STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coast Care Convalescent Center	14518 E. Los Angeles St. Baldwin Park, CA 91706

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for one of one sampled resident (Resident 14). Certified Nursing Assistant 2 (CNA 2) was standing over the resident while assisting with lunch. This failure had the potential to affect Resident 14's self-esteem and self-worth. Findings: During a review of Resident 14's Admission Record (AR), the AR indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (disturbance of brain function) and muscle weakness. During a review of Resident 14's History and Physical (H&P) dated 4/2/2024, the H&P indicated Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Nutritional Assessment (NA), dated 4/4/2024, the NA indicated Resident 14's eating ability was categorized as a feeder (a person who is fed by an assistant during meals) and Resident 14 needed assistance with feeding. During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/16/2024, the MDS indicated Resident 14 had severely impaired cognition and required partial/moderate assistance (helper does less than half the effort; helper lifts, hold, or supports trunk or limbs, but provides less than half the effort) from staff with eating. During an observation on 10/22/2024 at 12:37 pm in Resident 14's room, CNA 2 was feeding lunch to Resident 14 while standing at Resident 14's right side. CNA 2 was standing over Resident 14 while feeding the resident who was seated up in bed with the bedside table and meal tray in front of the resident. During an interview on 10/22/2024 at 12:53 pm with CNA 2, CNA 2 stated, occasionally she will bring in a chair while feeding the resident but prefers to stand while feeding Resident 14 because the bed was too high to place the table. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 12:32 pm with Registered Nurse 2 (RN 2), RN 2 stated feeding assistance was provided by the certified nursing assistants or restorative nursing assistants (RNA - a certified nursing assistant who has specialized training in rehabilitation to help patients with limited mobility and self-care) who were usually standing next to the resident while feeding, until the resident was done eating. During an interview on 10/25/2024 at 1:35 pm with the Director of Nursing (DON), the DON stated staff should be seated at eye level with the resident when feeding. The DON further stated, sitting while feeding the resident promoted independence and dignity to the resident. During a review of the facility's undated Policy and Procedure (P&P) titled, Resident Dignity, the P&P indicated, the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The P&P defined dignity to mean during their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. The P&P indicated promoting resident independence and dignity in dining such as the avoidance of staff standing over residents while assisting them to eat.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for one of one sampled resident (Resident 30) by failing to ensure the resident's call light was within reach and appropriate to the resident's physical ability. This deficient practice had the potential for Resident 30 not to receive necessary care or services and placed the resident at high risk for fall. Findings: During a review of Resident 30's Admission Record (AR), the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following unspecified cerebrovascular disease (includes all disorders in which an area of the brain is temporarily or permanently affected by bleeding or lack of blood flow) affecting right dominant side. During a review of Resident 30's untitled Care Plan (CP), revised on 4/29/2024, the CP indicated Resident 30 was at risk for falls related to history of cerebrovascular accident with right hemiplegia. The CP interventions indicated for nursing staff to provide call light within reach and instruct the resident to use it and wait for assistance. During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/23/2024, the MDS indicated Resident 30 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 30 required maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) with toileting hygiene, shower, and upper body dressing. The MDS indicated Resident 30 was dependent (helper did all of the effort and lifted or held trunk or limbs) to staff for putting on/taking off footwear and lower body dressing. During a review of Resident 30's Fall Risk Assessment (FRA- a method of assessing a patient's likelihood of falling) dated 10/22/2024, the FRA indicated Resident 30 was assessed as high risk for fall due to chair bound- and/or needing assistance with elimination, unable to stand with both feet or walk and presence of predisposing disease condition. During an observation on 10/23/2024 at 9:50 am, Resident 30 was lying in bed. Resident 30's call light was hanging on the foot part of the bed by Resident 30's lower extremities. Resident 30 was unable to reach the call light. During a concurrent observation and interview on 10/23/2024 at 9:53 am, with the facility's Director of Nursing (DON), the DON stated Resident 30 was unable to reach the call light because it was at the foot of the bed. The DON stated, Resident 30's call light needed to be within reach of Resident 30 to use, to call staff if Resident 30 needed help or in case of any emergency and the resident needed assistance from the facility staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's Policy and Procedure (P&P) titled, Call Lights revised on 7/18/2018, the P&P indicated to keep the call light within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to follow the facility's policy regarding advance directive's (AD, a written document that indicates to health care providers (HCP) who should speak on resident's behalf and what medical decisions to make if resident is unable to speak for self) and Physician Orders for Life Sustaining Treatment (POLST, written medical order from a medical doctor (MD) that indicate specific medical treatment the resident would want to receive during a medical emergency or if the resident is unable to speak for self) for three of three sampled residents (Residents 19, 37, and 43) by failing to: a. Ensure an Advance Healthcare Directive Acknowledgement form (AHCD) was filled out correctly and the POLST was signed by Resident 43's legal representative upon admission. b. Complete an AHCD for Resident 19 upon admission. c. Ensure the AHCD was filled out and the POLST was signed for Resident 37. These failures had the potential to result in conflict with Residents 19, 37, and 43 wishes regarding health care. Findings: a. During a review of Resident 43's Admission Record (AR), the AR indicted Resident 43 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (brain disease that slowly causes impairments in memory and abilities to carry out simple tasks), dementia (loss of memory and mental abilities that interfere with daily life which is caused by physical changes in the brain), and metabolic encephalopathy (alteration in consciousness which results in confusion, memory loss, or personality changes). During a review of Resident 43's history and physical (H&P, formal document of a medical provider's examination of a patient) dated [DATE], the H&P indicated Resident 43 does not have the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated [DATE], the MDS indicated Resident 43's cognitive abilities (ability to think, learn, and process information) were impaired. During an interview on [DATE] at 9:28 AM with Family Member (FM) 1, FM 1 stated FM 1 was the legal responsible party for Resident 43. FM 1 stated Resident 43 is unable to make decisions for self, was not made aware of the purpose of an AD on admission and stated Resident 43 does not have an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 3:25 PM with Social Services (SS) 1, Resident 43's AHCD dated [DATE] and POLST dated [DATE] were reviewed. The AHCD indicated Resident 43 had an AHCD and which was attached to Resident 43's Medical Record (MR). Resident 43's POLST indicated Resident 43 did not have an AD and indicated it was signed by a caregiver. SS 1 stated the AHCD and the POLST forms were inconsistent and stated Resident 43 does not have an AD. The SS 1 stated the AHCD form was not filled out correctly and stated the risk of not properly filling out the form was not being able to provide education to the resident or representative party (RP) on the purpose of an AD and to offer assistance, if the resident or RP wanted to create an AD. SS 1 stated the signature on Resident 43's POLST was not the signature of FM 1 who was the legal representative. SS 1 stated the signature on the POLST was the Administrator from the previous facility. SS 1 stated SS 1 saw the discrepancy when Resident 43 was readmitted to the facility on [DATE] but did not correct it. SS 1 stated it should've been corrected upon admission and stated the risk of the POLST not being signed by the legal representative was that the facility might provide interventions that the legal representative did not agree to. During a concurrent interview and record review on [DATE] at 9:28 AM with FM 1, Resident 43's POLST dated [DATE] was reviewed. The POLST indicated a checkmark for attempt resuscitation/Cardiopulmonary Resuscitation (CPR, emergency lifesaving procedure performed when the heart stops beathing). FM 1 stated FM 1 was not aware the POLST was signed and stated the signature on the POLST was the owner at the previous facility. FM 1 stated FM 1 did not agree with the checkmark of attempt resuscitation/CPR and stated Resident 43 should be do not attempt resuscitation (DNR) and allow natural death. During an interview on [DATE] at 1:22 PM with the Director of Nursing (DON), the DON stated the purpose of the AHCD was to implement the wishes of the resident. The DON stated staff should've called the family member if staff were unsure if the resident had an AD. The DON stated the risk of not properly assessing if the resident had an AD or properly filling out the AHCD form was that staff would not be able to provide education and resources to the resident or RP about AD. The DON stated Resident 43's AHCD and POLST were inconsistent and should've been signed by the legal representative. The DON stated staff should've addressed the inconsistent signatures during the admission process and stated having the wrong signature on the POLST would put the resident at risk for receiving treatments without the resident or RP's consent. During a review of the facility's policy and procedure (P&P) titled, Advance Directives the P&P indicated at the time of a resident's admission, written information describing the right to formulate an advanced directive shall be provided and acknowledged by the resident or surrogate decision maker on the Advance Directive Acknowledgement form. The P&P indicated a copy of the resident's advance directive was to be placed in the resident's medical and business file. During a review of the facility's P&P titled, Physician Orders for Life Sustaining Treatment (POLST) or request regarding Resuscitative measures the P&P indicated the POLST must be signed by a physician and the resident or his or her legally recognized healthcare decision maker. 49252 b. During a review of Resident 19's AR, the AR indicated Resident 19 was readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction (stroke, loss of blood flow to a part of the brain) and Parkinson's Disease (disease that affects the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and balance). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's H&P dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 had severely impaired (never/rarely made decisions) cognitive skills for daily decision making and resident's overall goal for discharge (answered by family) was to remain in the facility. During a review of Resident 19's undated Advance Healthcare Directive (AHCD) Acknowledgement Form, the AHCD Acknowledgment Form indicated the option boxes were all unchecked, providing no documentation whether the resident representative were provided with information regarding Advance Healthcare Directive creation, if they would/would not like to receive more information, if the resident representative had or did not have an Advance Healthcare Directive, if the advance directive was attached or if a copy was requested by the facility. The form was signed and filled out by the facility's Social Services 1 (SS 1) with the resident's name, resident representative and relationship, staff name and signature. The form was not signed or dated by the resident's representative and was left undated by SS 1's signature. During a concurrent interview and record review on [DATE] at 11:14 am with SS 1, Resident 19's Advance Healthcare Directive (AHCD) Acknowledgement Form was reviewed. The ACHD Acknowledgement Form indicated no documentation that Resident 19 or a family member were provided information regarding the resident's right to formulate or provide an advance directive to the facility. SS 1 stated Resident 19's Advance Healthcare Directive (AHCD) Acknowledgement Form should have been completed and that SS 1 needed to speak to Resident 19's representative. SS 1 stated having advance directive documentation available in the resident's chart gives the facility direction what needed to be done for the resident and be aware of the resident's and/or their family's wishes. During an interview on [DATE] at 1:24 pm with the Director of Nursing (DON), the DON stated if the facility was not properly assessing if a resident had an advance directive, the facility failed to give the resident or resident's representative the opportunity to create an advance directive and their wishes may not be followed. c. During a review of Resident 37's AR, the AR indicated Resident 37 was readmitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that affects one or both lungs) and muscle weakness. During a review of Resident 37's H&P dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 had moderately impaired cognition. During a concurrent interview and record review on [DATE] at 11:14 am with SS 1, Resident 37's undated Advance Healthcare Directive (AHCD) Acknowledgement Form was reviewed. The AHCD Acknowledgment Form indicated no documentation for the date when signed by the resident and was missing the facility staff name and title of who signed. SS 1 stated the form was signed by SS 1 and should have been completed without any missing information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 11:14 am with SS 1, Resident 37's undated Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was reviewed. The POLST indicated no documentation for: the date when prepared, whom it was discussed with, the signature of a physician/nurse practitioner/physician assistant, the date when the resident signed, and the patient's name on the back of the form. SS 1 stated, SS 1 prepared Resident 37's POLST and it was missing information, making it an incomplete POLST. During an interview on [DATE] at 1:24 pm with the DON, the DON stated the AHCD Acknowledgment Form and POLST should have been completed for the resident. The DON stated, the AHCD Acknowledgment Form and POLST would give the facility staff knowledge of the resident's or legal representative's wishes and if not completed, the resident's wishes would not be followed. During a review of the facility's P&P titled, Physician Orders for Life Sustaining Treatment (POLST), or Request Regarding Resuscitative Measures Forms, dated ,d+[DATE], the P&P indicated the POLST form must be signed by a physician. During a review of the facility's undated P&P titled, Policy and Procedure on Advance Directives, the P&P indicated the facility recognizes the resident's right to complete an advance directive indicating what form of treatment are or are not provoked in a medical emergency or near the end of life and who is authorized to make medical decisions on resident's behalf if resident loses the ability to make such decisions independently. The P&P indicated an acknowledgment to this right shall also be completed by the resident or his/her surrogate decision maker (refer to Advance Directive Acknowledgement Form). The acknowledgement should be included in the resident's medical file (chart) and business file within 24 hours of admission, if incomplete after five days of admission it shall be forwarded to the facility administrator for necessary actions. The P&P further stated, for any subsequent readmission, a determination shall be done to verify if all information concerning the advance directive remains the same. During a review of the facility's undated P&P titled, Medical Record Policy and Procedures, the P&P indicated the facility must have documentation of whether the resident has executed an advance directive or notation that information about Advanced Directives were given to the resident as required by federal law. The P&P further stated, entries are made in accordance with acceptable legal medical documentation standards including signing, dating and legibility for all entries, signatures include the first initial, last name, and title, and medical record entries must be accurate and documented in a timely manner.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 14330 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) Level II recommended specialized add-on services that were appropriate to resident's condition were included into Resident 38's assessment, care planning, and transitions of care for one of two sampled residents (Resident 38). This deficient practice placed Resident 38 at risk of not getting the appropriate specialized care needed for the well- being of the resident. Findings: During a review of Resident 38's Admission Record (AR), the AR indicated the facility readmitted Resident 38 on 9/12/24, with diagnoses that included chronic obstructive pulmonary disease (COPD-progressive lung disease that makes it hard to breathe) and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). During a review of Resident 38's PASRR Level II individualized determination report dated 9/20/24, the report indicated mental health rehabilitation activities and psychotherapy /counselling were recommended specialized add-on services needed by Resident 38. The PASSR report indicated that these services and supports would supplement nursing facility care to address the mental needs of Resident 38. During a record review and concurrent interview with the Director of Staff Development (DSD) on 10/25/24 at 11:12 a.m., the DSD stated she was responsible for completion and submission of PASSR Level I and to follow up the result of PASSR Level II to ensure the resident was appropriately placed in the nursing home for a long-term care. DSD stated she did not know PASSR Level II recommended specialized add-on services needed were to be included in Resident 38's assessment, care planning and transitions of care in the facility. During a review of the facility's Policy and Procedures (P&P) titled, Pre-Admission Screening and Resident Review dated 10/25/24, the P&P indicated PASSR Level II and/or PASSR evaluation report will be incorporated into the residents' assessment, care planning, and transition of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to create a care plan (CP) for one of one sampled resident (Resident 25) when Resident 25 had a 10% weight loss within three months. This failure had the potential to result in Resident 25 to develop further weight loss. Findings: During a review of Resident 25's Admission Record (AR), the AR indicated Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included major depressive disorder (MDD, a mental health condition that causes persistently low or depressed mood and a loss of interest in activities). During a review of Resident 25's history and physical (H&P, formal document of a medical provider's examination of a patient) dated 9/30/2024, the H&P indicated Resident 25 had the ability to understand and make decisions. During a review of Resident 25's Weekly Weights Monitoring (WWM) dated 10/4/2024, the WWM indicated Resident 25 weighed 116 lbs. on 10/4/2024, 113 lbs. on 10/11/2024, 113 lbs. on 10/18/2024, and 113 lbs. on 10/25/2024. During a review of Resident 25's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/14/2024, the MDS indicated Resident 25's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 25 required setup or clean up assistance with eating. During a review of Resident 25's Monthly Weight Report (MWR) dated 5/2024 to 10/2024, the MWR indicated Resident 25 weighed 129 pounds (lbs., unit of measurement for weight) on 7/2024, 125 lbs. on 8/2024, 122 lbs. on 9/2024, and 116 lbs. on 10/2024. During an interview on 10/23/2024 at 11:43 AM with Resident 25, Resident 25 stated Resident 25 had unplanned weight loss and used to weigh 130 lbs. but weighed around 112 lbs. During a concurrent interview and record review on 10/24/2024 at 10:37 AM with Registered Nurse (RN) 1, Resident 25's CP was reviewed. RN 1 stated RN 1 was not aware Resident 25 had lost weight and stated Resident 25 did not have a CP for weight loss. RN 1 stated if the resident had lost weight or a significant amount of weight a CP should be created. RN 1 stated if a CP for weight loss was not created, staff would not be able to monitor the resident's weight loss. During an interview on 10/25/2024 at 1:38 PM with the Director of Nursing (DON), the DON stated the purpose of the CP was to monitor specific behaviors or conditions, implement interventions, and guide staff in providing care to the resident. The DON stated a CP should've been created to monitor Resident 25's weight loss and stated the risk of not developing a CP would put the resident at risk for further weight loss because staff would not be aware of Resident 25's weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Care Plans revised 1/20/2024, the P&P indicated a comprehensive care plan has been designed to incorporate identified problem areas and indicated CP's are revised as changes in the resident's condition dictate.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 14330 Based on observation, interview, and record review, the facility failed to provide a communication board and/or other functional communication system to a non English speaking resident (Resident 24) for one of one sampled resident. This deficient practice placed Resident 24 at risk for miscommunication and delayed care. Findings: During a review of Resident 24's Admission Record (AR), the AR indicated the facility readmitted the resident on 8/9/24, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) and dementia (a progressive decline in mental abilities). During a review of Resident 24's Care Plan (CP) titled, Communication Deficit related to Language Barrier dated 8/9/24, the CP indicated Resident 24 would be able to communicate needs daily using a communication device (unspecified). During an observation and concurrent interview on 10/22/24 at 4:10 p.m., Resident 24 was lying on her back in bed and awake. Resident 24 only speaks and understand Vietnamese language. The Director of Staff Development (DSD) was present in the room. There was no communication board and/or other functional communication system in Vietnamese language for Resident 24 to communicate her needs to the staff. The DSD stated DSD was unable to find a communication device in Vietnamese language after she searched the bed side table and drawer of Resident 24. The DSD stated communication board and/or other functional communication system in Vietnamese language should always be available to Resident 24 to avoid delay of care in case of an emergency for a non-English speaking resident. The facility had no Vietnamese speaking staff. The DSD stated staff would be able to provide appropriate care if staff knew the specific needs of a non-English speaking resident. During a review of the facility's Policy and Procedure (P&P) titled, Resident's with Communication deficit dated 10/2022, the P & P indicated communication board will be provided for residents whose primary language was other than English and do not speak/understand English. In addition, the facility's P&P titled Limited English Proficiency dated 10/24/24 indicated the facility will have a designated cellular phone that has a translation application and the staff will be able to choose the specific language that the resident speaks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coast Care Convalescent Center	14518 E. Los Angeles St. Baldwin Park, CA 91706

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to attempt to use appropriate alternative interventions prior to the installation of side rails for one of one sampled resident (Resident 13). This failure had the potential for Resident 13 to be at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body parts in the tight spaces around the bedrail) and physical injuries. Findings: During a review of Resident 13's Admission Record (AR), the AR indicated Resident 13 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included morbid obesity (having too much body fat), schizophrenia (a serious mental disorder in which people interpret reality abnormally), and major depressive disorder (MDD, a mental health condition that causes persistently low or depressed mood and a loss of interest in activities). During a review of Resident 13's Order Summary Report (OSR) dated 9/4/2024, the OSR indicated an order for bilateral one-half side rails up in bed per resident's request due to fear of falling and to aid in self-repositioning. During a review of Resident 13's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 9/24/2024, the MDS indicated Resident 13's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 13 required substantial/maximum assistance with rolling left and right. During a concurrent observation and interview on 10/23/2024 at 10:23 AM with Resident 13 in Resident 13's room, bilateral side rails were observed to be up and installed onto Resident 13's bed. Resident 13 stated Resident 13 uses the side rails to help Resident 13 turn in bed. During an interview on 10/24/2024 at 10:43 AM with Registered Nurse (RN) 1, RN 1 stated Resident 13 has bilateral side rails up. RN 1 stated Resident 13 uses the side rails to turn self in bed. RN 1 stated there was no documentation of the use of alternative interventions prior to the installation of the side rails. RN 1 stated alternative interventions could include floor mats, roll guards, and concave mattresses. RN 1 stated the risk of not attempting alternative interventions is that the resident could be at risk for entrapment. (continued on next page)

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	555199	A. Building B. Wing	10/25/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/25/2024 at 8:53 AM with Licensed Vocational Nurse (LVN) 1, Resident 13's Nursing Note (NN) dated 11/8/2023 at 5:56 PM was reviewed. It indicated foam bolsters were attempted but removed due to the resident stating to having anxiety. LVN 1 stated no other alternative interventions were attempted after 11/8/2023. LVN 1 stated the risk of not attempting more alternative interventions was that the staff would not know if other alternatives would work and benefit the resident and stated it would put the resident at risk for entrapment. During an interview on 10/25/2024 at 1:46 PM with the Director of Nursing (DON), the DON stated staff need to attempt more than one alternative, reassess, and document alternatives that have been attempted prior to installing side rails. The DON stated the risk of not attempting appropriate alternatives is that it would put the resident at risk for entrapment. During a review of the facility's policy and procedure (P&P) titled, Bedside Rail Assessment and Management revised 11/10/2023, the P&P indicated the facility is to assess residents prior to the implementation and use of siderails to ensure appropriate protocols have been followed such as alternative methods have been attempted.

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	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 48905 Based on observation, interview, and record review, the facility failed to follow their policy for posting nurse staffing data for one of two sampled locations (lobby) by failing to: a. Post accurate hours for Certified Nurse Assistants (CNA) on 10/15/2024, 10/16/2024, 10/17/2024, 10/18/2024, 10/19/2024, and 10/23/2024. b. Post nurse staffing information at the beginning of the shift on 10/23/2024 in the lobby, an area readily accessible by everyone. These failures had the potential to result in posting inaccurate nursing hours and nurse staffing information that could affect the quality of care given to the residents. Findings: a. During a concurrent interview and record review on 10/25/2024 at 9:51 AM with the Director of Staff Development (DSD), the facility's Staffing and Nursing Hours (SNH) and Nursing Staffing Assignment and Sign-in Sheet (NSASS) dated 10/15/2024, 10/16/2024, 10/17/2024, 10/18/2024, 10/19/2024, and 10/23/2024 were reviewed. The DSD stated the DSD is responsible for posting the SNH in the nursing station and lobby. The DSD stated the number of CNAs who worked were incorrect on the following days: 1. On 10/15/2024 during the 3 PM to 11 PM (afternoon) shift, four CNAs worked instead of five. 2. On 10/16/2024 during the 7 AM to 3 PM (morning) shift, five CNAs worked instead of six. During the afternoon shift, four CNAs worked instead of five. 3. On 10/17/2024 during the morning shift, six CNAs worked instead of seven. 4. On 10/18/2024 during the morning shift, four CNAs worked instead of five CNAs. 5. On 10/19/2024 during the morning shift, six CNAs worked instead of seven CNAs. 6. On 10/21/2024 during the morning shift, five CNAs worked instead of six. During the afternoon shift, four CNAs worked instead of five. 7. On 10/23/2024 during the morning shift, six CNAs worked instead of seven. The DSD stated the DSD posted the projected hours in the morning for all three shifts and did not post the actual hours worked. The DSD stated the risk of not providing the actual hours of staff who worked is not providing quality care to the residents and not providing accurate information to residents and family members. (continued on next page)

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	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/2024 at 1:55 PM with the Director of Nursing (DON), the DON stated the purpose of the SNH form was to indicate accurate hours staff provided direct care to residents. The DON stated if the SNH form was not posted or correct, it would not provide accurate information to residents or visitors. During a review of the facility's Policy and Procedure (P&P) titled, Posting Nurse Staffing Data, the P&P indicated the nurse staffing data shall include specific shift schedules listing the number of all licensed and unlicensed nursing staff for each shift that provided direct nursing care. The P&P indicated any changes in numbers of licensed and unlicensed staff or number of hours worked shall be reflected on the posted nurse staffing data. The P&P indicated the nurse staffing data shall be posted daily at the beginning of each shift and posted in a prominent place that is readily accessible to residents and visitors. 42781 b. During an observation on 10/23/2024 at 9:38 AM, there was no staffing information posted at the facility's lobby or prominent location that was readily accessible to visitors. During a concurrent observation and interview on 10/23/2024 at 9:42 AM with the Director of Staff and Development (DSD), there was no staffing information posted at the lobby. The DSD stated, there was no staffing information posted at the lobby. The DSD stated the staffing information was only posted at the nursing station. During an interview on 10/23/2024 at 3:44 PM, the DSD stated, staffing information needed to be posted at the lobby because not all visitors went or have access to the nursing station. The DSD stated nursing staffing information needed to be posted in the lobby and in a prominent place accessible to staff, residents and visitors. During a review of facility's undated P&P titled, Posting Nurse Staffing Data,, the P&P indicated nurse staffing data shall be posted in a prominent area readily accessible to residents and visitors (e.g. Lobby Area) and displayed in a clear and readable format.

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	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 49252 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of one sampled resident (Resident 23). Licensed Vocational Nurse 1 (LVN 1) did not explain the medication and its purpose to Resident 23 during a medication pass, in accordance with the facility's Policy and Procedure (P&P) on Medication and Treatment Administration This failure resulted in Resident 23 being uninformed about the resident's medication and had the potential for medication error. Findings: During a review of Resident 23's Admission Record (AR), the AR indicated Resident 23 was readmitted to the facility on [DATE] with diagnoses that included Parkinson's Disease (disease that affects the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and balance) and muscle weakness. During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/15/2024, the MDS indicated Resident 23 was cognitively intact (the mental action or process of acquiring knowledge and understanding). During a medication pass observation on 10/24/2024 at 8:43 am in Resident 23's room, LVN 1 stated to Resident 23 that LVN 1 was giving Resident 23 his morning medications for 9 am medication schedule. LVN 1 gave Resident 23 the medication cup with medications and Resident 23 swallowed all the medications. LVN 1 did not name or explain any of the nine (9) medications in the medication cup that were given/administered to Resident 23. During an interview on 10/24/24 at 9:17 am with LVN 1, LVN 1 stated each medication that was given to Resident 23 should have been explained to the resident. LVN 1 stated, explaining the medication to the resident would allow the resident to be knowledgeable and informed about their own medications. During a review of Resident 23's Medication Administration Record (MAR) dated October 1, 2024 to October 31, 2024, the MAR indicated the medications that were administered to Resident 23 by LVN 1 on 10/24/2024 at 8:43 am for the 9am medication schedule were: 1. Risperdal (a medication to treat certain mental/mood disorders) oral tablet, 2 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth daily for schizophrenia (a mental illness characterized by disturbances in thought) manifested by paranoid delusion that people were after him. 2. Seroquel (a medication to treat the symptoms of schizophrenia and other mental illnesses) oral tablet, 200 mg by mouth daily for schizophrenia manifested by auditory hallucinations hearing that people are talking bad things about him. (continued on next page)

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	555199	A. Building B. Wing	10/25/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Vascepa (a medication to treat a type of fat that flows through the blood) oral capsule, 1 gram, 2 capsules by mouth daily for hyperlipidemia (high cholesterol) 4. Benztropine Mesylate (medication to treat symptoms of Parkinson's Disease) oral tablet, 2 mg by mouth twice a day for Parkinson's Disease 5. Colace (a stool softener) oral capsule, 100 mg by mouth twice a day for bowel management. 6. Keppra (a medication to treat seizure disorders) oral tablet, 500 mg by mouth every 12 hours for seizure disorder. 7. Depakote (a medication to treat seizure disorders) oral tablet, 500 mg by mouth three times a day for seizure disorder. 8. Ropinirole (a medication to treat symptoms of Parkinson's Disease) HCl Oral tablet, 0.5 mg by mouth three times a day for Parkinson's Disease. 9. Sinemet (a medication to treat symptoms of Parkinson's Disease) oral tablet 25-100 mg, 2 tablets by mouth three times a day for Parkinson's Disease. During an interview on 10/25/2024 at 1:37 pm with the Director of Nursing (DON), the DON stated medications should be explained to a resident during medication pass to ensure the resident was aware of the medications the resident was taking and the purpose of the medication. The DON stated, without explaining the medications to the resident, the resident would not know what medications were being administered and the resident could possibly be given the wrong medications. During a review of the facility's undated Policy and Procedure (P&P) titled, Medication and Treatment Administration, the P&P indicated the facility administer medication or treatment within the scope of professional standard of practice and the licensed nurse should explain medication use including side effects to the resident.

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	555199	A. Building B. Wing	10/25/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 38 and 43) on psychotherapeutic drugs (any drug capable of affecting mood, emotions, and behavior) were free from unnecessary medication by failing to: a. Identify specific target symptoms for Resident 43 on Seroquel (medication used to treat schizophrenia [a serious mental disorder in which people interpret reality abnormally]) 50 milligrams (mg, unit of measurement) for schizophrenia manifested by hearing voices and responding to internal stimuli and attempted to perform gradual dose reduction (GDR-stepwise tapering of a dose) for the use of Paroxetine HCL (Paxil, medication used to treat depression [persistent low mood or loss of interest]) 30 mg daily for depression. b. Ensure Resident 38 had GDR for Lexapro (antidepressant drug) 10 mg since 2021, and Zyprexa (antipsychotic drug) 5 mg every 12 hours since 2023 and the target symptom for Zyprexa was specific. These failures had the potential for the facility to use psychotropic drugs inappropriately and had the potential to affect Resident 38 and 43's physical, emotional, and psychosocial wellbeing. Findings: a. During a review of Resident 43's Admission Record (AR), the AR indicated Resident 43 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (brain disease that slowly causes impairments in memory and abilities to carry out simple tasks), dementia (loss of memory and mental abilities that interfere with daily life) and metabolic encephalopathy (alteration in consciousness which results in confusion, memory loss, or personality changes). During a review of Resident 43's Physician's Orders (PO) dated [DATE], the PO indicated Resident 43 had an order for Paroxetine HCL (Paxil) 30 mg daily for depression. The PO indicated on [DATE] Resident 43 had an order for Paroxetine HCL 30 mg every night for depression. During a review of Resident 43's History and physical (H&P) dated [DATE], the H&P indicated Resident 43 does not have the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 43's cognitive abilities (ability to think, learn, and process information) were impaired. During a review of Resident 43's PO dated [DATE], the PO indicated Resident 43 had an order for Seroquel 50 mg at bedtime for schizophrenia, manifested by hearing voices responding to internal stimuli. (continued on next page)

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	555199	A. Building B. Wing	10/25/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:03 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there was no specific target behavior to Resident 43's internal stimuli. LVN 1 stated, the target behavior needed to be specific because responding to internal stimuli was a vague target behavior. LVN 1 stated Resident 43 talked to self and to Resident 43's deceased husband. LVN 1 stated the risk of not indicating specific target behaviors for the use of antipsychotic medications (medications used to treat disorganized thinking) was inaccurate monitoring of behaviors and unable to monitor if behaviors were improving. During an interview on [DATE] at 2:30 PM with the Director of Nursing (DON), the DON stated, the target behavior of responding to internal stimuli was not specific and vague and staff would not be able to monitor the resident's target behavior. The DON stated responding to internal stimuli was not a specific target behavior. The DON stated, not indicating a specific behavior to monitor for antipsychotic medications placed the resident at risk for not being accurately monitored to assess effectiveness of medication. During concurrent Interview and record review on [DATE] at 1:29 PM with the DON, Resident 43's Note to Attending Physician/Prescriber (NAP) dated [DATE] was reviewed. The NAP indicated a GDR for Paxil 30mg as associated behaviors and monitoring parameters indicated no worsening of depression and indicated behaviors were minimal to none. The NAP indicated Resident 43 required medication at the current dose and indicated benefits of continuing medication outweigh the risk. The DON stated no GDR was attempted for Resident 43 on Paxil at 30 mg. The DON stated a GDR needed to be attempted at least once a year and stated the risk of not properly monitoring proper dose for the resident was that the resident may be at a higher dose than required. 14330 b. During a review of Resident 38's AR, the AR indicated the facility readmitted Resident 38 on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD-progressive lung disease that makes it hard to breathe) and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). During a review of Resident 38's Order Summary Report (OSR), the OSR indicated the following: 1. Zyprexa 5 mg one tablet by mouth every 12 hours for schizophrenia as manifested by hearing voices responding to internal stimuli (unspecified), ordered on [DATE]. 2. Lexapro 10 mg one tablet by mouth every day for depression as manifested by verbalization of feeling sad, ordered on [DATE]. During a review of Resident 38's Medication Administration Record (MAR) dated [DATE] through [DATE], the MAR indicated Resident 38 received Zyprexa 5 mg one tablet by mouth at 9 AM. and 9 PM, and Lexapro 10 mg at 9 AM, by mouth every day. During an observation and concurrent interview on [DATE] at 4:17 PM., Resident 38 was sitting in a wheelchair, alert and coherent. Resident 38 stated she was not feeling sad in the facility. (continued on next page)

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	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coast Care Convalescent Center	14518 E. Los Angeles St. Baldwin Park, CA 91706

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON) on [DATE] at 1:48 PM., the DON stated Resident 38 was on Zyprexa 5 mg every 12 hours since [DATE], and it was the same dose order as of [DATE]. The DON stated, Resident 38 was also on Lexapro 10 mg daily since [DATE], and it was the same dose order as of [DATE]. There was no documented evidence in Resident 38's medical record of a past failed attempt of GDR for Zyprexa and Lexapro that it would be clinically contraindicated to lower the dose for Resident 38. The DON stated GDR would be necessary to evaluate if the resident's target symptom could be managed by the least amount of psychotropic drug to prevent an adverse drug reaction. The DON stated the DON did not ask Resident 38 what specific internal stimuli Resident 38 was responding to whenever Resident 38 talked to herself. The DON stated the DON assumed Resident 38 was hearing voices because Resident 38 was talking to self loudly. The DON further stated it was important to monitor the specific target symptom to determine if the medication was effective and if the resident would benefit from GDR. During a review of the facility's Policy and Procedure (P&P) titled, Psychotropic and Psychotherapeutic Drugs the P&P indicated when a resident requires a psychotherapeutic drug a written physician order specifies the duration of the use of the medication and the circumstances under which the medication is to be used (the health record must contain a diagnosis and specific behavior manifestations for the medication is being used). During a review of the facility's P&P titled, Dose Drug Reduction the P&P indicated dose drug reduction should be done gradually at least twice within one year and as often as necessary.

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	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coast Care Convalescent Center	14518 E. Los Angeles St. Baldwin Park, CA 91706

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review the facility failed to ensure medications were secured and stored in the medication cart in Station One for one of one sampled resident (Resident 34). This failure had the potential to result in missing medications or medication diversion (illegal distribution or abuse of medications for purposes not intended by the prescriber) for Resident 34. Findings: During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (MDD, a mental health condition that causes persistently low or depressed mood and a loss of interest in activities), attention and concentration deficit, and anxiety. During a review of Resident 34's History and Physical (H&P) dated 3/14/2024, the H&P indicated Resident 34 had the ability to understand and make decisions. During a review of Resident 34's Order Summary Report (OSR) dated 3/13/2024, the OSR indicated Resident 34 had an order for Actos (medication used for diabetes mellitus) 45 milligrams (mg) daily, Aspirin (ASA) 81 mg daily, Bupropion (medication used for smoking cessation) 150 mg twice a day, Docusate Sodium (medication used to treat constipation) 100 mg twice a day, and Prednisolone Acetate Ophthalmic Suspension % (medication used to treat inflammation) one drop (gtt., unit of measurement) in the right eye, four times a day. During a medication pass observation on 10/24/2024 at 8:30 AM in front of Resident 34's room, Registered Nurse 1 (RN 1) prepared Resident 34's medication. RN 1 walked away from the medication cart without locking the medication cart. RN 1 returned to the medication cart and stated RN 1 accidentally dropped Resident 34's medications on the floor. RN 1 placed three medications on top of the medication cart, pulled out Actos, ASA, Bupropion, and Colace, and walked away from the medication cart without locking the medication cart again, leaving three medications unattended. During an interview on 10/24/2024 at 8:39 AM with RN 1, RN 1 stated RN 1 left Actos, ASA, and Bupropion on top of the medication cart unattended. RN 1 stated Colace was in the trash and RN 1 picked it up after administering new medications to Resident 34. RN 1 stated the medication cart was left unlocked and stated the medication cart should have been locked when RN 1 administered medications to Resident 34 because any resident could open the medication cart. RN 1 stated the medications that were dropped should have been disposed of immediately and not left on top of the medication cart unattended because any resident could have taken it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555199	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/2024 at 1:48 PM with the Director of Nursing (DON), the DON stated licensed staff needed to lock the medication cart every time the licensed staff walk away, to ensure the medications were stored securely. The DON stated the risk of leaving the medication cart unlocked was that residents would take the medications. The DON stated licensed staff were to discard medications inside of the medication room in a disposal container and licensed staff should place medications that were dropped inside of the medication cart for safekeeping until discarding the medications. The DON stated the risk of leaving medications on top of the medication cart unattended was that residents could have taken the medications. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage and Labeling, the P&P indicated the manner of storage of medication shall prevent access by other residents. During a review of the facility's P&P titled, Disposal of Non-Controlled Drugs, the P&P indicated removal of medication from the medication cart will be transferred to the designated holding area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555199	A. Building B. Wing	10/25/2024

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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. 48905 Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for one of one sampled ice machine (IM) by failing to: a. Follow the manufacturer's recommendations for interior cleaning and sanitizing of the Manitowoc IM when moderate amounts of black and yellow substances were observed in the internal components of the Manitowoc IM around the sides of the ice dicer and on the water outlet. The contaminated ice was distributed to 40 residents before breakfast on 10/22/2024. b. Ensure the Manitowoc was deeply cleaned weekly and cleaned monthly as indicated by the cleaning log. These failures had the potential to result in residents to develop water borne illnesses from contaminated ice. Findings: During a concurrent observation and interview on 10/22/2024 at 9:30 AM with the Dietary Supervisor (DS) in the kitchen, the Manitowoc IM was observed to have yellow liquid when a napkin test was performed on the IM. Upon closer inspection, black substances were observed on the sides of the ice dicer and in the water outlet. The DS stated there was an unknown yellow substance on the napkin and unknown black substances around the ice dicer. The DS stated the black substances were there because Maintenance might have missed cleaning the machine. The DS stated the black and yellow substances in the ice machine should not be there and stated the unknown substances could get into the ice and cause a health hazard for residents. During a concurrent in interview and record review on 10/22/2024 at 10:28 AM with Dietary Aide (DA) 1, the facility's Weekly Ice-O-Matic Deep Cleaning Log (WIDC) dated 7/23/2024 to 10/19/2024 was reviewed. The WIDC indicated staff members signed off on the task of deeply cleaning the IM. DA 1 stated DA 1 cleaned the exterior of the IM and stated DA 1 did not clean the inside of the IM. DA 1 stated DA 1 was instructed by DS to only clean the outside of the IM. DA 1 stated deep cleaning would consist of the inside and outside of the IM. DA 1 stated DA 1 would not consider the cleaning to be deep cleaning if only the exterior was cleaned. DA 1 stated DA 1 was not instructed to inspect the inside of the IM because Maintenance was responsible for cleaning the interior compartments. DA 1 stated the importance of cleaning the interior and exterior of the IM to ensure the ice is contained in a clean compartment and stated the risk of serving contaminated ice was that residents could get sick. DA 1 stated black substances looked like mold and stated if residents ingested it residents could possibly get diarrhea. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/2024 at 10:40 AM with the DS, the DS stated staff should not be signing off on a form for deep cleaning if the IM was not deeply cleaned. The DS stated deep cleaning would require cleaning the internal components of the IM. The DS stated if the IM was not cleaned, mold, bacteria, and fungus can grow. The DS stated it was important to clean the IM because the resident could ingest the unknown yellow and black substances and have health concerns. The DS stated food should be served in a sanitary condition and stated if it was not served in a sanitary condition, residents could develop diarrhea, stomach cramps, nausea, vomiting and be at risk for developing waterborne illnesses. During a concurrent interview and record review on 10/22/2024 at 11:06 AM with Maintenance Worker (MW) 1, the facility's Ice Machine Cleaning Log (IMCL) dated 1/2024 to 9/2024 and the Manitowoc Technician's Handbook (MTH) was reviewed. The IMCL indicated the IM was cleaned on 9/16/2024. The MTH indicated to only use approved Manitowoc Ice Machine Cleaner and Sanitizer to clean and sanitize the IM. MW 1 stated MW 1 did not clean the IM for 10/2024 and it was supposed to be cleaned every month. MW 1 stated it was past due to be cleaned and should be completed monthly which was every 30 days. MW 1 stated MW 1 cleaned the IM with one gallon of water to one tablespoon (TBSP, unit of measurement) of bleach. MW 1 stated MW 1 was unaware MW 1 had to use a specific cleaner and sanitizer to clean the IM. MW 1 stated MW 1 did not check the IM manual because MW 1 was using the same process to clean the IM at MW 1's previous job. MW 1 stated the manual was not followed and should've been followed. MW 1 stated the black substances inside the IM looked Slimy and stated if residents ingested it could possibly cause diarrhea and nausea. During an interview on 10/22/2024 at 1:40 PM with the DS, the DS stated Certified Nursing Assistant (CNA) 1 passed out 40 pitchers with contaminated ice to residents at 6:00 AM on 10/22/2024. During an interview on 10/22/2024 at 2:47 PM with the Assistant Administrator (AADM), the AADM stated the AADM saw CNA 1 passing ice water to residents in the morning on 10/22/2024. During an interview on 10/22/2024 at 2:50 PM with the Administrator (ADM), the ADM stated two solutions are to be used to clean the Manitowoc IM: the Manitowoc IM descaler to cleanse the IM and the Manitowoc IM sanitizer to sanitize the machine. During an interview on 10/25/2024 at 1:51 PM with the Director of Nursing, the DON stated the black and yellow substances should not be in the IM, and stated the IM did not keep the ice in a sanitary condition. The DON stated the risk of having unknown black and yellow substances inside the IM was that residents could get sick and develop symptoms of nausea, vomiting, and diarrhea because it was not cleaned properly. During a review of the facility's policy and procedure (P&P) titled Sanitation the P&P indicated a cleaning schedule will list all cleaning tasks and specifies the frequency of the task and the person responsible for completion of the task.

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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** 42781 Based on observation, interview, and record review, the facility failed to ensure 18 of 21 resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20 and 22) met the square footage requirement of 80 square feet (sq. ft., unit of measurement) per resident in multiple resident rooms. This deficient practice had the potential for the residents not to have enough space for activities of daily living and hinder staff from providing nursing care to the residents, affecting the overall quality of life of the residents. Findings: During a review of the facility's request for room waiver letter dated 10/22/2024, the request for room waiver letter indicated there was ample room to accommodate wheelchairs and other medical equipment as well as space for mobility and movement of ambulatory residents. The request for room waiver letter indicated there was an adequate space for nursing care and that the health and safety of the residents occupying these rooms were not in jeopardy. The request for room waiver letter indicated the rooms were in accordance with special needs of the resident's health and safety and do not impede the ability of resident in the rooms to attain his or her highest practicable well-being. During a review of the facility's Client Accommodations Analysis (CAA) dated 10/22/2024, the CAA indicated the following: Room Sq. Ft. Beds 1 301.11 4 2 154 2 3 154 2 4 156.75 2 5 154 2 6 299.98 4 7 154 2 8 155.87 2 10 154 2 11 155.87 2 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	12 155.87 2 14 155.87 2 15 312.62 4 17 155.87 2 18 155.87 2 19 155.87 2 20 155.87 2 22 154 2 During an interview with the facility Administrator (ADM) on 10/23/2024 at 9:25 am, the ADM stated the facility would request a room waiver for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20 and 22. The ADM stated nothing was changed from the last recertification survey and the number of bed occupancy remained the same in Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20 and 22. During an observation from 10/23/2024 to 10/24/2024 during the Health Recertification Survey, Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20 and 22 had adequate space, nursing care, comfort, and privacy to the residents. The residents had enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport) and walkers (a device that gives additional support to maintain balance or stability while walking). The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents in Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20 and 22. During an interview on 10/23/2024 at 9:50 am with Resident 30 inside room [ROOM NUMBER], Resident 30 was awake and lying in bed. Resident 30 stated, Resident 30 was able to wheel herself in and out of the room with no concerns or issues. Resident 30 stated, the room space was enough for her. During an interview on 10/23/2024 at 9:57 am with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, there were enough space in the rooms and staff were able to provide care to the residents. CNA 1 stated she was able to move wheelchairs and walkers inside the rooms with no issues.