STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to promote dignity and respect for two of three sampled residents (Resident 16 and 11) for the dignity care area by: 1. Ensuring Resident 16's urinary catheter bag (tube that drains urine from the bladder into a drainage bag) was covered with a dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so it is not visible). 2. Failing to ensure facility staff did not stand above Resident 11's eye level while assisting the resident to eat. These deficient practices have the potential to affect Resident 16 and 11's self-esteem and self-worth and violates Resident 16 and 11's right to be treated with dignity. Findings: 1. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening in airway function and respiratory symptoms), urinary tract infection (UTI, an infection of the bladder and urinary system), and difficulty in walking. A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident) dated 3/26/2024, indicated Resident 16 had the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care planning tool), dated 2/11/2024, indicated Resident 16's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were cognitively intact. The MDS indicated Resident 16 was dependent (helper does all the effort and resident does none of the effort to complete the acidity or the assistance of two or more helpers are required) for sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bath self, lower body dressing, putting on/taking off footwear, roll left and right, and toilet transfer. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's Care Plan, dated 2/26/2024, indicated Resident 16 had an foley catheter due to diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow caused by structural or functional hinderance). During on observation on 3/26/24 at 12:56 PM in Resident 16's room, Resident 16 was lying in bed with an indwelling catheter bag with no dignity bag. During a concurrent observation and interview on 3/26/2024 at 2:22 PM in Resident 16's room with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 16's indwelling catheter bag was not covered with dignity bag, and it was supposed to be covered. During an interview on 3/27/2024 at 3:43 PM with CNA 3, CNA 3 stated the dignity bag should cover the indwelling catheter bag to protect the resident's dignity. CNA 3 stated the dignity bag prevents others from seeing the resident's urine. CNA 3 stated the dignity bag should had been placed as soon as Resident 16 returned from the hospital on 3/25/2024. During an interview on 3/29/2024 at 8:29 AM with the Infection Prevention Nurse 2 (IPN 2), IPN 2 stated a dignity bag should be placed to cover the indwelling catheter bag to protect the residents' dignity. IPN 2 stated some residents may feel self-conscious about having their indwelling catheter bag uncovered. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated residents who had an indwelling catheter bag should have a dignity bag to preserve their dignity. 46919 2. A review of Resident 11's Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover and protect it), paroxysmal atrial fibrillation (irregular heartbeat), and epilepsy (abnormal electrical activity in the brain that happens quickly). A review of Resident 11's MDS, dated [DATE], indicated Resident 11 was assessed having moderately impaired cognition for daily decision making and required substantial/maximal assistance with eating, personal hygiene, upper/lower body dressing, and toileting hygiene. During a concurrent observation in Resident 11's room and interview with CNA 1 on 3/26/2024, at 12:50 PM, Resident 11 was observed eating in bed with the head-of-the bed elevated (resident in a sitting position). CNA 1 stood on the right side of the bed and above Resident 11's eye level while feeding the resident's lunch. CNA 1 stated she should be sitting down at eye level of Resident 11 while assisting with feeding. CNA 1 stated she was not sitting because there was no available chair to sit on inside Resident 11's room. During an interview with Licensed Vocational Nurse 2 (LVN 2), on 3/27/2024, at 2:38 PM, LVN 2 stated staff assisting residents with meals need to be at eye level with the residents to encourage the resident to eat and ensure that the resident is eating properly. LVN 2 stated sitting down next to the resident while feeding makes the resident feel good and dignified. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P), titled, Resident Rights, 1/1/2012, the P&P indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure that the call light (a device used by patients to call for assistance from hospital staff) was within reach (an arm's length) of three of 13 sampled residents (Resident 5, Resident 27, and Resident 15). This deficient practice had the potential to result in delayed provision of services, delay in care and Residents 5, 27, and 15 not receiving assistance with activities of daily living (ADLs). Findings: a. A review of Resident 5's Admission Record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses of difficulty of walking, lack of coordination, neuralgia (severe, sharp, often shock-like pain that follows the path of a nerve) and neuritis (inflammation of the nerves), and schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves). A review of Resident 5's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 11/6/2023, indicated Resident 5 had fluctuating capacity to understand and make decisions. A review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/8/2024, indicated Resident 5's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 5 required setup assistance (helper assists only prior to or following the activity) with lying to sitting on side of bed. A review of Resident 5's Care Plan, dated 2/8/2024, indicated Resident 5 was at risk for falls related to postural dizziness (dizziness relating to or involving the body when lying, sitting, or standing), and multiple psychotropic medications (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). Staff interventions were to ensure the resident's call light was within reach and encourage the resident to use the call light for assistance as needed. During an observation on 3/26/2024 at 8:59 AM in Resident 5's room, Resident 5 was sleeping in bed and his call light was placed inside of the closed drawer of the nightstand. During a concurrent observation and interview on 3/26/2024 at 9:18 AM in Resident 5's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 5's call light was placed in the closed drawer of the nightstand. CNA 1 stated call lights were supposed to be placed within reach on the resident's bed and clipped on the bed. During an interview on 3/28/2024 at 2:38 PM with the Director of Nursing (DON), the DON stated it was not appropriate to keep the call light inside of the drawer. The DON stated the call light was out of reach. The DON stated the resident would not be able to call for help or assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/2024 at 10:34 AM with the DON, the DON stated call lights should be left within reach of the resident. The DON stated call lights may be placed at a different location based on the resident's preference. The DON stated if the resident preferred to have the call light placed in a different location which was not within reach of the resident, then it would have been discussed with the resident and included in the resident's care plan. The DON stated Resident 5's care plan would indicate the resident's preference where to place the call light. b. A review of Resident 27's Admission Record indicated Resident 27 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of psychosis (a mental disorder characterized by a disconnection from reality), dementia (progressive brain disorder that slowly destroys memory and thinking skills) with psychotic (mental health disorder which a person loses touch with reality) disturbance, schizophrenia, and difficulty in walking. A review of Resident 27's H&P, dated 2/29/2024, indicated Resident 27 did not have the capacity to understand and make decisions. A review of Resident 27's MDS, dated [DATE], indicated Resident 27's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 27 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower/bath self, upper and lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair, toilet transfer, and walk ten feet (once standing). The MDS also indicated Resident 27 had a fall in the last two to six months. A review of Resident 27's Care Plan, dated 3/3/2024, indicated Resident 27 was at risk for falls related to confusion, gait (a manner of walking or moving on foot)/balance problems, psychoactive (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) drug use. Staff interventions included were to ensure the resident's call light was within reach, encourage the resident to use the call light for assistance as needed, a safe environment with floors free from spills and/or clutter, a working and reachable call light, and personal items within reach. A review of Resident 27's Care Plan, dated 3/4/2024, indicated Resident 27 was at risk for impaired mobility, activity of daily living (ADL) decline due to medical conditions Alzheimer's Dementia (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks), Osteoarthritis (the cartilage within a joint begin to break down and the underlying bone begins to change causing reduced function and disability) of left and right shoulder and knees; and needed substantial/maximal assist (helper does more than half the effort) with ADLs. Staff interventions included were to keep call light within reach at all times, assist with ambulation and transfer, and encourage to use assistive devices as needed. During an observation on 3/26/2024 at 9:07 AM in Resident 27's room, Resident 27 was lying in bed. Resident 27's call light cord was wrapped and hanging on the wall located above his bed frame. During a concurrent observation and interview on 3/26/2024 at 9:16 AM in Resident 27's room with CNA 1, CNA 1 stated the call light was hanging on the left side of the wall. CNA 1 stated Resident 27's call light should be placed on the bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2024 at 2:38 PM, the DON stated the resident would not be able to call for help or assistance when the call light was not within reach. During an interview on 3/29/2024 at 10:34 AM with the DON, the DON stated call lights should be left at the reach of the resident. The DON stated call lights may be placed at a different location based on the resident's preference. The DON stated if the resident preferred to have the call light placed in a different location which was not within reach of the resident, then it would have been discussed with the resident and included in the resident's care plan. The DON stated Resident 27's care plan would indicate the resident's preference where to place the call light. 45523 c. A review of the admission record indicated Resident 15 was admitted to the facility on [DATE], with diagnoses that included bilateral primary osteoarthritis of knee (a degenerative joint disease that affects both knees, causing pain, stiffness, swelling, and decreased mobility), unspecified protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), unspecified hearing loss, stiffness of unspecified joint, not elsewhere classified (unable to move one or more joints properly), cellulitis of left lower limb (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin). A review of the MDS, dated [DATE], indicated Resident 15 was severely impaired in cognitive skills for daily decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing. A record review of Resident 15's care plan initiated on 6/17/2024 and revised on 3/27/2024 indicated Resident 15 was at risk for falls, injuries due to Alzheimer's disease .immobility. The care plan interventions indicated, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Maintain call light within reach and answer promptly. During an observation on 3/26/2024 at 8:52 AM, Resident 15 was in bed in a crouch position in the lower part of the bed (near the foot board) with legs up. Resident 15's call light was inside the nightstands drawer away from Resident 15's reach. During interview with CNA 1 on 3/26/2024 at 8:57 AM, CNA 1 stated Resident 15's call light was inside the nightstands drawer and is out of the residents' reach. During an interview with Registered Nurse 1 (RN 1) on 3/27/2024 at 8:40 AM, RN 1 stated the call light should not be inside the nightstands drawer. RN 1 stated, the call light should be clipped to the resident's bedside closer to the pillow or linen to be always within the resident's reach. RN 1 also stated, It would be dangerous for a resident not to have the call light within reach, the resident could have an accident or fall. During an interview with the DON on 3/28/2024 at 2:51 PM, the DON stated, The resident's call light should always be within reach. It is not appropriate for the call light to be inside a drawer. The resident cannot call for help or assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Communication-Call System, revised 1/1/2012, indicated, To provide a mechanism for residents to promptly communicate with Nursing Staff. The policy also indicated call cords (call light) will be placed within the resident's reach in the resident's room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) related to eating was accurately documented to reflect the resident's ability to eat for one of one sampled resident (Resident 6) for the resident assessment care area. This deficient practice had the potential to negatively affect Resident 6's plan of care and delivery of necessary care and services. Findings: A review of Resident 6's Admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included anorexia (lack of loss of appetite for food), legal blindness, and unspecified hearing loss. A review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/7/2024, indicated Resident 6 was assessed having severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making and required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with upper and lower body dressing, personal hygiene, toileting hygiene, and eating. During an observation in Resident 6's room on 3/26/2024, at 12:41 PM, Resident 6 was observed eating lunch inside her room by herself. During an interview with Certified Nursing Assistant (CNA 6), on 3/28/2024, at 12:45 PM, CNA 6 stated Resident 6 was blind and hard of hearing. CNA 6 stated she assists Resident 6's for her meals by making her sit up on the bed and telling Resident 6 what her food is and where the food is placed on her plate. CNA 6 often needs encouragement to eat. CNA 6 stated Resident 6 smells and touches her food so she knows what she is eating. CNA 6 stated Resident 6 was able to eat by herself. During an interview with the Infection Control Nurse (IPN 2), on 3/28/2024, at 1:45 PM, the IPN 2 stated Resident 6 was able to feed herself and move her upper extremities. During a concurrent interview with the Minimum Data Set Coordinator (MDSC) and record review of Resident 6's MDSC, on 3/28/2024, at 2:22 PM, the MDSC stated Resident 6's eating ability in the MDS was based on the weekly notes of the licensed nurses, interview and documents from the certified nursing assistants, and the assessment of the MDSC. MDSC stated Resident 6's MDS, dated [DATE], indicated Resident 6 needed substantial/maximal assistance for eating because she was blind. MDSC stated Resident 6's eating assessment should be set-up or clean up assistance if she was able to sit up on her own during meals and only needed to be informed where her food was on the plate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview with MDSC on 3/28/2024, at 2:22 PM, MDSC stated the MDS needs to reflect the correct level of acuity (the measure of a resident's severity of illness or medical condition) of the resident. MDSC stated the MDS entry under eating was based on the assessment of the charge nurse. MDSC stated he does not remember if he assessed Resident 6's eating ability during the look back period (the time period over which the resident's condition or is captured by the MDS assessment). A review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument (RAI, assessment tool that helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) Process, revised on 10/4/2016, indicated that the purpose of the policy was to provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and date submission requirements.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure the preadmission screening assessment (PASRR - Preadmission Screening and Resident Review - a federal requirement to ensure that every person entering a Medicaid Certified Nursing Facility [NF] receive a Level I screening and if necessary a Level II evaluation to ensure that their NF residence is appropriate and to identity what specialized services they may need) form was accurately completed for a resident who had a mental illness for one of three sampled residents (Resident 24) for PASRR care area. This deficient practice led to the resident not receiving the necessary and appropriate psychiatric level of treatment and evaluation in the facility. Findings: A review of the Resident 24's Admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). A review of Resident 24's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 3/1/2024, indicated Resident 24 was intermittently able to understand and make decisions. Resident 24's mental status was confused. Resident 24 was not oriented to time, place, and person. A review of the Minimum Data Set (MDS, an assessment and care screening tool) dated 3/12/2024, indicated Resident 24's cognitive (mental action or process of acquiring knowledge and understanding) patterns were severely impaired. Resident 24 required substantial/maximal assist (helper does more than half the effort) for shower/bathe self and putting on/taking off footwear. Resident 24 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene and personal hygiene (the ability to maintain hygiene including combing hair, shaving, washing/drying face and hands). The MDS also indicated Resident 24 had a psychiatric (relating to mental illness or its treatment)/mood disorder and was taking antipsychotic drugs (the main class of drugs used to treat people with schizophrenia). A review of Resident 24's PASRR Level I Screening document, dated 8/31/2023, indicated the PASRR Level I was negative. Section three of the PASRR indicated Resident 24 did not have a serious diagnosed mental disorder such as depressive disorder (low mood or loss of pleasure or interest in activities for long periods of time), anxiety disorder (persistent and excessive worry that interferes with daily activities), panic disorder, Schizophrenia/Schizoaffective (a mental illness that causes loss of contact with reality) disorder, or symptoms of psychosis (a mental disorder characterized by a disconnection from reality), delusions (believed to be true or real but is actually false or unreal), and/or mood disturbance. Section three also indicated Resident 24 was not prescribed psychotropic medications (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) for mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 24's PASRR Level I Screening document, dated 1/29/2024, indicated the PASRR Level I was negative. Section three of the PASRR indicated Resident 24 was did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, Schizophrenia/Schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. Section three also indicated Resident 24 was not prescribed psychotropic medications for mental illness. A review of Resident 24's Care Plan, dated 1/29/2024, indicated resident with diagnosis of paranoid Schizophrenia (characterized by predominately positive symptoms of schizophrenia including delusions and hallucinations) manifested by extreme paranoid hallucination interfering with activity of daily living (ADL) causing fear and inability to process internal stimuli causing stress and anger. Staff interventions were to give medication at bedtime for Schizophrenia, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, monitor behavior episodes, and attempt to determine underlying cause. During an interview on 3/29/2024 at 7:38 AM with the Admission Coordinator (AC), AC stated he was in charge of completing the PASSR. AC stated the facility was responsible for submitting the PASRR when a resident was readmitted to the facility. AC stated the resident's clinical records were reviewed for mental illness and medications and were inputted into the PASRR. AC stated it was important to review and input the resident's mental illness when completing the PASRR. AC stated if the PASRR was filled out incorrectly the resident would not get the recommendations needed for their plan of care. During the same concurrent interview with AC on 3/29/2024 at 7:38 AM and record review of the PASRR placed in Resident 24's chart, indicated the latest PASARR was completed on 8/31/2023. AC stated Resident 24 was readmitted to the facility. AC stated Resident 24 was negative for the Level I screening. AC reviewed section III indicating Resident 24 had no mental disorder and no psychotropic medications for mental illness. AC stated Resident 24 did not have any mental conditions. During the same concurrent interview with AC on 3/29/2024 at 7:38 AM and record review of Resident 24's Admission Record, indicated Resident 24 had a diagnosis of Schizophrenia. A concurrent record review via the PASRR website with the AC indicated there was an updated PASRR dated 1/29/2024. The PASRR dated 1/29/2024 did not indicate Resident 24's mental illness (Schizophrenia) and psychotropic medication. A record review of Resident 24's medical record with AC, the AC was not able to determine when Resident 24 was diagnosed with Schizophrenia and when he started the psychotropic medication. During a concurrent interview and record review of Resident 24's medical record on 3/29/2024 at 8:12 AM with the Minimum Data Set Coordinator (MDSC), MDSC stated Resident 24 was first admitted on [DATE] with the diagnosis of schizophrenia and was taking psychotropic medication. MDSC stated Resident 24 was readmitted from the acute hospital on 1/29/2024 and a PASSR was completed on 1/29/2024. MDSC stated Resident 24 had the diagnosis of schizophrenia and was taking psychotropic medication during this time (1/29/2024). MDSC stated the MDSC, AC, and licensed nurses were responsible for verifying the PASRR was completed accurately within seven days. MDSC stated another PASRR should had been submitted within the seven days since the PASRR done on 1/29/2024 was not correct since it indicated Resident 24 did not have mental disorder. MDSC stated it was important to submit an accurate PASRR in order to implement the recommendations made on the PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated PASRR needed to be completed accurately to determine the appropriate care needed and the correct placement for the resident. The DON stated the acute hospital would initiate the PASRR and the facility would follow up. The DON stated the PASRR should be reviewed for accuracy with seven days. A review of the facility's policy and procedure titled, Admission Screening Resident Review (PASRR), revised 9/1/2023, indicated the facility staff will ensure that a PASRR Level I is completed for each resident prior to admission. The facility staff will complete a new PASRR upon readmission from the acute hospital if there has been a significant change in the resident's condition. A copy of the PASRR will be printed and placed in the resident's medical record.

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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** 46919 Based on interview and record review the facility failed to review and revise the care plan for one of 13 sampled residents (Resident 11) who has a history of seizures (epilepsy- abnormal electrical activity in the brain that happens quickly). This deficient practice had the potential to negatively affect the provision of care and services for Resident 11. Findings: A review of Resident 11's Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover and protect it), paroxysmal atrial fibrillation (irregular heartbeat), and epilepsy. A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/10/2024, indicated Resident 11 was assessed having moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making and required substantial/maximal assistance (helper does more than half the effort) with eating, personal hygiene, upper/lower body dressing, and toileting hygiene. A review of Resident 11's Order Summary Report, dated 3/26/2024, indicated a physician order for the following medications for seizures: 1. Depakote Oral (Divalproex Sodium, medication for seizure) Tablet Delayed Release 125 mg (milligram-unit of measurement) give 1 mg by mouth two times a day for seizure disorder with a start date of 2/15/2024. 2. Levetiracetam Oral (medication for seizure) Solution 100 mg/ml (milliliter- unit of measurement) give 5 ml by mouth every 12 hours for seizure disorder with a start date of 12/26/2023. 3. Vimpat Oral Tablet 100 mg (Lacosamide, medication for seizure) give 1 tablet by mouth two times a day for seizure activity with a start date of 12/24/2023. During a concurrent interview and record review of Resident 11's care plan for seizures, with Registered Nurse Supervisor 1 (RNS 1), on 3/28/2024, at 9:20 AM, RNS 1 stated Resident 11 had a history of seizures. RNS 1 stated Resident 11's Dilantin (medication for seizure) was discontinued on 2/15/24 and currently taking Depakote, Levetiracetam, and Vimpat for her seizures. RNS 1 stated Resident 11's care plan did not reflect all of Resident 11's seizure medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview with RNS 1 on 3/28/2024 at 9:20 AM, RNS 1 stated Resident 11's care plan should be revised to reflect all of Resident 11's current seizure medications. RNS 1 stated it is important for the care plan to be revised and updated because licensed staff follow the interventions indicated on the care plan for seizures. RNS 1 stated all licensed staff are responsible in revising the care plan. During an interview with the Director of Nursing (DON), on 3/29/2024, at 1:52 PM, the DON stated all licensed staff are responsible for revising and updating the care plan. The DON stated Resident 11's medication should have been revised and corrected when Resident 11's Dilantin was discontinued. The DON stated it is important for care plans to be revised so staff know what the interventions are needed to care for the residents. A review of the facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Planning, effective on 9/7/2023, indicated: 1. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. 2. The comprehensive care plan will be periodically reviewed and revised by Interdisciplinary Team (IDT- a group of healthcare professionals who work together to help residents receive the care they need) after each assessment which means after each MDS assessment as required, except discharge assessments. In addition, the comprehensive care plan will also be reviewed and revised at the following times: a. Onset of new problems. b. Change of condition. c. Other times as appropriate or necessary. d. Appropriate or necessary.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview and record review, the facility failed to provide the necessary care and services to ensure the resident's abilities in activities of daily living (ADLs) for two of two sampled residents (Resident 15 and 29) of advance daily living (ADLs) care area. 1. Facility failed to ensure Resident 15 was provided communication device with the resident's primary language and failed to ensure Resident 15 with limited range of motion (ROM - movement of the joints) receive appropriate positioning in bed. 2. Facility failed to ensure Resident 29 was provided a communication device (a visual aid with symbols, pictures, or words that users can point to or select to express their thoughts and needs) with the language that the resident was able to understand. This deficient practice prevented the resident from communicating with the staff and had a potential to delay receiving appropriate care/treatment the resident needed. Findings: 1. A review of the admission record indicated Resident 15 was admitted to the facility on [DATE], with diagnoses that included bilateral primary osteoarthritis of knee (a degenerative joint disease that affects both knees, causing pain, stiffness, swelling, and decreased mobility), unspecified protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and unspecified hearing loss, stiffness of unspecified joint, not elsewhere classified (unable to move one or more joints properly). A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 3/15/2024, indicated Resident 15 was severely impaired in cognitive skills (ability to understand and make decision) for daily decision making, and needed total assistance from the staff for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing. A record review of Resident 15's care plan initiated on 6/17/2021, indicated the resident has an ADL self-care performance deficit r/t confusion, dementia, impaired balance, limited mobility, bilateral primary osteoarthritis of knee. Interventions indicated to maintain safe and hazard free environment. A record review of Resident 15's care plan revised on 3/11/2024, indicated the resident has communication problem related to (r/t) language barrier. The goal indicted, the resident will maintain current level of communication function by .using communication board. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan indicated the following interventions: a. To use alternative communication tools as needed. b. Resident prefers to communicate in Language 1. c. Resident requires (translate from staff or online translator assistance) with communication. During an observation in Resident 15's room on 3/26/2024 at 8:52 AM, Resident 15 was in bed, awake, there was no communication board in the resident's room. Observed Resident 15's head of bed was at approximately 90 degrees; Resident 15 was very low in bed in a crouch position with legs up. During an interview with Certified Nurse Assistant 1 (CNA 1) on 3/26/2024 at 8:57 AM, CNA 1 stated Resident 15 was too low in bed and did not look comfortable. CNA 1 stated, he is too low, he should be more up, sometimes he slides down, he does not look comfortable. The head of the bed should be lower. The head of the bed looks to be at about 90 degrees, it is all the way up, it should be at 45 degrees so he would not slide down. During the same interview with CNA 1 on 3/26/2024 at 8:57 AM, CNA 1 stated there was no communication or picture board at Resident 15's bedside to be able to communicate to staff. During an interview with the Director of Nursing (DON) on 3/28/2024 at 2:51 PM, the DON stated, Resident 15 has been here for a very long time. He does not like to be repositioned; he does not like to be moved. If I was as old as Resident 15, I would not want to be bothered either, but there should be more frequent visual checks to make sure Resident 15 is positioned correctly in bed. A review of the facility's Policy titled Position and Body Alignment, revised 1/1/2012, indicated, to improve or maintain the resident's self-performance in moving to and from a laying position, turning side to side, and positioning while in bed. IV. Position resident to maintain comfort and redistribute pressure. VII. When changing resident's positions: F. Avoid excess stress on contractures (a fixed tightening or shortening of muscles, tendons, ligaments, or skin that affect joint mobility). G. Semi-Fowler's Position (a position in which an individual lies on their back on a bed, with the head of the bed elevated between 30-45 degrees, and the legs of the patient can be either straight or bent at the knees). ii. Prevent resident from sliding to foot of bed by raisin knees slightly, using frame of bed or a pillow. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of the admission record indicated Resident 29 was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly] or a kidney [a pair of small organs in the body that take away waste matter from the blood] transplant to maintain life), paroxysmal atrial fibrillation (a type of irregular heartbeat), and cardiomegaly (enlargement of the heart). A review or Resident 29's History and Physical dated 7/13/2023 indicated Resident 29 has the capacity to understand and make decisions. A review of the MDS dated [DATE], indicated Resident 29 was independent for the activities of daily living such as eating, oral and toilet hygiene, shower, and dressing. A record review of Resident 29's care plan initiated on 1/5/2024 and revised on 2/20/2024, indicated the resident has communication problem r/t language barrier. The goal indicted, the resident will maintain current level of communication function by .using communication board. The care plan indicated the following interventions: a. To use alternative communication tools as needed. b. Resident prefers to communicate in Language 1. c. Resident requires (translate from staff or online translator assistance) with communication. During an observation in Resident 29's room on 3/26/2024 at 9:34 AM, Resident 29 was resting in bed and greeted surveyor in Language 1. There was no communication board at bedside. During an interview with Registered Nurse 1 (RN1) on 3/27/2024 at 8:40 AM, RN1 stated, for Language 1 speaking residents the staff use CNAs or a housekeeper to translate. RN1 stated, we also use communication boards, we provide them for the residents. We use translation from other staff, it they are busy we should use the communication board at bedside., if it pertains to nursing information or medical terms, we should not use the housekeeper to translate that. During an interview with the Director of Nursing (DON) on 3/28/2024 at 2:51 PM, the DON stated, Resident 15 is Language 1 speaking and hard of hearing. Most of the time we assign stated, Resident 15 and Resident 29 did not have communication boards at bedside. During an interview with Resident 29 on 3/29/2024 at 8:54 AM, Resident 29 stated that some of the staff did communicate with Resident 29 in Language 1 but others would speak to her in English. Resident 29 stated in Language 1, I understand a few words in English, but I have asked them since I was admitted I would prefer to speak in Language 1, that way I would understand what they are telling me. Resident 29 stated she had not been provided with a communication board since admitted in the facility and the nurses that spoke to her in a different language were nice but most of the time, she did not understand what they were saying and could not hold a full conversation with them. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy titled Accommodation of Residents' Communication Needs Operations Manual-Social Services, revised March 2017, indicated, The Facility provides assistance to residents with communication challenges through a number of adaptive services. VI. The following are examples of adaptive devices the staff may provide the resident: B. Communication Boards/Charts

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 16 and 36) were provided with a safe environment to prevent avoidable accidents and hazards for accidents care area. This deficient practice had the potential to place the residents at risk for falls, injuries, and delayed care. Findings: 1. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD- disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening in airway function and respiratory symptoms), dependence on supplemental oxygen, anxiety disorder (persistent and excessive worry that interferes with daily activities), and difficulty in walking. A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident) dated 3/26/2024, indicated Resident 16 had the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 2/11/2024, indicated Resident 16's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were cognitively intact. The MDS indicated Resident 16 was dependent (helper does all the effort and resident does none of the effort to complete the acidity or the assistance of two or more helpers are required) for sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bath self, lower body dressing, putting on/taking off footwear, roll left and right, and toilet transfer. The MDS indicated Resident 16's ability to walk ten feet and ability to sit to stand were not attempted due to medical condition or safety concerns. The MDS also indicated Resident 16 was taking high-risk drugs: antianxiety (treat symptoms of anxiety), antidepressant (treat depression), antibiotic (treat bacterial infections), opioid (treat persistent or severe pain), and antiplatelet (prevent blood clots) medications. A review of Resident 16's Care Plan, dated 1/14/2023 indicated Resident 16 uses antianxiety medications related to anxiety disorder. Staff interventions were to monitor the resident for safety. Resident 16's antianxiety medication was associated with an increased risk of confusion, amnesia (a partial or total loss of memory), loss of balance, and cognitive impairment that looks like dementia (progressive brain disorder that slowly destroys memory and thinking skills) and increases the risk of falls, broken hips, and legs. Adverse reactions to antianxiety therapy included drowsiness, clumsiness, slow reflexes, confusion and disorientation, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, and blurred or double vision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's Fall Care Plan, dated 2/3/2024, indicated Resident 16 was at risk for falls due to the following diagnosis anxiety (on Xanax, [medication used to treat anxiety disorders and panic disorders]), pain (on gabapentin, medication used to treat partial seizures [sudden bust of electrical movement in the brain which causes changes in behavior, movements and consciousness] and neuropathic [nerve damage leads to pain, weakness, numbness, or tingling in one or more parts to the body] pain) and Norco [(medication used to relieve moderate to severe pain)] - which cause dizziness), and depression (on Remeron [medication used to treat depression]). Staff interventions were to anticipate the resident's needs, be sure the resident's call light was within reach, and monitor/intervene for factors causing falls. A review of Resident 16's Altered Mood State Care Plan, dated 2/3/2024, indicated depression manifested by verbalization of sadness. Staff interventions were to monitor/document/report adverse reactions to antidepressant therapy: gait (a manner of walking or moving on foot) changes, rigid (stiff) muscles, balance problems, movement problems, tremors (shaking or trembling movements), muscle cramps, falls, and dizziness. A review of Resident 16's Care Plan, dated 2/3/2024, indicated Resident 16 has a decreased ability to perform self-care related to impaired activity tolerance, imbalance/safety, impaired coordination, and weakness. Staff interventions were to provide functional mobility training (rehabilitation techniques), graded functional activities (increasing or decreasing the difficulty of the activity provided), and occupational therapy treatment as indicated. A review of Resident 16's Care Plan, dated 2/5/2024, indicated Resident 16 uses antidepressant medication Remeron related to depression manifested by feelings of sadness. Staff interventions were to monitor adverse reactions to antidepressant therapy such as hallucinations/delusions, suicidal thoughts, decline in activities of daily living ability, gait changes, rigid muscles, balance problems, movement problems, muscle cramps, falls, and dizziness/vertigo (feeling of spinning, even when not moving). A review of Resident 16's Care Plan, dated 3/26/2024, indicated Resident 16 presented with tendency to lose balance during transfers and ambulation related to decreased motor planning (ability to organize the body's actions), decreased safety awareness, increased loss of balance, and leg weakness. Staff interventions were to provide physical therapy orders daily three times a week for four weeks, gait training, and group therapy. A review of Resident 16's Fall Risk Evaluation, dated 3/25/2024, indicated Resident 16 was at high risk for falls. During an observation on 3/26/2024 at 8:40 AM in Resident 16's room, Resident 16 was sleeping with a nasal canula (NC - device used to deliver supplemental oxygen placed directly on a resident's nostril) infusing oxygen at 2 liters per minute (LPM - volume of oxygen supplied over a period of time). Resident 16's right side of the bed was against the wall. On the left side of Resident 16's bed was a nightstand, 2 cabinets each with four drawers, a black stand, a trash can, an oxygen concentrator (a medical device that gives extra oxygen), and a bedside table. All the items on the left side of the bed were parallel and equivalent to the length of the bed. At the foot of Resident 16's bed was his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/29/2024 at 8:37 AM of Resident 16's room with the Infection Prevention Nurse 2 (IPN 2), IPN 2 stated there were 3 nightstands, an oxygen concentrator, a trash can, and a bedside table placed parallel on the left side of the resident's bed. IPN 2 stated Resident 16's room had a lot of clutter. IPN 2 stated it was not safe for Resident 16 to have all the items next to the resident's bed. IPN 2 stated there was too much stuff on the floor. IPN 2 also stated Resident 16's wheelchair was at the foot of the bed. IPN 2 stated in an emergency situation, all the stuff on the left side of bed needed to be moved out before we can bring the wheelchair closer to the resident to be able to assist him with transfer and evacuate. IPN 2 stated the clutter would cause a delay to access Resident 16. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated Resident 16's room was tight. The DON stated it was Resident 16's preference for all the items to be placed next to his bed and she did not think Resident 16 was at risk for falls. The DON stated Resident 16's room was not free of accident hazards with all the items next to his bed. The DON stated Resident 16 was able to walk around in short distances and the resident's room arrangement was not an ideal environment for the resident. The DON stated staff would take longer to reach Resident 16 in case of an emergency because of all the clutter next to the resident's bed. During the same interview and a concurrent record review of the facility's room measurements with the DON on 3/29/2024 at 10:34 AM, the DON stated Resident 16's room was one room that required a room waiver (a document recording the waiving of a right or claim). The DON stated Resident 16's room was less than the required 80 square feet (sq ft - unit of measurement) per resident. The DON stated Resident 16 was high risk for fall according to the fall risk evaluation and the resident was taking medications which put him at risk for falls. The DON also stated Resident 16 had anxiety attacks which could place him at risk for falls and injury. The DON stated if Resident 16 had an emergency, staff would be slowed down in reaching the resident and providing him with the needed care due to the items placed next to the resident's bed. A review of the facility's policy and procedure titled, Resident Safety, reviewed 1/2024, indicated residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. 45523 2. A review of the admission record indicated Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included unspecified atrial fibrillation (an irregular heart rhythm), acute respiratory failure with hypoxia (a condition where the body doesn't have enough oxygen in the tissues), morbid obesity (weight more than 80 to 100 pounds above the ideal body weight), dysphagia, and oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). A review of the History and Physical report completed on 2/7/2027, indicated Resident 36 did have the capacity to understand and make decisions. A review of Resident 1's MDS, dated [DATE], indicated the resident needed maximal assistance from the staff for the activities of daily living and was dependent for toileting hygiene, showers, and dressing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 36's care plan initiated 2/5/2024 and revised on 3/27/2024, indicated the resident has an activities of daily living (ADL) self-care performance deficit with an overhead trapeze (a triangle-shaped metal bar. It hangs from a metal frame, which is attached to the headboard and footboard of the bed) on bed to help increase bed mobility. The care plan indicated interventions which include encourage the resident to use bell to call for assistance and to encourage the resident to participate to the fullest extent possible with each interaction. During an observation on 3/26/2024 at 9:17 AM, Resident 36 was sitting up in bed watching television (TV). Overhead trapeze hanging next to resident's head had multiple cords hanging from it. The call light, bed remote were some of the cords that were hanging from the overhead trapeze. During an interview with Registered Nurse (RN) 1 on 3/28/2024 at 7:31 AM, RN 1 stated, the resident has a trapeze overhead. She attaches the call light up on the trapeze. She can reach the cords, the bed remote and the call light. That is not the practice of the facility of have the wires up with the trapeze, the resident can hurt herself and possibly also hurt her head. She has periods of confusion, and she could get tangled and that can cause an accident. During concurrent observation on 3/28/2024 at 7:54 AM, Resident 36 was sitting up in bed eating breakfast. The metal overhead trapeze was hanging above the resident's bed, hanging next to resident left side making contact and slightly hitting Resident 36's face. Resident 36 stated, it is hitting the side of my face, unfortunately I have no choice. I have the wires there because I cannot reach the remote for the bed or call light most of the time. During a concurrent observation and interview with Certified Nurse Assistant (CNA) 1 on 3/28/2024 at 7:59 AM, CNA1 stated the metal overhead trapeze was making contact with Resident 36's face and head. CNA1 stated, The trapeze can hurt her if it hits her face or head. I cannot remove it; I would have to call maintenance. The trapeze is heavy and it can cause an accident. During an interview with Director of Nursing (DON) on 3/28/2024 at 2:59 PM, the DON stated, Resident 36 loves to put the call light up there and the resident is fluctuating with being alert and confused at times. The DON also stated, the trapeze might be metal or made out of iron. I would say she could get injured if it makes contact with her face or head. A review of the facility's policy and procedure, Resident Rights-Accommodation of Needs, revised 1/1/2012, indicated, to ensure that the facility provides an environment and services that meet residents' individual needs. The policy also indicated Residents' individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. A review of the facility's policy and procedure titled, Resident Rooms and Environment, reviewed 1/2024, indicated the facility will provide residents with a safe, clean, comfortable, and homelike environment. The facility staff will aim to create a personalized, homelike atmosphere, paying close attention to the cleanliness and order.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one (1) of 1 sampled resident (Resident 16) for respiratory care area by failing to: 1. Ensure Resident 16's nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril) tubing was changed per facility's policy. This deficient practice had the potential for Resident 16 to develop a respiratory infection. 2. Place visible oxygen signage by Resident 16's door/wall prior to entering the room. This deficient practice had the potential for harm to Resident 16 and other residents, in an event of a fire. Findings: A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening in airway function and respiratory symptoms), dependence on supplemental oxygen, anxiety disorder (persistent and excessive worry that interferes with daily activities), and acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (lack of oxygen in the tissues to sustain bodily function). A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 3/26/2024, indicated Resident 16 had the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/11/2024, indicated Resident 16's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were cognitively intact. The MDS indicated Resident 16 was dependent (helper does all the effort and resident does none of the effort to complete the acidity or the assistance of two or more helpers are required) for sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bath self, lower body dressing, putting on/taking off footwear, roll left and right, and toilet transfer. The MDS indicated Resident 16's ability to walk ten feet and ability to sit to stand were not attempted due to medical condition or safety concerns. The MDS also indicated Resident 16 was on continuous oxygen therapy. A review of Resident 16's Care Plan, dated 2/3/2024, indicated Resident 16 was at risk for ineffective airway clearance potential for shortness of breath associated with COPD. Staff interventions included were to administer oxygen two (2) to three (3) liters per minute (LPM, volume of oxygen supplied over a period of time) via NC continuously via concentrator (a medical device that gives extra oxygen) for comfort, change oxygen tubing weekly and as needed every Monday, and encourage sustained deep breaths. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 16's Physician Order Summary Report, dated 3/25/2024, indicated to: a. Administer oxygen 2 to 3 LPM via NC continuously via concentrator for comfort. b. Change oxygen tubing weekly and as needed every Monday. During an observation on 3/26/2024 at 8:40 AM in Resident 16's room, Resident 16 was sleeping with a nasal canula infusing oxygen at 2 LPM. Resident 16's NC tubing was dated 3/18/2024 (tubing used for eight days). There was no visible oxygen in use signage on Resident 16's door or wall. During a concurrent observation and interview on 3/26/2024 at 10:27 AM in Resident 16's room with Restorative Nursing Assistant 2 (RNA 2), RNA 2 stated Resident 16 was receiving oxygen. RNA 2 stated the NC tubing label was dated 3/18/2024. During a concurrent observation and interview on 3/26/2024 at 10:43 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 16 received 2 to 3 LPM of oxygen. LVN 2 stated Resident 16's NC tubing was labeled and dated 3/18/2024. During a concurrent observation and interview on 3/26/2024 at 12:09 PM outside Resident 16's door, RNA 2 placed an oxygen signage. RNA 2 stated there was no oxygen signage indicated Resident 16 was using oxygen. During an interview on 3/29/2024 at 8:29 AM with the Infection Prevention Nurse 2 (IPN 2), IPN 2 stated the oxygen tubing should be labeled and changed weekly. IPN 2 stated the oxygen tubing used longer than a week could cause the resident to develop an infection since the tubing could accumulate a lot of bacteria with continued use. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated oxygen tubing should be labeled to know when the tubing was changed. The DON stated oxygen tubing should be changed weekly. The DON stated oxygen tubing should not be used longer than one week (seven days) to prevent harboring of bacteria. The DON stated harboring of bacteria could lead to the resident developing an infection. The DON also stated when residents were using oxygen, an oxygen label was supposed to be placed outside the door to allow everyone to know oxygen was in use. A review of the facility's Policy and Procedure titled, Oxygen Therapy, revised 11/2017, indicated No Smoking signs will be prominently displayed wherever oxygen is being stored or administered. Oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. The supplies will be dated each time they are changed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 45523 Based on observation, interview, and record review, the facility failed to follow its policy to post the nurse staffing information hours at the start of each shift. On 3/26/2024, the facility did not post the nurse staffing information for the current date and did not indicate the total number of projected hours and the actual hours of licensed and unlicensed nursing staff directly responsible for resident care per shift. This deficient practice had the potential to inaccurately reflect the actual nurses providing direct care to the residents. Findings: During a general observation at the nurse's station and interview on 3/26/2024 at 9:19 AM, Director of Staff Development (DSD) stated the Nurse Staffing Information posted was not updated, and last date the Nurse Staffing Information document posted was 3/24/26. DSD further stated, today's date is 3/26/2024. During a follow up interview, on 3/27/2024 at 2:20 PM, the DSD stated she was not quite sure of what the Nurse Staffing Information sheets format was required to post. DSD stated, the staffing sheet was created by the previous DSD. I made copies and just update it daily. I was just using that one. It was what I was handed from the previous DSD. DSD also stated the Nursing staffing information sheet that is being used and posted was not for the current date and did not indicate whether the numbers in the column was the projected nursing hours or the actual nursing hours. A review of the facility's policy and procedure titled, Nursing Department-Staffing, Scheduling & Postings, reviewed January 2024, indicated Nurse Staffing Postings: A. The Facility will post the following information on a daily basis: i. Facility name ii. The current date iii. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. B. The Facility will post the nurse staffing data specified above, on daily basis at the beginning of each shift

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure one (1) of six (6) sampled residents (Resident 40) receive all medications in accordance with the physician's order and facility's policy and procedure (P&P) when Resident 40 was observed in possession of three (3) clear red capsules on 3/28/2024. This deficient practice had the potential for Resident 40 to have an overdose of the medication, which could result in harm. Findings: A review of Resident 40's Admission Record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting the left non-dominant side, degenerative disease of the nervous system (chronic condition that damage and destroy parts of the nervous system over time especially the brain), noninfective (not caused by an infection) gastroenteritis (inflammation of the lining of the stomach and intestines) and colitis (inflammation of the large intestine), and Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). A review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/15/2024, indicated Resident 40's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 40 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, shower/bath self, upper and lower body dressing, putting on/taking off footwear, personal hygiene (ability to maintain personal hygiene including combing hair, shaving, washing/drying face and hands), roll left and right, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and walk ten feet. A review of the Physician Order Summary Report, dated 1/22/2024, indicated to give 1 capsule of docusate sodium (Colace, a stool softener that makes bowel movements softer and easier to pass, relieving constipation) by mouth two times a day for constipation, hold for loose stool. A review of Resident 40's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of March 2024, indicated Resident 40 was administered all 56 doses of docusate sodium from 3/1/2024 to 3/27/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass observation on 3/28/2024 at 8:28 AM in Resident 40's room with the Infection Prevention Nurse 2 (IPN 2), IPN 2 handed Resident 40's four medications (including 1 capsule of Colace) in a medication cup to Resident 40. Resident 40 took all the medications except the Colace capsule. Resident 40 took out a small clear zip lock bag from his bag on the bed which contained three (3) clear red capsules and took the Colace from the medication cup and placed the Colace into the zip lock bag along with the other 3 capsules. Resident 40 stated, I already took the pill this morning. During a concurrent interview on 3/28/2024 at 8:28 AM with IPN 2, IPN 2 stated Resident 40 had 3 Colace capsules with him. IPN 2 stated Resident 40 informed him he was hiding the Colace capsules. IPN 2 stated the 3 red and clear capsules in the possession of Resident 40 were Colace capsules. IPN 2 stated the capsules in Resident 40's possession were compared and verified when IPN 2 inspected the Colace bottle, and verified that they were Colace capsules that he was going to administer to Resident 40. During an interview on 3/28/2024 at 9:59 AM in Resident 40's room, Resident 40 stated, I don't want to take too much, so I hid the pill. Resident 40 stated the nurses gave him the pill and he did not want to have diarrhea, so he kept the pills. Resident 40 stated, This morning, I used the pill I saved and took it, that's why I didn't want the one from earlier. Resident 40 stated when the nurses gave him the medications in the cup, he waited for the nurses to leave. Resident 40 stated, he took out the pill from the medication cup and hid it once the nurses left. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated when any Licensed Vocational Nurse (LVN), brings the residents the medication(s), the LVN, needed to observe the residents take the medication(s). The DON stated the LVN should make sure the residents were taking all the medications that they needed to take. The DON stated when the LVN does not witness the residents taking the medication(s) given, it could lead to double dosing, missed medications, and could cause adverse reactions to the residents. A review of the facility's P&P titled, Medication Administration, revised 1/1/2012, indicated medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. Medications must be given to the resident by the Licensed Nurse preparing the medication. The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to ensure the storage, preparation and distribution of food was done under sanitary conditions for fifty-two (52) residents of the facility by: 1. Facility failed to ensure that conventional oven temperature knob indicates the temperature setting. 2. Facility failed to ensure that food items inside kitchen produce refrigerator and dry storage were labeled with a received date and/ or expiration date, and expired food items were discarded and not mixed with other non-expired foods. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: 1. During observation and interview with the Dietary Staff Supervisor (DSS) and Cook on [DATE] at 8:31 AM, in the kitchen, DSS stated, we do not know the temperature of the oven, the knob has no settings printed on there. It was difficult to guess, maybe the food does not heat or cook properly and that can be dangerous for the residents if the food does not cook properly. Cook stated, the stove knobs have no settings (unable to recall since when), sometimes it does not heat accordingly. I have to guess the temperature when I cook. During an interview with Maintenance Supervisor (MS) on [DATE] at 8:55 AM, MS stated, the numbers on the temperature knob are faded. MS stated, the exact temperature is important to cook since it can be an issue, it can be dangerous to not know the exact temperatures when cooking the food for the residents. 2. During concurrent observation of the kitchen produce refrigerator and interview with the DSS on [DATE] at 8:03 AM, DSS stated some of the food items inside the kitchen produce refrigerator were not labeled with date opened or expiration date. DSS further stated today's date was [DATE] and some of the food had passed the use by date. DSS stated the following foods observed in the produce refrigerator were as follows: a. Parmesan cheese with date of best by (use by) [DATE]. b. Whole egg mayonnaise use by [DATE]. c. Premium sweet pickle relish use by [DATE]. d. Liquid whole eggs with citric acid use by [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Cream cheese with open date of [DATE] best by date [DATE]. f. Frozen sausage labeled with used by date of [DATE]. g. Frozen pizza dough and doughnuts not labeled with used by or expiration date. During concurrent observation of the kitchen produce refrigerator and interview with the DSS on [DATE] at 8:07 AM, DSS stated, I go through the produce section when I do inventory, when things go bad, I take them out. I must have missed all the expired food items. During concurrent observation of the dry storage and interview with the DSS on [DATE] at 8:10 AM, DSS stated the black eye peas was not labeled with open date or expiration date. DSS stated, I do not know why the black eye peas are not labeled, all staff must check the food. During the same observation of the shelves above the stove, the following items did not have a label of open date and/ or expiration date: ground black pepper, oregano leaves, domestic paprika and dark chili powder. During a review of the facility's policies and procedures titled Food Storage, reviewed [DATE], indicated, Food items will be stored, thawed, and prepared in accordance with good sanitary practice. All items will be correctly labeled and dated.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to implement its protocol for Antibiotic Stewardship to reduce inappropriate antibiotic (medication used to kill bacteria and to treat infections) use by not administering antibiotic drug if the McGeers (named Infection Screening Evaluation in facility's medical record, surveillance definitions of infections in Long-Term Care Facilities) criteria were not met for two (2) of three (3) sampled residents (Residents 16 and 35) for antibiotic care area. This deficient practice had the potential for the residents to develop antibiotic resistance (when bacteria, viruses, fungi, and parasites no longer respond to antimicrobial medicine and become ineffective making infections difficult or impossible to treat increasing the risk of disease spread, severe illness, disability, and death) and suffer adverse side effects from unnecessary or inappropriate antibiotic use. Findings: 1. A review of Resident 16's Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening in airway function and respiratory symptoms), pneumonia (lung inflammation caused by bacterial or viral infection), sepsis (the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death), and urinary tract infection (UTI, an infection of the bladder and urinary system). A review of Resident 16's History and Physical (H&P, the initial clinical evaluation and examination of the resident) dated 3/26/2024, indicated Resident 16 had the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/11/2024, indicated Resident 16's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were cognitively intact. The MDS indicated Resident 16 was dependent (helper does all the effort and resident does none of the effort to complete the acidity or the assistance of two or more helpers are required) for sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bath self, lower body dressing, putting on/taking off footwear, roll left and right, and toilet transfer. A review of Resident 16's Physician Order Summary Report, dated 3/25/2024, indicated Resident 16 was prescribed Cefepime (an antibiotic used to treat a wide range of bacterial infections) one (1) gram (gm, unit of measurement) intravenous (IV, administered into a vein) every 12 hours for pneumonia for four days to start on 3/26/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's Care Plan, dated 3/26/2024, indicated Resident 16 had diagnosis of pneumonia and was on intravenous antibiotic until 3/30/2024. Staff interventions included were to administer antibiotic as per physician orders, notify the physician of any significant changes, and to monitor temperature/pulse as ordered. A review of Resident 16's Care Plan, dated 3/28/2024, indicated Resident 16 had a potential for adverse side effects from antibiotic therapy used 3/27/2024 to 3/30/2024 due to not meeting McGeers Criteria (named Infection Screening Evaluation in facility's medical record, surveillance definitions of infections in Long-Term Care Facilities) for Cefepime. Staff interventions included were to monitor resident for any adverse side effects, monitor for change in level of consciousness, and inform the physician of any changes in the resident's status. During a concurrent interview and record review on 3/28/2024 at 11:00 AM of Resident 16's Infection Screening Evaluation with the Infection Prevention Nurse 1 (IPN 1), IPN 1 stated the Infection Screening Evaluation was the computer version of the McGeer's Criteria. IPN 1 stated Resident 16's screening score was zero (0). IPN 1 stated a score of 0 was a suspected infection and the physician should be informed. IPN 1 stated score of 1 met the McGeer's Criteria to receive the antibiotic. IPN 1 stated the physician was not notified of Resident 16's Infection Screening Evaluation score of 0. IPN 1 stated the physician should have been notified immediately when the assessment score was 0 and did not meet the criteria to receive the antibiotic. IPN 1 stated the purpose of the Infection Screening Evaluation was to determine if the symptoms the resident was experiencing required the antibiotic. IPN 1 stated Resident 16 should not be given the antibiotic if he did not need the antibiotic. IPN 1 stated when residents were given unnecessary antibiotics, the residents could develop resistance to the antibiotic. 2. A review of Resident 35's Admission Record indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of Extended Spectrum Beta Lactamase (ESBL, enzymes break down and destroy some commonly used antibiotics) resistance, open wound of unspecified external genital organs male (penis, scrotum [external pouch that contains the testicles] and testicles), cutaneous (relating to the skin) abscess (an enclosed collection of pus in tissues, organs, or confined spaces in the body) of groin (area between the abdomen and the thigh), bacteremia (bacteria in the blood), and Type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel) with diabetic neuropathy (a type of nerve damage that can occur in people with diabetes). A review of Resident 35's H&P, dated 3/1/2024, indicated Resident 35 had the capacity to understand and make decisions. A review of Resident 35's MDS, dated [DATE], indicated Resident 35's cognitive skills for daily decision making were cognitively intact. The MDS indicated Resident 35 required substantial/maximal assistance for toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear, personal hygiene (ability to maintain personal hygiene including combing hair, shaving, washing/dry face and hands), roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. The MDS also indicated Resident 35 had an indwelling catheter (tube that drains urine from the bladder into a drainage bag). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 35's Physician Order Summary Report, dated 2/29/2024, indicated Resident 35 was prescribed Ertapenem Sodium (an antibiotic used to treat severe infections caused by a wide variety of bacterial infections) 1 gm - use 1 dose intravenously one time a day for ESBL of urine for nine days to start on 3/1/2024. A review of Resident 35's Care Plan, dated 3/28/2024, (care plan created 28 days after Resident 35 received antibiotic) indicated Resident 35 had a potential for adverse side effects from antibiotic therapy used 3/1/2024 to 3/8/2024 due to not meeting McGeers Criteria for Ertapenem. Staff interventions included were to monitor resident for any adverse side effects to antibiotic, monitor vital signs for any abnormalities, and inform the physician of any adverse side effects or changes in level of consciousness. During a concurrent interview and record review on 3/28/2024 at 11:00 AM of Resident 35's Infection Screening Evaluation IPN 1, IPN 1 stated Resident 35's screening score was 0. IPN 1 stated Resident 35's physician was not notified of the Infection Screening Evaluation score that indicated he did not meet the criteria to receive the antibiotic. IPN 1 stated the physician should have been notified immediately when the assessment score was 0 and did not meet the criteria to receive the antibiotic. IPN 1 stated the purpose of the Infection Screening Evaluation was to determine if the symptoms the resident was experience required the antibiotic. IPN 1 stated Resident 35 should not be given the antibiotic if he did not need to antibiotic. IPN 1 stated when residents were given unnecessary antibiotics, the residents could develop resistance to the antibiotic. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated the physician should be notified when a resident's McGeer's Criteria had a score of 0. The DON stated the physician should be made aware the resident did not meet the criteria to receive the antibiotic and ask if the physician wanted to continue with the antibiotic. The DON stated the physician should be notified as soon as Infection Screening Evaluation was completed and showed the resident did not meet the criteria to receive the antibiotic. The DON stated the importance of implementing the Infection Screening Evaluation and notifying the physician when the criteria was not met was to prevent the residents from developing drug resistance to antibiotics. A review of the facility's policy and procedure titled, Antibiotic Stewardship, revised 5/20/2021, indicated the purpose of the Antibiotic Stewardship Program was to optimize use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use. The facility will implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for residents.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44636 Based on interview and record review, the facility failed to provide education, offer, and/or document the updated Covid-19 (Coronavirus Disease 19, a respiratory viral infection that affects primarily the lungs and result in cough and difficulty breathing) for the year 2023-2024 vaccinations for 96 of 105 employees. This deficient practice placed the residents and staff at risk for possible Covid-19 infection due to missed vaccination dosage. Findings: A review of the undated Employee List and Vaccines, it did not indicate how many employees were offered, received, and/or declined the updated Covid-19 for the year 2023-2024 vaccine. The Employee List indicated 3 employees were exempt from the vaccination. A review of the Covid-19 Vaccination Employee Consent or Refused, dated 11/16/2023, 11/28/2023, and 11/29/2023, indicated 3 employees received the updated Covid-19 2023-2024 vaccination offsite (not at the facility). During an interview on 3/28/2024 at 10:18 AM with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated CNA 7 the last covid vaccine offered (unable to recall when) by the facility was the bivalent (Covid booster) vaccination. CNA 7 stated CNA 7 was not offered the updated Covid-19 for the year 2023-2024. CNA 7 stated CNA 7 had not declined any covid vaccinations offered by the facility. CNA 7 stated every time a vaccine was offered, CNA 7 consents and receives the vaccination. CNA 7 did not have a consent or refusal form for the updated Covid-19 for the 2023-2024 vaccine. During a concurrent interview and record review of the staff Covid-19 immunizations records on 3/28/2024 at 11:50 AM with the Infection Prevention Nurse 1 (IPN 1), IPN 1 stated she verbally offered and consented two (2) employees for the updated Covid-19 for the year 2023-2024 vaccine on 11/13/2023. IPN 1 stated she received the vaccine along with two other employees on 11/13/2023. IPN 1 stated there were 3 employees who received the updated Covid-19 for the year 2023-2024 vaccine offsite and declined the vaccine. IPN 1 stated the updated Covid-19 for the year 2023-2024 vaccine should be offered to all employees. IPN 1 stated the employees needed to sign a consent or declination form when she offered the updated Covid-19 for the year 2023-2024 vaccination to the employees. IPN 1 stated there was no declination forms signed by the employees who did not receive the updated Covid-19 for the year 2023-2024 vaccination. During the same interview and record review of the Employee List and Vaccines on 3/28/2024 at 11:50 AM with IPN 1, IPN 1 stated the Employee List and Vaccines form was not completed. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview 3/28/2024 at 11:50 AM with IPN 1, IPN 1 stated the Covid-19 for the year 2023-2024 vaccine became available around October 2023. IPN 1 stated she was responsible to offer and document when the vaccination was consented, received, or declined. IPN 1 stated the updated Covid-19 for the year 2023-2024 vaccinations were not ordered for the employees. IPN 1 did not respond when asked how all employees were notified of the vaccination clinic since employees had different work schedules and shifts. During an interview on 3/28/2024 at 2:46 PM with CNA 1, CNA 1 stated CNA 1 could not remember the last time the facility offered her the Covid- 19 vaccination. CNA 1 stated when the facility offered a vaccination, she would need to sign a consent or refusal form. CNA 1 did not have a consent or refusal form for the updated Covid-19 for the year 2023-2024 vaccine. During an interview on 3/28/2024 at 5:50 PM with the Minimum Data Set Coordinator (MDSC), MDSC stated MDSC could not recall the last time the facility offered the Covid- 19 vaccine. MDSC stated if the facility had offered him the updated Covid-19 for the year 2023-2024 vaccine then he would have signed a refusal form. MDSC did not have a consent or refusal form for the updated Covid-19 for the year 2023-2024 vaccine. During an interview on 3/29/2024 at 10:34 AM with the Director of Nursing (DON), the DON stated the facility offered her the covid vaccine sometime in June of 2023 (prior to the availability of Covid-19 for the year 2023-2024 vaccine). The DON stated when the covid vaccination was offered they need to sign the consent or declination form and be provided a copy. The DON did not have a consent or refusal form of the facility staff for the updated Covid-19 for the year 2023-2024 vaccine. A review of the facility's policy and procedure titled, SARS-CoV-2 (Covid- 19) Vaccination Program, revised 8/2/2023, indicated although the California Department of Public Health has rescinded its requirement for healthcare worker vaccination, the facility will continue to offer vaccine and booster doses per the requirements of Centers for Medicare & Medicaid Services (CMS), the Centers and Disease Control (CDC), and the Advisory Committee on Immunization Practices (ACIP) and document such. The facility must also maintain records of the vaccination status of all workers. A review of the CDC website titled, Stay Up to Date with Covid-19 Vaccines, dated 3/7/2024, indicated the CDC recommends the 2023-2024 updated Covid-19 vaccines: Pfizer-BioNTech, Moderna, Or Novavax, to protect against serious illness from Covid-19. The CDC 2023-2024 updated vaccines: As of 10/3/2023, the 2023-2024 updated Novovax vaccine was recommended by the CDC for use in the United States. As of 9/12/2023, the 2023-2023 updated Pfizer-BioNTech and Moderna Covid-19 vaccines were recommended by the CDC for use in the United States. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#preferential

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure 12 out of 22 resident rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18) met the requirements of 80 square feet (sq. ft.) for each resident in multiple resident bedrooms. This deficient practice had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care. Findings: During an observation of the facility and resident's rooms from 3/26/2024 to3/29/2024, Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18 did not meet the minimum requirement of 80 sq. ft. per resident in multiple residents' rooms. During an interview with Resident 33 on 3/29/2024, at 9:50 AM, Resident 33 stated he was comfortable in his room and had enough space for his belongings and wheelchair. A review of the facility's Client Accommodation Analysis Form, dated 3/27/2024, the facility had several rooms that measured less than the required 80 square footages per resident in multiple bedrooms. The following resident bedrooms were: 1) room [ROOM NUMBER] (3 beds) and measured 222 sq. ft., to equal 74 sq. ft. per resident. 2) room [ROOM NUMBER] (3 beds) and measured 194 sq. ft., to equal 64.6 sq. ft. per resident. 3) room [ROOM NUMBER] (3 beds) and measured 212 sq. ft., to equal 70.6 sq. ft. per resident. 4) room [ROOM NUMBER] (2 beds) and measured 148 sq. ft., to equal 74 sq. ft. per resident. 5) room [ROOM NUMBER] (3 beds) and measured 219 sq. ft., to equal 73 sq. ft. per resident. 6) room [ROOM NUMBER] (3 beds) and measured 209 sq. ft., to equal 69.6 sq. ft. per resident. 7) room [ROOM NUMBER] (3 beds) and measured 227 sq. ft., to equal 75.6 sq. ft. per resident. 8) room [ROOM NUMBER] (3 beds) and measured 211 sq. ft., to equal 70.3 sq. ft. per resident. 9) room [ROOM NUMBER] and room [ROOM NUMBER] (3 beds) and measured 221 sq. ft., to equal 73.6 sq. ft. per resident. 10) room [ROOM NUMBER] (3 beds) and measured 230 sq. ft., to equal 76.6 sq. ft. per resident. 11) room [ROOM NUMBER] (4 beds) and measured 293 sq. ft., to equal 73.25 sq. ft. per resident. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation of the facility and residents' room from 3/26/2024 to 3/29/2024, the residents residing in the rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18) with an application for variance were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and side tables with drawers. There was an adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing are to these residents. The Department is recommending approval of the room waiver request for 12 of 22 rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure that a shower chair used by residents was in good condition and free from stains. This deficient practice had the potential for the resident to feel uncomfortable during showers and affect the resident's quality of life. Findings: During an observation on 3/28/2024, at 10:06 AM, an unnamed Certified Nursing Assistant (CNA) pushed a white shower chair and placed it outside of room [ROOM NUMBER]. The shower chair seat had brown and yellowish stains and the plastic woven backrest was ripped and worn out. During a concurrent observation and interview with Registered Nurse Supervisor 1 (RNS 1), on 3/28/2024, at 10:10 AM, RNS 1 stated the brown marks on the shower chair seat were old stains. RNS 1 stated the shower chair look old and needed to be replaced. RNS 1 stated she would not want to sit on that shower chair if she was a resident in the facility. During an interview with the Maintenance Supervisor (MS) on 3/28/2024, at 10:15 AM, the MS stated the shower chair should not be used in the facility based on the condition that it was in. MS stated he was not aware that a shower chair in that condition was being used in the facility. During an interview with the Director of Nursing (DON), on 3/28/2024, at 3 PM, the DON stated the shower chair had brown and yellowish stains and backrest was ripped. The DON stated CNAs should inform the charge nurse right away if the supplies and equipment in the facility are old so it can be replaced. The DON stated the resident's dignity and self-worth are affected if they use equipment that are stained and old and in addition it is to provide a safe and clean equipment for the resident. A review of the facility's policy and procedure (P&P), titled, Resident Rooms and Environment, revised on 1/1/2012, indicated, The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.