Meloxicam (commonly used to reduce pain and inflammation) 15 milligram (mg) tablet by mouth once a day for pain management dated 01/07/2025. 2. Acetaminophen (can treat minor aches and pains and reduces fever) 500 mg tablet by mouth at bedtime for pain management dated 01/07/2025. 3. Tramadol (can treat moderate to severe pain) 50 mg tablet by mouth, administer 100 mg at bedtime for moderate to severe pain dated 01/07/2025. During a concurrent interview and record review with the Clinical Manager (CM) on 01/15/2025 at 10:32 a.m. , reviewed Resident 170`s admission baseline care plan dated 01/07/2025. The care plan goals and interventions were not indicated under the sections of Pharmacological Pain Regimen and Pain Goal and Interventions. The CM stated that upon admission, the facility will initiate a care plan based on the resident`s diagnosis and medications. The CM stated that the baseline care plan identifies the resident's treatment goals and interventions and must be completed within 48 hours of admission. The CM stated that without a care plan, they would be unable to identify the appropriate interventions for the resident`s diagnosis. The CM stated not having a base line care plan addressing Resident 170's complaints of pain had the potential to result in ineffective management of the resident's pain. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedure titled Baseline Care Plan, last reviewed on 10/2024, it indicated that It is the facility policy to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .within 48 hours of admission the baseline care plan will be developed and will include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to develop and develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) for three of three sampled residents (Resident 26, 50, and 170) investigated under accidents care area and one of five sampled residents (Resident 44) investigated under psychotropic (a drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior)/opioid (drugs that are used to treat pain and can be highly addictive) medication side effects care area when the facility failed to: 1. Develop Resident 26, 50, and 170's care plan for use of bed side rails (adjustable metal or rigid plastic bars that attach to the bed). This deficient practice had the potential for the residents to not receive the necessary care and services to prevent potential injury from the use of bed siderail. 2. Develop Resident 44's care plan for use of Hydrocodone- Acetaminophen (a combination medication that contains hydrocodone [an opioid painkiller] and acetaminophen [analgesics/pain relivers]). This deficient practice had the potential to place Resident 44 at risk for health complications related to the use of opioids and ineffective management of Resident 44's pain. Findings: 1.a During a review of Resident 26's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 08/30/2024 and readmitted on [DATE] with diagnoses including, pulmonary hypertension (a serious condition that occurs when blood pressure in the lungs is abnormally high) and heart failure (a chronic condition that occurs when the heart cannot pump enough blood and oxygen to the body). During a review of Resident 26's Minimum Data Set (MDS-standardized assessment and screening tool) dated 01/17/2025, the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS further indicated that Resident 26 required assistance with activities of daily living (activities of daily living [ADL] are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a concurrent interview and record review on 01/14/25 at 09:29 a.m., with the Clinical Manager (CM) reviewed Resident 26's care plans and Bed Rail assessment dated [DATE]. The CM stated Resident 26 did not have a care plan addressing the resident's potential risk of bed side rail entrapment. The CM stated that after completing the Bed Rail assessment, the Interdisciplinary team (IDT-a group of healthcare professionals who work together to provide care for residents) should have developed a care plan for the resident's use of bed side rails to ensure interventions are in place to promote resident safety and prevent injuries resulting from entrapment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.b. During a review of Resident 50's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 12/09/2024 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (a group of lung disease that make it difficult to breathe) and chronic pain syndrome (a condition characterized by persistent pain that lasts for at least 3-6 months and significantly impacts daily life). During a review of Resident 50's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/12/2024, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 50 required substantial assistance with toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 01/15/25 at 8:28 a.m., with the Clinical Manager, reviewed Resident 50's care plans and Bed Rail assessment dated [DATE]. The CM stated Resident 50 did not have a care plan addressing the resident's potential risk of bed side rail entrapment. The CM stated that after completing the Bed Rail assessment, the IDT team should have developed a care plan for the resident's use of bed side rails to ensure interventions are in place to promote resident safety and prevent injuries resulting from entrapment. 1.c. During review of Resident 171's Face Sheet, the Face Sheet indicated that the facility admitted the resident on 12/30/2024 with diagnoses that included dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (prevents airflow to the lungs, causing breathing problems). During a review of Resident 171's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 01/05/2025, the MDS indicated Resident 171's cognition (a mental process of acquitting knowledge and understanding) is intact. The MDS indicated Resident 171 required substantial assistance with toileting hygiene, shower, dressing and moderate assistance with personal hygiene. During a concurrent interview and record review on 01/15/25 at 09:57 a.m., with the Clinical Manager, reviewed Resident 171's care plans and Bed Rail assessment dated [DATE]. The CM stated Resident 171 did not have a care plan addressing the resident's potential risk of bed side rail entrapment. The CM stated that after completing the Bed Rail assessment, the IDT team should have developed a care plan for the resident's use of bed side rails to ensure interventions are in place to promote resident safety and prevent injuries resulting from entrapment. During a review of the facility`s policy and procedures, titled Care Plans- Comprehensive, last reviewed 10/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objective and timetables to meet the resident/patient`s medical, nursing, mental and psychological needs is developed for each resident/patient. During a review of the facility`s policy and procedure, titled Bed Rails, last reviewed on 10/2024, the policy indicated that the facility will continue to provide necessary treatment and care in accordance with professional standards of practice and the resident`s choice . if the IDT determines the need for resident to use a bed rail, a care plan will be initiated and include, but not limited to, the following components: A. The type of monitoring and supervision provided during the use of the bed rails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. The identification of how needs will be met during use of bed rails. C. Ongoing assessment to assure that the bed rail is used to meet the resident`s needs. D. Ongoing evaluation of risks. E. The identification of who may determine the bed rail will be discontinued. F. The identification and interventions to address any residual effects of the bed rail. 47883 2. During a review of Resident 44's Face Sheet, the Face Sheet indicated that the facility originally admitted the resident on 9/25/2020, and readmitted on [DATE], with diagnoses including displaced fracture of left femur (the thigh bone in left leg has broken in a way that broken pieces are not aligned rest of the bone) and type 2 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was mildly impaired (a slight decline in mental abilities, memory and completing complex tasks). The MDS indicated that Resident 44 was dependent on the staff (helper does all of the effort) for toileting hygiene and lower body dressing and requiring moderate to-maximal assistance for showering/bathing, upper body dressing, and personal hygiene. During a review of Resident 44's physician order dated 1/10/2025, the physician order indicated to give Resident 44 Hydrocodone- Acetaminophen 2.5-162.5 milligram (mg -unit of measurement) three times a day: 8 a.m., 12 p.m., 8 p.m. During a review of Resident 44`s care plans, there was no care plan developed and initiated to address Resident 44's risk and side effects of receiving pain medication containing opioids.  During a concurrent interview and record review on 1/16/2025 at 8:35 a.m., with the MDS Nurse (MDSN), reviewed Resident 44`s care plans. The MDSN stated that she (MDSN) is in charge of developing and updating the residents' care plans in the facility. The MDSN stated that there is no short-term care plan developed for Resident 44`s risk and side effects for using Hydrocodone- Acetaminophen. The MDSN stated the potential outcome of not developing a person-centered care plan for a resident who is on opioid medication is the inability to address the appropriate care and treatment that the resident needs and an increased risk for overlooking the side effects of medication. During an interview on 1/16/202 at 1:46 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to develop care plan with appropriate goal and interventions based on the residents` problems and identified needs. The DON stated, licensed staff did not develop a care plan to address Resident 44's risk and side effects associated with using Hydrocodone- Acetaminophen. The DON stated the potential outcome of not a having a care plan addressing us of Hydrocodone- Acetaminophen is lack of care, monitoring, and the inability to deliver necessary interventions to prevent side effect of opioid medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Care Plans -Comprehensive, reviewed 10/2024, the P&P indicated a comprehensive plan of care will be developed to meet each resident`s medical, developmental, and psychosocial needs. This care plan will incorporate identified problem area; incorporate risk factors associated with identified problems; reflect treatment goals and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventive or reducing declines in the resident/patient's functional status and /or functional level.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44309

Based on interview, and record review the facility failed to follow facility policy and procedure (P&P) titled Care Plans-Comprehensive, for two of three sampled residents (Resident 2 and Resident 34) by failing to:

1.Update and revise Resident 2`s care plan for fluid volume deficit (a shortage) and electrolyte imbalance related to use of Lasix (water pill, a medication commonly used to reduce edema).

This deficient practice had the potential to result in Resident 2 receiving inadequate care and supervision in the facility.

2.Engage Resident 34`s Family Member 2 (FM2) in the resident`s care planning process.

This deficient practice had the potential for Resident 34 to fall and sustain an injury.

Findings:

1. During a review of Resident 2's Face Sheet, the Face Sheet indicated that the facility originally admitted the resident on 8/13/2020, and readmitted on [DATE], with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), edema (swelling caused by too much fluid trapped in the body's tissues), and cellulitis (a skin infection that causes swelling and redness) of left lower leg.

During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 11/26/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 2 was dependent to staff (helper does all of the effort) for toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 2 was taking diuretic (a medication that help reduce fluid buildup in the body).

During a review of Resident 2's Physician Order Report dated 6/18/2023, the order indicated to apply ace wrap to the resident`s right and left leg every 12 hours from 6:00 a.m.- 6:00 p.m.

During a review of Resident 2's Physician Order Report dated 11/24/2023, the order indicated to administer Lasix tablet 20 milligrams (mg-a unit of measure of mass) by mouth once a day for bilateral lower extremity (BLE-both legs) edema.

During a review of Resident 2's Physician Order Report dated 8/17/2024, the order indicated to elevate the resident`s BLE for increased swelling.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's fluid volume deficit and electrolyte imbalance related to use of Lasix care plan (written guide that organizes information about the resident's care) initiated on 12/10/2021, the care plan indicated a goal that the resident will consume at least 75% of meals and fluids offered daily for three months. The care plan interventions were to assess for dehydration (when the body loses too much water and other fluids that it needs to work normally), monitor labs and notify the physician if abnormal, observe extremities for increased edema and encourage elevation of effected extremities. During an observation on 1/14/2024 at 10:15 a.m., inside Resident 2`s room, the resident was observed sitting on her wheelchair in front of TV. Resident 2`s lower legs were wrapped with ace wrap. However, her legs were not elevated. During an observation on 1/14/2024 at 12:10 p.m., inside Resident 2`s room, the resident was observed sitting on her wheelchair. Resident 2`s legs were not elevated. During a concurrent observation and interview on 1/14/2025 at 2:24 p.m., with Certified Nursing Assistant 1 (CNA1), inside Resident 2`s room, the resident`s legs were not elevated. CNA1 stated that Resident 2 does not like her legs to be elevated. CNA1 stated Resident 2 normally sits on her wheelchair with her legs down unless she is in bed sleeping. During a concurrent observation and interview on 1/14/2025 at 2:45 p.m., with Licensed Vocational Nurse 1 (LVN1), inside Resident 2`s room, Resident 2 was observed siting on her wheelchair with her legs not elevated. LVN 1 stated Resident 2 does not like her BLE elevated and if the nurses attempt to elevate her legs, she will start screaming. During a concurrent interview and record review on 1/14/2025 at 3:50 p.m., with the MDS Nurse (MDSN), Resident 2`s care plans and physician orders were reviewed. The MDSN stated that he (MDSN) is in charge of reviewing, updating, and revising residents` care plans. The MDSN stated that he revises and updates all care plans quarterly, if there a change in residents` condition, and as needed. The MDSN stated that Resident 2`s fluid volume deficit and electrolyte imbalance care plan was initiated on 12/10/2021, and last reviewed/revised on 11/26/2024. The MDSN stated Resident 2`s physician ordered to apply ace wrap to the resident`s BLE from 6:00 a.m.- 6:00 p.m. However, this intervention is not included in Resident 2's care plan. The MDSN stated that Resident 2 has been refusing to elevate her BLE. However, Resident 2`s care plan was not updated and revised accordingly and does not indicate anything regarding the resident refusing to elevate her BLE. The MDSN stated Resident 2`s care plan for fluid volume deficit and electrolyte imbalance was not revised according to the resident`s current condition and this failure could lead to insufficient care for the resident.  During an interview on 1/16/2024 at 1:39 p.m., with the Director of Nursing (DON), the DON stated that residents` care plans are required to be reviewed/revised quarterly, and with every change of condition. The DON stated the purpose of reviewing and re-evaluating the care plans is to check the effectiveness of the care plan interventions and make sure all the pertinent information and intervention regarding residents` care are included in the care plan. The DON stated Resident 2`s fluid volume deficit and electrolyte imbalance care plan was last reviewed/revised on 11/26/2024. However, application of ace wrap to the resident`s BLE and refusal of the resident to elevate BLE were not included in the care plan. The DON stated the potential outcome of not updating Resident 2's care plan is inadequate care and supervision. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Grancell Village of the Jewish Homes for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE: 7150 Tampa Ave, Reseda, CA 91335	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Care Plans, revised 10/2024, the P&P indicated that each resident`s comprehensive care plan has been designed to incorporate identified areas and risk factors associated with identified problems. The care plans are revised as change in the resident`s condition dictate. Care plans are reviewed at least quarterly. CNAs are responsible for reporting to the nurse supervisor any change in the resident`s condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Documentation must be consistent with the resident`s care plan. 47883 2. During a review of Resident 34's Face Sheet, the Face Sheet indicated that the facility originally admitted the resident on 9/4/2024, and readmitted on [DATE], with diagnoses including atherosclerotic heart disease (thickening of the arteries caused by a buildup of plaque in the inner lining of an artery), type 2 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. During a review of Resident 34's MDS dated [DATE], the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated that Resident 34 was dependent on the staff (helper does all of the effort) for showering/bathing, toileting hygiene, upper and lower body dressing, and personal hygiene and requiring maximal assistance for eating and bed mobility. During a review of Resident 34`s fall prevention care plan, updated 12/17/2024, the care plan intervention indicated Resident 34 will wear non-skid socks. The goal of the care plan was to reduce severity of fall-related injury for Resident 34. During a review of Resident 34's nursing progress notes, dated 12/17/2024, it indicated that FM 2 was notified of Resident 34's fall incident. The nursing progress notes did not indicate that FM 2 was told that Resident 34 was to use non-skid socks. During a concurrent observation and interview on 1/15/2025 at 2:10 p.m., in the dining room, Resident 34 was sitting in wheelchair wearing green colored socks. Certified Nursing Assistant 2 (CNA 2) stated Resident was wearing regular socks brought in by a FM. CNA 2 also stated that the socks Resident 34 was currently wearing are not non-skid socks. During a concurrent observation and interview on 1/16/2025 at 8:18 a.m., Resident 34 in the dining room , Resident 34 was in a wheelchair wearing grey colored socks. Licensed Vocational Nurse 1 (LVN 1) stated Resident 34 was wearing regular socks brought in by a FM, which were not non-skid socks as indicated by Resident 34 fall prevention care plan. LVN 1 also stated there was no documentation indicating that FM 2 was aware that Resident 34 should be wearing non-skid socks. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 12:30 PM with Director of Nursing (DON), the DON stated that the resident's FMs should be involved in the president's plan of care. The potential outcomes for not involving FM will lead to reoccurrence of the fall incident, that the licensed nurses should be informing the interdisciplinary team (IDT) if family member does not agree with the care plan, so the IDT can address the issue. During a review of the facility's policy and procedure (P&P) titled, Care Plans - Comprehensive, last reviewed on 10/2024, the P&P indicated the facility's care planning/interdisciplinary team, in coordination with the resident/patient, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident/patient that identifies the highest level of functioning the resident/patient may be expected to attain .Resident/patients, their families, and/or their legal representatives, are invited to attend and participate in the resident/patient's care planning conference.

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F 0660

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Plan the resident's discharge to meet the resident's goals and needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44309

Based on interview, and record review the facility failed to follow the facility's policy and procedure (P&P) titled Transfer and Discharge, for one of two sampled residents (Resident 21) investigated under closed record review

by failing to:

1. Develop a discharge plan and review the plan with Resident 21 and/or his family at least 24 hours before the resident`s discharge from the facility.

2. Complete documentation of Resident 21's discharge progress notes.

This deficient practice placed the resident at risk for not receiving the necessary care and services related to the resident's discharge goals and needs.

Findings:

During a review of Resident 21's Face Sheet, the face sheet indicated that the facility admitted the resident on 11/30/2024, with diagnoses including displaced trimalleolar fracture (a fracture of the three large bones that make up the ankle joint) of left lower leg, history of falling, and muscle weakness.

During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 11/20/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 21 required staff substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene.

During a review of Resident 21`s Intradisciplinary Team (IDT- a group of healthcare workers from different health care disciplines to help people receive the care they need) meeting notes dated 11/20/2024, the notes indicated that the resident`s discharge plan is to possibly go home with his wife.

During a review of Resident 21`s Social Service assessment dated [DATE], the assessment indicated that the resident would stay in the facility for a short period of time and the anticipated length of stay was identified as 21 days to one month. The assessment indicated that Resident 21 lived in Assisted Living Facility 1 (ALF 1- a facility that provides room and board and help with activities of daily living) prior to his admission to this facility.

During a review of Resident 21`s Social Service Progress Notes dated 12/18/2024 at 1:30 p.m., the notes indicated that Social Worker 1 (SW1) contacted Resident 21`s Family Member 1 (FM1) to schedule a discharge plan meeting. The Note further indicated that the FM 1 confirmed attendance for 12/20/2024 at 1:30 p.m., for the discharge plan meeting.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's Physician Order Report dated 12/24/2024, the order indicated to discharge the resident back home on 12/27/2024 with 24/7 caregiver and Home Health (HH- medical services provided at home to help you recover from illness, injury, or surgery) for Occupational Therapy (OT- treatment that focuses on improving the patient's ability to perform activities of daily living), and Physical Therapy (PT- treatment that helps you improve how your body performs physical movements). During a review of Resident 21`s Discharge Instructions completed on 12/27/2024 at 9:15 a.m., the discharge instruction indicated that the resident will be discharged home with FM 2 and caregiver with HH and OT/PT.  During a concurrent interview and record review on 1/15/2025 at 11:00 a.m., with the facility`s Medical Record Director (MRD), Resident 21`s medical chart was reviewed. The MRD stated that Resident 21 was discharged to ALF 1 on 12/27/2024. During an interview on 1/15/2025 at 11:48 a.m., with SW 2, SW 2 stated that she is not involved with the discharge of short term stay residents. SW 2 stated that Resident 21 was in Unit 1 and the facility`s Social Service Designee (SSD) was in charge of discharging the residents from Unit 1. SW 2 stated when the SSD was on leave in December 2024, SW 1 and herself (SW 2) took over the SSD`s assignments. SW 2 stated that she did not participate in Resident 21`s discharge plan meeting on 12/20/2024. SW 2 stated that SW 1 was the one who participated in Resident 21`s discharge meeting. During an interview on 1/15/2025 at 12:06 p.m., with the facility`s MRD, the MRD stated that he (MRD) made documentation in Resident 21`s medical records by mistake indicating that the resident was discharged to ALF 1. The MRD stated that Resident 21 was discharged home with FM 1 and FM 2 on 12/27/2024. During a concurrent interview and record review on 1/15/2025 at 12:20 p.m., with SW 1, Resident 21`s social service notes were reviewed. SW 1 stated that during Resident 21`s stay in the facility, FM 1 informed him that she (FM 1) discharged Resident 21 from ALF1 he was previously residing, and she (FM 1) decided to take care of the resident at home. SW 1 stated he forgot to make a note in Resident 21`s medical chart regarding this change. SW1 stated that he reached out to FM 1 on 12/18/2024 to set up a discharge plan meeting on 12/20/2024. SW 1 stated he did not participate in Resident 21`s discharge plan meeting on 12/20/2024, but instead SW 2 did. SW1 further stated there are no notes in Resident 21`s chart regarding the discharge plan meeting held on 12/20/2024. SW 1 stated that the social worker who participates in the resident's discharge plan meeting is responsible to make a note including the name of the participants and the final discharge plan including the proposed discharge date , destination, and any other arrangements that maybe necessary which must be completed prior to the resident`s discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/16/2025 at 11:00 a.m. with the SSD, Resident 21`s social service notes, discharge instructions and care plans were reviewed. The SSD stated SW 1 scheduled a discharge plan meeting for Resident 21 on 12/20/2024. However, there is no documentation regarding the discharge plan meeting in Resident 21`s progress notes. SSD stated that the facility`s Director of Rehab and one of the SWs usually participate in the discharge plan meeting. SSD stated during the discharge meeting, the following should be documented in the resident's notes: the name of the members that participated in the meeting including resident, family members, the facility's staff members, the final discharge plan and destination, and the anticipated discharge date . The SSD stated there is no documentation regarding these information in Resident 21`s chart. The SSD stated Resident 21`s discharge instructions were completed by SW 1 on 12/27/2024 at 9:15 a.m., and Resident 21 was discharged on [DATE]. The SSD stated that the discharge instructions are normally completed 24 hours prior to the resident`s discharge. The SSD stated she (SSD) does not know why the discharge instructions were not completed earlier as per facility`s policy. The SSD stated that per facility`s discharge policy the facility is required to place the resident`s address and mode of resident`s transportation in the discharge instructions. However, Resident 21`s discharge instructions are missing the discharge address and mode of transportation. The SSD stated it is important to comply with the facility`s discharge policy and procedure and document all the discharge information thoroughly in the resident`s medical record for an effective discharge planning and to prevent any confusion. During an interview on 1/16/2025 at 1:50 p.m., with the Director of Nursing (DON), the DON stated staff are required to follow the facility`s discharge policy and procedure. The DON stated Resident 21`s discharge notes are incomplete. The DON stated there is no documentation regarding Resident 21`s discharge plan meeting and it is unclear who participated in the meeting on 12/20/2024. The DON stated the discharge instructions should include the date and time of discharge, the complete address of the discharge location and also the mode of transportation. The DON stated this information is missing from Resident 21`s discharge instructions. The DON stated the potential outcome of an incomplete documentation about a resident`s discharge is the inability to provide necessary discharge care and services to the resident. During a review of facility`s Policy and Procedure (P&P) titled Transfer and Discharge, reviewed 10/2024, the P&P indicated that when a resident is discharged to home, a post discharge plan, in Layman`s terms, is developed prior to his or her discharge. Review the plan with the resident and/or his or her family, at least 24 hours before the resident`s discharge from the facility. The Medical Records department records the discharge on the Admission/Discharge Register and follows the Discharge Records procedure. The progress note must include at least the following, as they may apply: the date and time of the transfer or discharge, the complete address and phone number of the new location of the resident and the mode of transportation. During a review of facility`s Policy and Procedure (P&P) titled Social Work Services Documentation, reviewed 10/2024, the P&P indicated that Social Services would document information gathered or observed upon interaction with the resident, family, legal representative, or outside agencies involved in the well-being and care of the resident. Ongoing documentation between assessment periods should occur upon interactions and/or interventions which take place by social services in regard to well-being and care of the resident. This is documented in medical records on the IDT progress notes. The resident care plan should also be reviewed and updated to ensure it reflects the current status of the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview and record review, the facility failed to ensure a Bladder and Bowel Retraining Program (a simple and effective method used to try and overcome bladder problems including, urgency, frequency and incontinence, which can involve assisting a resident to the restroom at specific timed intervals) was implemented to prevent the development of skin impairment for one of two residents (Resident 60) investigated under pressure ulcer/injury (PU-a localized area of skin damage that develops when pressure on the skin cuts off blood flow to the area). This deficient practice had the potential to result in worsening of Resident 60's stage 1 pressure ulcer (the mildest form of pressure injury, characterized by a localized area of non-blanchable redness on intact skin, usually over a bony prominence, indicating potential skin damage but without any open wounds or skin breakdown). Findings: During a review of Resident 60's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/12/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems). During a review of Resident 60's History and Physical (H&P-a medical evaluation that involves gathering information about a patient`s medical history and performing a physical examination) dated 12/13/2024, the H&P indicated that Resident 60 is unable to make her own decisions. The H&P indicated that Resident 60 had a gait and balance disorder with fall precautions.  During a concurrent interview and review of Resident 60`s medical records with the Clinical Manager (CM) on 01/15/25 at 11:45 a.m., reviewed the following: a. Bowel & Bladder (B&B) Admission assessment dated [DATE], the B&B indicated in the observation details the following responses: i. How Long? Incontinent since present admission ii. Type? Bowel and Urine iii. Mental State? Oriented/Aware iv. Due To? Surgery or Infection v. Attitude? Shows initiative/willingness. vi. Total Number of Points: Score 4- good candidate for bowel and/or bladder retraining. (continued on next page)

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

b. Braden Scale Assessment (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries) dated 01/01/2025: Score 18 indicating mild risk.

c. Safety Events- SBAR (stands for Situation, Background, Assessment, and Recommendation. It is a communication tool that helps healthcare professionals share information about a patient's condition) Communication Tool and Progress Note for Change of Condition (COC) and Transfer dated 01/04/2025, the SBAR/COC indicated that Resident 60 had developed Stage 1 PU left buttocks that was identified on 01/04/2025.

d. Wound Management Detail Report dated 1/4/2024: Wound Location- Left Buttock 0.5 centimeter (cm) by 0. 5 cm; Stage 1 PU.

The CM stated that a B&B Assessment score of four (4) indicates that Resident 60 is a good candidate for B&B retraining. The CM stated that incontinence of B&B can result to PU and skin breakdown. The CM stated that B&B retraining can help prevent the development of PU. The CM stated that they should have placed Resident 60 on the B&B retraining program when the B&B Admission Assessment determined that she is a good candidate. The CM stated Resident 60`s developing of Stage 1 PU could have been prevented. The CM stated that after the SBAR/COC on 01/04/2025, Resident 60 became at risk for worsening of her Stage 1 PU which has the potential to lead to skin tissue damage (can occur when the skin or underlying soft tissues are injured).

During an interview on 01/15/25 at 03:43 p.m., with Registered Nurse Supervisor 1 (RN1), RN 1 stated after residents` are determined to be a good candidate for B&B retraining program, they are immediately placed on the program as part of then skin management per policy.

During an interview on 01/15/2025 at 03:56 p.m., with Resident 60, the resident stated that she can feel the urge to urinate or move her bowel but if staff do not come to assist her to the bathroom, then she would just urinate in her pants.

During a wound treatment observation on 01/16/25 at 08:21 a.m., with Licensed Vocational Nurse 2 (LVN 2), observed LVN 2 providing treatment to Resident 60. Observed Resident 60 to have a redness on the intergluteal cleft (the groove between the buttocks) with the skin intact.

During a review of the facility`s policy and procedures titled Wound and Skin Management, last reviewed 10/2024, the policy indicated that it is the policy of this facility that any resident/patient who enters the facility without pressure injuries will have appropriate preventative measure taken to insure the resident/patient does not develop pressure injuries unless the resident`s/patient`s clinical condition makes the development unavoidable .develop a plan for urinary incontinence, bowel and bladder training, toileting or cueing

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedures titled Bowel and Bladder Program, last reviewed 10/2024, the policy indicated that the B&B program is implemented to ensure that residents/patients entering the facility will remain continent unless his/her clinical condition demonstrates that it is unavoidable. To ensure that a resident/patient who is incontinent of bowel and bladder receives the necessary care and treatment. To protect skin integrity and prevent complications such as urinary tract infections and constipation .it is the policy of this facility to assess each resident`s/patient`s elimination status on admission and to develop an individualized plan of care for those resident/patients who require a bowel and/ or bladder management program within fourteen (14) days of admission .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47883 Based on observation, interview, and record review the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding (any method of feeding that uses the gastrointestinal tract to deliver nutrition and calories) to one out of eight sampled residents (Resident 47) investigated during the medication administration task when Licensed Vocational Nurse 3 (LVN 3) failed to check Resident 47's gastrostomy tube (G-tube, a tube inserted through the abdomen] to deliver nutrition and medications directly to the stomach]) residual volume (the amount of fluid in the stomach after a feeding) before administering a medication. This deficient practice had the potential to interfere with the absorption and effectiveness of the medication, potentially reducing its therapeutic effect. Findings: During a review of Resident 47's Face Sheet, the Face Sheet indicated that the facility admitted Resident 47 on 1/10/2019 and readmitted the resident on 8/16/2023 with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), gastrostomy status(G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/27/2024, the MDS indicated that the resident had severely impaired cognition (a severe damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 47 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 47's History and Physical, dated 6/18/2024, the History and Physical indicated that Resident 47 did not have the capacity to make decisions. During A review of Resident 47's Order Summary Report, the Order Summary Report indicated an order dated 5/19/2021 to check tube placement/residual every shift before giving medications and starting feeding. During the review of Resident 47's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) regarding gastrostomy status initiated on 6/19/2024, and revised on 9/12/2024, the care plan indicated the goal of care plan was to minimize risk of infection at G-Tube site. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on 1/15/2025 at 12:11 p.m., in Resident 47's room, observed LVN 3 sanitized her hands, donned gloves, placed the resident in semi-Fowler position, checked for G-tube placement with stethoscope and flushed the G-tube with 30 ml of water. Observed LVN 3 administered crushed Carbidopa-Levodopa 12.5-50 mg via G-tube and flushed the G-tube with 30 ml of water and clamped the G-tube. During an interview on 1/15/2025 at 12:15 p.m., LVN 3 stated that she (LVN 3) did not check the residual volume from Resident 47's stomach. LVN 3 stated that residual volume has to be checked after G-tube placement has been confirmed and before medication administration to achieve therapeutic effect of the medication. During an interview on 1/15/202 at 12:27 p.m. with the Director of Nursing (DON), the DON stated that the LVN 3 should follow nursing procedure during medication administration and check the residual from Resident 47's stomach before administering medications. The DON stated that this deficient practice placed the resident at risk for feeding intolerance. During a review of the facility policy named Enteral Feeding Tube Drug Administration, last reviewed on 10/2024, the policy stated: This hospital will provide a standardized method of administering medication via G-tube .The administering nurse shall follow nursing procedures for proper care and monitoring of the patient, enteral pump, and tubing during the administering of medications (e.g. aspirating stomach contents, checking for tube placement . monitor for potential complications).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grancell Village of the Jewish Homes for the Aging	7150 Tampa Ave Reseda, CA 91335

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38469

Based on interview and record review, the facility failed to ensure an order for Hydrocodone-Acetaminophen 10- 325 milligram (Norco 10/325 mg- used to relieve moderate to severe pain) was clarified with the physician to ensure accurate assessment of the resident's pain. The physician's order did not indicate the specific pain scale rating (The Numerical Rating Pain Scale is a simple pain scale that grades pain levels from 0=no pain, 1,2, and 3= mild pain, 4,5, and 6= moderate pain, 7,8, and 9= severe pain and 10= worst pain) to be used as a basis for administering the medication to one of two residents (Resident 50) investigated under pain management.

This deficient practice had the potential to result in ineffective pain management and placed the resident at risk for experiencing adverse consequences (are unwanted undesirable effects that are possibly related to a drug) including constipation, nausea and vomiting,

Findings:

During a review of Resident 50's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 12/09/2024 and readmitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a group of lung disease that make it difficult to breathe) and chronic pain syndrome (a condition characterized by persistent pain that lasts for at least 3-6 months and significantly impacts daily life).

During a review of Resident 50's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/12/2024, the MDS indicated that the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 50 required substantial assistance with toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.

During a review of Resident 50`s physician`s orders, an order dated 1/2/2025 indicated to administer Norco 10-325 mg oral tablet not to exceed 3 grams every day from all acetaminophen sources: offer nonpharmacological interventions prior to administration of Norco every 6 hours as needed dated 01/02/2025.

During an interview and record review on 01/15/2025 at 09:11 a.m. with the Clinical Manager (CM), reviewed Resident 50`s physician`s order for Norco 10-325 on 01/02/2025 and Medication Administration Record (MAR- includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for the month of January 2025. The MAR indicated administration of Norco 10-325 mg and the documented reason/comments for the administration on the following dates and times:

1. 01/06/2025 at 01:08 p.m.- no pain assessment was documented. The documented reason for the administration was Early Administration: Resident will be out.

2. 01/11/2025 at 05:36 p.m.- pain of 6/10

(continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. 01/11/2025 at 11:01 a.m.- no pain assessment was documented, The documented reason for the administration was resident request 4. 01/14/2025 at 5:11 a.m.- pain of 6/10 During the interview, the CM stated that the physician`s order for Norco 10-325 dated 01/02/2025 should have been clarified with the physician to indicate the specific numeric pain equivalent to severe pain, preventing any confusion about when to administer Norco. The CM stated that Norco`s adverse effects include constipation and respiratory depression which could lead to desaturation and hospitalization for Resident 50. During a review of the facility`s Nursing Policy and Procedure (NPP) titled Pain Management, last reviewed on 10/2024, the NPP indicated that the purpose of the policy is to assure an accurate assessment of the resident`s pain and respond in a timely manner with administration of pain medication or non-drug intervention as appropriate for the resident/patient .assessment of pain shall be based on the pain scale . The NPP uses the pain scale or pain severity as follows: A. 0= no pain B. 1-3= mild pain C. 4-6= moderate pain D. 7-10= severe pain

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34659 Based on interview, and record review, the facility failed to ensure the consultant pharmacist's (CP -a healthcare specialist who provides expert advice on medications and pharmaceutical services, including patient safety) recommendation was carried out for two of five sampled residents (Resident 43 and Resident 46) investigated for unnecessary medications by failing to: 1. Act upon the facility consultant pharmacist's recommendation on 10/29/2024 to conduct a lipid panel blood draw for Resident 43. This deficient practice had the potential for Resident 43 to experience high levels of fats in the blood. 2. Act upon the facility consultant pharmacist's recommendation on 11/2024 to clarify the behavior manifestation for the use of Seroquel (a psychoactive medication-any medication capable of affecting the mind, emotions, and behavior) for Resident 46. This deficient practice increased the risk of receiving medication that was not optimal for Resident 46's medical condition and increased the risk of adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the medication therapy. Findings: 1. During a review of Resident 43's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the document indicated that the facility admitted the resident on 10/15/2023, with diagnoses including hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). During a review of Resident 43's Minimum Data Set (MDS, a federally mandated assessment tool) dated 10/21/2024, the MDS indicated Resident 43 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 43 required setup or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. During a review of Resident 43's MRR, dated 10/29/2024, the document indicated the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This resident has an order for: cholecalciferol (a supplement to treat vitamin D [essential for bones] deficiency), aspirin (medication to prevent stroke [loss of blood flow to a part of the brain]), cyanocobalamin (vitamin B12, essential for body functions), ferrous sulfate (medication to treat anemia [a condition where the body does not have enough healthy red blood cells]), Lipitor (medication to treat high cholesterol), Plavix (medication to prevent stroke), and magnesium oxide (essential for heart health). To comply with Centers for Medicare and Medicaid Services (a federal agency that manages health care programs in the United States, may we obtain the following labs: 25 (OH) D level (25-hydroxyvitamin D, a form of Vitamin D), Complete Blood Count (CBC, a blood test that measures the blood cells), Vitamin B12 level (important for bodily functions), ferritin level (a protein to store iron in the body), fasting lipid panel (a blood test that measure cholesterol taken after one has not eaten for a period of time), and magnesium level. There was an acknowledgement of the document by facility staff, dated 10/31/2024. During a review of Resident 43's Nursing Progress Notes, dated 10/30/2024, the Nursing Progress Note indicated following pharmacy consultant recommendation to obtain Vitamin D25 level, CBC, Vitamin B12, ferritin, fasting lipid panel, and magnesium level, due to Resident 43 has orders for aspirin, Vitamin B12, Lipitor, Plavix, and Vitamin D. The MRR indicated Resident 43's primary medical doctor was aware, agreed, noted, and carried out. During a review of Resident 43's Physician's Orders, dated 10/31/2024, the orders indicated an order to draw blood laboratory tests: fasting metabolic panel (a group of labs including kidney and liver function, glucose levels (blood sugar), and electrolyte levels (particles in the body essential for body functioning), ferritin, magnesium, Vitamin B12, Vitamin D - 25 (OH). The physician's order did not include a laboratory (lab) test for fasting lipid panel. During a review of Resident 43's Laboratory Values, dated 10/31/2024, the laboratory results indicated the above labs were drawn except for the fasting lipid panel. During a review of Resident 43's Physician's Orders, dated 1/01/2025, it indicated an order to conduct a blood draw of labs. The fasting lipid panel was included in this order. During a review of Resident 43's Laboratory Values, dated 1/03/2025, the labs indicated a fasting lipid panel was conducted. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN), reviewed Resident 43's Laboratory Values for 10/31/2024 until 1/03/2025. The MDSN was unable to find a fasting lipid panel until the lab that was drawn on 1/03/2025. During a concurrent interview and record review with the Director of Nursing (DON) on 1/16/2025, reviewed the facility policy and procedure titled, Consultant Pharmacist Services Provider Requirements, last reviewed 10/2024. The DON stated the Clinical Manager (CM) acts upon a resident's MRR. The DON stated there is no time frame for licensed staff to act upon a recommendation and that the quality control nurse should be contacted for the completion time frame. The DON stated it appeared to be an oversight by the licensed nurses and the lipid panel should have been drawn before the two-month time frame after receiving the MRR. The DON stated this process should be followed to monitor the lipid level to avoid polypharmacy (the simultaneous use of multiple drugs by a single patient, for one or more conditions) and adjust the medication dosage if need be. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the CM on 1/16/2025 at 10:26 a.m., the CM stated she is the licensed nurse to respond to the MRR report or sometimes assigns the task to another licensed nurse. The CM stated the process should be completed within one to two weeks of receiving the MRR from the pharmacist consultant. 44309 2. During a review of Resident 46's Face Sheet, the Face Sheet indicated that the facility admitted the resident on 9/24/2023, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified mood affective disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling). During a review of Resident 46's Minimum Data Set (MDS- a resident assessment tool) dated 11/26/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 46 was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated that Resident 46 did not display any physical and verbal behavioral symptoms directed towards others (e.g., hitting, kicking, grabbing, screaming at others, and threatening others). The MDS further indicated that Resident 46 was taking antidepressant (medication used to treat depression) and antipsychotic medications (medication that are used to treat mental disorders). During a review of Resident 46`s Physician Order Report dated 9/11/2024, the order indicated to monitor the resident`s behavior of mood disorder manifested by agitation, constant loud blowing raspberry in the air (make a sound by putting your tongue out and blowing) during every shift. This order was discontinued on 12/10/2024 at 2:47 p.m. During a review of Resident 46`s Physician Order Report dated 11/16/2024, the order indicated to administer Seroquel 25 milligrams (mg-a unit of measure of mass) by mouth, twice a day for mood disorder manifested by agitation.  During a review of Resident 46`s Consultant Pharmacist`s Medication Regimen Review (MRR- a review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) notes from 11/1/2024-11/17/2024, the MRR notes indicated the following:  Please review Resident 46`s diagnosis and behavior manifestation to ensure appropriate use of Seroquel. Mood disorder may not be viewed as an appropriate diagnosis. Also, agitation is too subjective and does not demonstrate how this may cause the resident harm. Once the order is reviewed for appropriate diagnosis and behavior, review all active orders for behavior monitoring to ensure they are accurate and discontinue any behavior monitoring orders no longer needed. The MRR notes were marked with a handwritten note indicating, Will Review. During a review of Resident 46`s Medication Administration Records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated that Resident 46 received Seroquel 25 mg from 1/1/2025 through 1/15/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46`s mood disorder manifested by agitation care plan (written guide that organizes information about the resident's care) initiated on 9/25/2023, the care plan indicated a goal that the resident will have reduced episodes of agitation for the next three months. The care plan interventions were to approach the resident in a quiet, calm, and positive manner, involve him in activities on a daily basis, to administer medication (Seroquel) as ordered by the physician, monitor and document behaviors/triggers, monitor for agitation, observed the effectiveness of the medication, and report any changes to the physician. During a concurrent interview and record review on 1/16/2025 at 9:45 a.m., with the Clinical Manager (CM), Resident 46`s physician orders and MAR were reviewed. The CM stated that Resident 46`s physician ordered to administer Seroquel 25 mg twice a day for mood disorder manifested by agitation. The CM stated the order for Resident 46`s Seroquel did not include a clear indication and the specific behavior to be monitor and requires clarification. The CM stated agitation is considered a subjective behavior and not an indication to administer Seroquel. The CM stated Resident 46 has a behavior of blowing in the air once in a while, but she (CM) has never seen him agitated. The CM stated Resident 46`s physician order to monitor behavior of mood disorder manifested by agitation has been discontinued since 12/10/2024. The CM stated licensed nurses forgot to reactivate this order and they were not monitoring and documenting Resident 46`s behavior in the MAR. The CM stated all psychotropic medications are required to have a specific and clear indication for use and measurable target behaviors so the licensed staff can monitor the frequency of the behavior. The CM stated the potential outcome of not having a clear indication and measurable target behavior to monitor is the inability to measure the effectiveness of the medication and exposure of the resident to unwanted side effects of this medication. During a concurrent interview and record review on 1/16/2025 at 10:00 a.m., with the CM, Resident 46`s CP`s MRR notes for 11/1/2024-11/17/2024 were reviewed. The CM stated that she (CM) is in charge of acting upon CP`s recommendation. The CM stated CP recommended in November 2024 to review Resident 46`s diagnosis and behavior manifestation to ensure the appropriate use of Seroquel because mood disorder may not be viewed as an appropriate diagnosis and agitation is subjective. The CM stated she received the recommendation and marked as Will Follow. However, she forgot to act upon this recommendation. The CM stated the potential outcome of not acting upon the pharmacy consultant's recommendation is the inaccurate monitoring and the inability to measure efficacy of the medication for the resident. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated Resident 46`s physician order for Seroquel did not include a specific measurable behavior to be monitored by a licensed staff member. The DON stated the behavior of agitation does not describe Resident 46's specific behaviors related to the use of Seroquel. The DON stated, without defining specific behaviors, monitoring for those behaviors cannot be objective as different nurses may document the behaviors for different reasons. The DON further stated that Resident 46`s physician order to monitor the resident`s behavior related to use of Seroquel was discontinued on 12/10/2024, never reactivated, and as result, this monitoring was not performed by the licensed staff since 12/10/2024. The DON stated all psychotropic medications are required to have an appropriate diagnosis, a specific and clear indication for use, and measurable target behaviors so the licensed staff can monitor the frequency of the behavior. The DON stated based on Resident 46`s MRR by CP for 11/1/2024-11/17/2024, the CP recommended to clarify the behavior manifestation of Seroquel use. The DON stated that the facility`s CM acts upon CP`s recommendation but, the CP's recommendation for Resident 46`s Seroquel use appeared to be an oversight and was not acted upon. The DON stated that the potential outcome of not monitoring behaviors related to psychotropic medication use is the inability to reevaluate the need of this medication and measure efficacy of the administration periodically as required which could negatively impact the resident`s quality of life.  During a review of the facility's Policies & Procedures (P&P) titled, Psychotropic medication Assessment and Monitoring, last reviewed 10/2024, the P&P indicated that psychotropic drugs are used only when necessary and then at the lowest effective dose. A physician`s order and an appropriate diagnosis is required for all psychotropic medications. The Interdisciplinary Team (IDT) assesses and monitors the appropriateness, effectiveness, and side effects associated with psychotropic medications for each resident. The behavior of residents receiving antipsychotic medication will be monitored by the licensed nurses at appropriate intervals, as determined by IDT team, using the behavior monitoring record. The Consultant Pharmacist reviews the appropriateness of the psychotropic medications order as part of each drug regimen. If at any time during the assessment for monitoring process, the psychotropic medication order is found to be inappropriate, the Director of Nursing is to be notified and the attending physician will be called for clarification. The behavior of residents receiving antipsychotic medication will be monitored by the Registered Nurses or LVN at appropriate intervals, as determined by the IDT using the behavior monitoring record. Record behavior, interventions and effectiveness of interventions taken in the behavior monitored. During a review of the facility's Policies & Procedures (P&P) titled, Consultant Pharmacist Services Provider Requirements, last reviewed 10/2024, the P&P indicated that specific activities that the CP performs includes but not limited to reviewing medication regimen of each resident at least monthly, or more frequently under certain conditions, incorporation federally mandated standards of care in addition to other applicable professional standards as outlines in the procedure for MRR and documentation the review and findings in the resident`s medical record or in a readily retrievable format if utilizing electronic documentation. Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues. The facility has a process to ensure that the findings are acted upon.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44309 Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 46) was free from unnecessary use of psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to monitor the specific, measurable target behaviors (the specific, undesirable behavior that a medication is intended to reduce or manage) related to the use of Seroquel (medication used to treat mental illness). This deficient practice had the potential to place Resident 46 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment (being weakened) or decline (gradually become less) in the resident's mental, physical condition, functional, and psychosocial status. Cross reference F756 Findings: During a review of Resident 46's Face Sheet, the Face Sheet indicated that the facility admitted the resident on 9/24/2023, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified mood affective disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling). During a review of Resident 46's Minimum Data Set (MDS- a resident assessment tool) dated 11/26/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 46 was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated that Resident 46 did not display any physical and verbal behavioral symptoms directed towards others (e.g., hitting, kicking, grabbing, screaming at others, and threatening others). The MDS further indicated that Resident 46 was taking antidepressant (medication used to treat depression) and antipsychotic medications (medication that are used to treat mental disorders). During a review of Resident 46`s Physician Order Report dated 9/11/2024, the order indicated to monitor the resident`s behavior of mood disorder manifested by agitation, constant loud blowing raspberry in the air (make a sound by putting your tongue out and blowing) during every shift. This order was discontinued on 12/10/2024 at 2:47 p.m. During a review of Resident 46`s Physician Order Report dated 11/16/2024, the order indicated to administer Seroquel 25 milligrams (mg-a unit of measure of mass) by mouth, twice a day for mood disorder manifested by agitation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46`s Consultant Pharmacist`s Medication Regimen Review (MRR- a review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) notes from 11/1/2024-11/17/2024, the MRR notes indicated the following: Please review Resident 46`s diagnosis and behavior manifestation to ensure appropriate use of Seroquel. Mood disorder may not be viewed as an appropriate diagnosis. Also, agitation is too subjective and does not demonstrate how this may cause the resident harm. Once the order is reviewed for appropriate diagnosis and behavior, review all active orders for behavior monitoring to ensure they are accurate and discontinue any behavior monitoring orders no longer needed. The MRR notes were marked with a handwritten note stating, Will Review. During a review of Resident 46`s Medication Administration Records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated that Resident 46 received Seroquel 25 mg from 1/1/2025 through 1/15/2025.  During a review of Resident 46`s mood disorder manifested by agitation care plan (written guide that organizes information about the resident's care) initiated on 9/25/2023, the care plan indicated a goal that the resident will have reduced episodes of agitation for the next three months. The care plan interventions were to approach the resident in a quiet, calm, and positive manner, involve him in activities on a daily basis, to administer medication (Seroquel) as ordered by the physician, monitor and document behaviors/triggers, monitor for agitation, observed the effectiveness of the medication, and report any changes to the physician. During a concurrent interview and record review on 1/16/2025 at 9:45 a.m., with the Clinical Manager (CM), Resident 46`s physician orders and MAR were reviewed. The CM stated that Resident 46`s physician ordered to administer Seroquel 25 mg twice a day for mood disorder manifested by agitation. The CM stated the order for Resident 46`s Seroquel did not include a clear indication and the specific behavior to be monitored and requires clarification. The CM stated agitation is considered a subjective behavior and not an indication to administer Seroquel. The CM stated Resident 46 has a behavior of blowing in the air once in a while, but she (CM) has never seen him agitated. The CM stated Resident 46`s physician order to monitor behavior of mood disorder manifested by agitation has been discontinued since 12/10/2024. The CM stated licensed nurses forgot to reactivate this order and they were not monitoring and documenting Resident 46`s behavior in the MAR. The CM stated all psychotropic medications are required to have a specific and clear indication for use and measurable target behaviors so the licensed staff can monitor the frequency of the behavior. She (CM) stated the potential outcome of not having a clear indication and measurable target behavior to monitor is the inability to measure the effectiveness of the medication and exposure of the resident to unwanted side effects of this medication. During a concurrent interview and record review on 1/16/2025 at 10:00 a.m., with the CM, Resident 46`s CP`s MRR notes for 11/1/2024-11/17/2024 were reviewed. The CM stated that she (CM) is in charge of acting upon CP`s recommendation. The CM stated CP recommended in November 2024 to review Resident 46`s diagnosis and behavior manifestation to ensure the appropriate use of Seroquel because mood disorder may not be viewed as an appropriate diagnosis and agitation is subjective. The CM stated she received the recommendation and marked as Will Follow. However, she forgot to act upon this recommendation. The CM stated the potential outcome is the inaccurate monitoring and the inability to measure efficacy of the medication for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Grancell Village of the Jewish Homes for the Aging		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Tampa Ave Reseda, CA 91335	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated Resident 46`s physician order for Seroquel did not include a specific measurable behavior to be monitored by a licensed staff member. The DON stated the behavior of agitation does not describe Resident 46's specific behaviors related to the use of Seroquel. The DON stated, without defining specific behaviors, monitoring for those behaviors cannot be objective as different nurses may document the behaviors for different reasons. The DON further stated that Resident 46`s physician order to monitor the resident`s behavior related to use of Seroquel was discontinued on 12/10/2024, never reactivated, and as result, this monitoring was not performed by the licensed staff since 12/10/2024. The DON stated all psychotropic medications are required to have an appropriate diagnosis, a specific and clear indication for use, and measurable target behaviors so the licensed staff can monitor the frequency of the behavior. The DON stated based on Resident 46`s MRR by CP for 11/1/2024-11/17/2024, the CP recommended to clarify the behavior manifestation of Seroquel use. The DON stated that the facility`s CM acts upon CP`s recommendation.  During a review of the facility's Policies & Procedures (P&P) titled, Psychotropic medication Assessment and Monitoring, last reviewed 10/2024, the P&P indicated that psychotropic drugs are used only when necessary and then at the lowest effective dose. A physician`s order and an appropriate diagnosis is required for all psychotropic medications. The Interdisciplinary Team (IDT) assesses and monitors the appropriateness, effectiveness, and side effects associated with psychotropic medications for each resident. The behavior of residents receiving antipsychotic medication will be monitored by the licensed nurses at appropriate intervals, as determined by IDT team, using the behavior monitoring record. The Consultant Pharmacist reviews the appropriateness of the psychotropic medications order as part of each drug regimen. If at any time during the assessment for monitoring process, the psychotropic medication order is found to be inappropriate, the Director of Nursing is to be notified and the attending physician will be called for clarification. The behavior of residents receiving antipsychotic medication will be monitored by the Registered Nurses or LVN at appropriate intervals, as determined by the IDT using the behavior monitoring record. Record behavior, interventions and effectiveness of interventions taken in the behavior monitored. During a review of the facility's Policies & Procedures (P&P) titled, Consultant Pharmacist Services Provider Requirements, last reviewed 10/2024, the P&P indicated that specific activities that the CP performs includes but not limited to reviewing medication regimen of each resident at least monthly, or more frequently under certain conditions, incorporation federally mandated standards of care in addition to other applicable professional standards as outlines in the procedure for MRR and documentation the review and findings in the resident`s medical record or in a readily retrievable format if utilizing electronic documentation. Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues. The facility has a process to ensure that the findings are acted upon.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview and record review, the facility failed to: 1. Implement its policy titled, Enhanced Barrier Precautions (EBP - an infection control method that uses targeted gown and gloves to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial [a substance that kills microorganisms such as bacteria or mold, or stops them from growing and causing disease agents]) by failing to ensure Licensed Vocational Licensed Nurse 3 (LVN 3) donned (to put on) a gown during medication administration via gastrostomy tube (G-tube -plastic tube to provide nutrition directly into stomach or small intestine) to one of eight sampled residents (Resident 47) investigated during the medication administration task. This deficient practice placed Resident 47 at increased risk of developing an infection. 2. Ensure a resident's nasal cannula (a medical device that delivers supplemental oxygen therapy to people with low oxygen levels) oxygen tubing was not touching the floor for one of one sampled resident (Resident 26) investigated under respiratory care. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. Findings: 1. During a review of Resident 47's Face Sheet, the Face Sheet indicated that the facility admitted Resident 47 on 1/10/2019 and readmitted the resident on 8/16/2023 with diagnoses including paroxysmal atrial fibrillation(a condition in which your blood does not have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), gastrostomy status (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 47's Minimum Data Set (MDS - a federally mandated assessment tool), dated 10/27/2024, the MDS indicated that the resident had severely impaired cognition (a severe damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 47 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 47's History and Physical , dated 6/18/2024, the History and Physical indicated that Resident 47 did not have a capacity to make decisions. During a review of Resident 47's Order Summary Report , the Order Summary Report indicated an order dated 5/19/2021 for Carbidopa-Levodopa (a medication that treats the symptoms of Parkinson disease) 12. 5-50 milligrams (mg - unit of measurement) via G-tube four times a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 47's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs), dated 4/10/2024 regarding increasing risk for contracting and/or spreading MDRO acquisition related to resident has a G-tube. The approach of care plan was staff to wear gloves and gown during high-contact care activities. During a medication administration observation on 1/15/2025 at 12:11p.m. in Resident 47's room, observed Resident 47's wall had a signage which indicated that the resident was on EBP, and to don a gown and gloves when performing high contact activity. Observed LVN 3 sanitized her hands, donned gloves, placed the resident in semi-Fowler position, checked for G-tube placement with stethoscope and flushed the G-tube with 30 ml of water. Observed LVN 3 administered crushed Carbidopa-Levodopa 12.5-50 mg via G-tube and flushed the G-tube with 30 ml of water and clamped the G-tube. During an interview on 1/15/2025 at 12:15 p.m., LVN 3 stated that she (LVN 3) did not wear a gown during medication administration. LVN 3 stated that he should have worn a gown before giving medication via G-Tube to Resident 47 to prevent possible spread of infection. During an interview on 1/16/2024 at 11:25 a.m. with Infection Prevention Nurse (IP), the IP stated that according to the facility's policy regarding EBP, LVN 1 should have donned a gown prior to administering medication via G-Tube to Resident 47. During an interview on 1/16/2024 at 3:50 p.m. with the Director of Nursing (DON), the DON stated that residents placed on EBP include residents at increased risk of developing an infection because they have a G-tube. The DON stated when a resident is placed on EBP, all staff are required to don gown and gloves when performing high contact resident care activities (activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated) such as administering medication via G -tube. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, last reviewed 10/2024, the P&P indicated the facility was to implement enhanced barrier precaution for the prevention of transmission of MDRO. The P&P indicated to wear gowns and gloves while performing the following tasks associated with the greatest risk for MDRO contamination of Health Care Providers (HCP) hands, clothes, and the environment: . Dressing . Bathing , showering . Transferring . Providing hygiene. . Changing linens. . Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. 38469 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 26's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 08/30/2024 and readmitted on [DATE] with diagnoses including, pulmonary hypertension (a serious condition that occurs when blood pressure in the lungs is abnormally high) and heart failure (a chronic condition that occurs when the heart can`t pump enough blood and oxygen to the body).  During a review of Resident 26's MDS dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS further indicated that Resident 26 required assistance with activities of daily living (activities of daily living [ADL] are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.). During a review of Resident 26`s physician`s orders dated 01/04/2024, the physician order's indicated an order to administer Oxygen at 2 liters per minute (LPM) via nasal cannula to keep oxygen saturation (the amount of oxygen that's circulating in the blood) above 92% every shift. During a concurrent room observation and interview on 01/13/2024 at 9:31 a.m., observed resident lying in bed awake. Observed Resident 26's nasal cannula prong attached to his nose and the other end of the oxygen delivery tubing (nasal cannula) was hooked up to oxygen wall outlet. Observed a part of the oxygen tubing was touching the floor During a follow-up observation on 01/13/2024 at 9:45 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 confirmed that Resident 26's oxygen tubing was touching the floor. LVN 2 stated that tubing should not be touching the floor because the floor is not clean, and the tubing can get contaminated. LVN 2 stated that Resident 26 can catch infection and become sick due to the contaminated tubing. LVN 2 stated that she will replace the tubing immediately to prevent the resident from developing complications. During an interview with the Infection Preventionist (IP) on 1/14/2025, the IP stated that if the oxygen tubing is touching the floor, it can cause respiratory infection and resident can get sick which could result to hospitalization . During a review of the Centers for Disease Control (CDC) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, 2003, indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.