STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai South Bay Healthcare Center	15115 S Vermont Ave Gardena, CA 90247

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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** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of seven residents (Resident 73) had a privacy bag for the indwelling catheter (a device that is inserted into the bladder that collects and drain urine). This deficient practice of not covering the indwelling catheter had the potential to effect Resident 73's dignity. Findings: During a review of Resident 73's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 73 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 73's diagnoses included paroxysmal atrial fibrillation (irregular heartbeat that causes blood to pool in the heart), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland), retention of urine (a condition that makes it difficult or impossible to empty the bladder), and extrapyramidal movement disorder (a condition that involve impaired motor control and abnormal movements). During a review of Resident 73's History and Physical (H&P), dated 1/8/2025, the H&P indicated, Resident 73 had the capacity to make decisions. During a review of Resident 73's Minimum Data Set ([MDS] a resident assessment tool), dated 12/31/2024, the MDS indicated Resident 73's cognition (ability to learn, reason, remember, understand, and make decisions) was cognitively intact. The MDS indicated Resident 73 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 73 had an indwelling catheter. During an observation on 1/7/2025 at 9:45 a.m. in Resident 73's room the resident had an indwelling catheter without a privacy bag. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/8/2025 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 1, a picture taken on 1/7/2025 of Resident 73's indwelling catheter was reviewed. LVN 1 stated Resident 73 did not have a privacy bag cover for his indwelling catheter. LVN 1 stated Resident 73 should have a privacy bag to cover the indwelling catheter. LVN 1 stated the privacy bag on the indwelling catheter is to keep the personal integrity for the resident. LVN 1 stated the result of not having the privacy bag could cause the resident to feel embarrassed when socializing with other residents and visitors. LVN 1 stated this could lead to him to stop participating with care. During a concurrent interview and record review on 1/10/2025 at 9:09 a.m. with Certified Nursing Assistant (CNA) 1, a picture taken on 1/7/2025 of Resident 73's indwelling catheter was reviewed. CNA 1 stated there should be a privacy bag placed on the indwelling catheter at all times. CNA 1 stated not having a privacy bag on the indwelling catheter could make Resident 73 feel that everyone knows it's an indwelling catheter and he no longer had privacy. During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, dated 8/2029, the P&P indicated each resident shall be cared for in a manner that promotes of enhances quality of life, dignity, respect, and individuality. The P&P indicated demeaning practices and standards of care that compromise dignity is prohibited including staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered.

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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** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of seven sampled residents (Resident 45) had the call light (a button or device that a patient can press to signal a nurse or healthcare provider that they need assistance) within reach. This has the potential for the resident's needs will not be met promptly. Findings: During a review of Resident 45's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 45 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 45's diagnoses included heart failure (a clinical syndrome where the heart can't pump enough blood to the body), acute myocardial infarction (a sudden and severe blockage of a coronary artery that leads to the death of the heart muscle tissue due to lack of oxygen), and [NAME] syndrome (a condition that causes the colon to suddenly expand without a mechanical blockage). During a review of Resident 45's History and Physical (H&P), dated 5/31/2024, the H&P indicated, Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set ([MDS] a resident assessment tool), dated 10/30/2024, the MDS indicated Resident 45's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 45 was dependent on staff for showering, dressing, and personal hygiene. During an observation on 1/7/2025 at 12:36 p.m. in Resident 45's room the call light was not within reach. During an observation on 1/7/2025 at 3:45 p.m. in Resident 45's room the call light was not within reach. During a concurrent interview and record review on 1/8/2025 at 1:46 p.m. with Licensed Vocational Nurse (LVN) 1, picture taken on 1/7/2025 of Resident 45's call light not within reach was reviewed. LVN 1 stated the call light was not within reach. LVN 1 stated the call light needed to be within reach for Resident 45 in case he needs to call for help. LVN 1 stated not having the call light within reach the resident could try to stand up and fall. LVN 1 stated keeping the call light within reach helps to prevent falls. During a concurrent interview and record review on 1/8/2025 at 2:08 p.m. with Certified Nursing Assistant (CNA) 2, picture taken on 1/7/2025 of Resident 45's call light not within reach was reviewed. CNA 2 stated the call light was not within reach. CNA 2 stated the call light should have been in front of the resident and not hanging down away from the resident. CNA 2 stated it was important to have the call light within reach so Resident 45 could call for help and be assisted. (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 review of facility's policy and procedure (P&P) titled, Call Light Answering, dated 12/2023, the P&P indicated it is the policy of this facility to provide the resident a means of communication with nursing staff. The P&P indicated placed the call device within resident's reach before leaving room. The P&P indicated the nursing staff will check the placement of the call light during care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of seven sample residents (Resident 144) had trimmed fingernails. This failure of not properly trimming Resident 144's fingernails had the potential to cause skin breakdown (a tear, blister, or cuts of the skin with the destruction of tissue and discomfort). Findings: During a review of Resident 144's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 143 was admitted to the facility on [DATE]. Resident 143's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and pleural effusion (a condition where too much fluid builds up between the lungs and the chest cavity). During a review of Resident 143's History and Physical (H&P), dated 12/21/2024, the H&P indicated, Resident 143 had fluctuated capacity to make decisions. During a review of Resident 143's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 143's cognition (ability to learn, reason, remember, understand, and make decisions) was mildly impaired. The MDS indicated Resident 143 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 143 required respiratory treatment of oxygen therapy. During an observation on 1/7/2024 at 10:45 a.m. in Resident 144's room, Resident 144 had dirty and long untrimmed fingernails. During a concurrent observation and interview on 1/8/2024 at 1:35 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 144 had dirty and untrimmed fingernails. LVN 1 stated the fingernails needed to be trimmed. LVN 1 stated the process was the Certified Nursing Assistants were to clean and cut the fingernails. LVN 1 stated it was important to keep the resident fingernails trimmed and clean to prevent the harboring of bacteria (microorganisms that can cause infections). LVN 1 stated due to the fingernails being long and dirty the resident could hurt himself by cutting into his skin. LVN 1 stated Resident 144's dirty and long fingernails was not a good appearance and that it is a part of daily grooming. During a concurrent observation and interview on 1/8/2024 at 2:04 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 144's room, CNA 2 stated Resident 144 had dirty and untrimmed fingernails. CNA 2 stated keeping Resident 144's nails clean and trimmed was a part of daily grooming. CNA 2 stated not having clean fingernails could cause infection while the resident is eating. (continued on next page)

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F 0677 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, Fingernails/Toenails, Care of, dated 2/2018, the P&P indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The P&P indicated general guidelines nail care includes daily cleaning and regular trimming, proper nail care to prevent skin problems around the nail bed, trimmed and smooth nails to prevent the resident from accidentally scratching and injuring his or her skin.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of seven sampled residents (Resident 84) the low air loss ([LAL] a mattress that helps prevent and treat pressure injuries) mattress had the correct settings. This deficient practice of not having the correct LAL mattress settings had the potential for Resident 84 to have skin breakdown (damage to the skin or underlying tissue caused by a loss of blood flow). Findings: During a review of Resident 84's Admission Record (Face Sheet), the Face Sheet indicated Resident 84 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 84's diagnoses included encephalopathy (a medical condition where brain function is impaired, leading to symptoms like confusion, memory loss, and personality changes), pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing). During a review of Resident 84's History and Physical (H&P), dated 11/8/2024, the H&P indicated, Resident 84 did not have the capacity to understand and make decisions. During a review of Resident 84's Minimum Data Set ([MDS] a resident assessment tool), dated 11/11/2024, the MDS indicated Resident 84's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 84 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 84 required oxygen therapy. The MDS indicated Resident 84 had one or more unhealed pressure ulcers. During a concurrent observation and interview on 1/8/2025 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 84's room, Resident 84's LAL mattress settings were set at 400 pounds ([lbs.] a unit of measurement for weight). LVN 1 stated Resident 84 weighed 135 lbs. LVN 1 stated the LAL mattress settings should be set closes to the resident's weight. LVN 1 stated the purpose of the LAL mattress is to help prevent pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and help with healing of pressure ulcers. LVN 1 stated if the LAL mattress settings are not correct Resident 84's skin integrity will not be sustained and could cause skin break down. During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines, dated 9/2013, the P&P indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P indicated selecting a mattress for the resident based on pressure ulcer risk. The P&P did not indicate how to use the LAL mattress. (continued on next page)

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F 0686 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, Prevention of Pressure Ulcers/Injuries, dated 7/2017, the P&P indicated the purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. The P&P indicated support surfaces and pressure redistribution support surfaces based the resident's mobility, continence, skin moisture, body size, weight, and overall risk factors.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of seven sampled residents (Resident 143) to follow physician orders for oxygen therapy (a medical treatment that provides extra oxygen to a patient through a mask or nasal cannula). This failure had the potential of the resident not receiving appropriate medical care. Findings: During a review of Resident 143's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 143 was admitted to the facility on [DATE]. Resident 143's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and pleural effusion (a condition where to much fluid builds up between the lungs and the chest cavity). During a review of Resident 143's History and Physical (H&P), dated 12/21/2024, the H&P indicated, Resident 143 had fluctuated capacity to make decisions. During a review of Resident 143's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 143's cognition (ability to learn, reason, remember, understand, and make decisions) was mildly impaired. The MDS indicated Resident 143 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 143 required respiratory treatment of oxygen therapy. During an observation on 1/8/2025 at 11:30 a.m. in Resident 143's room the oxygen therapy was set at 3 liters. During a review of Resident 143's physician order, titled Order Summary Report, dated 12/25/2024, the Order Summary Report indicated, Resident 143 was to receive 2 liters of oxygen via nasal canula (a device that delivers extra oxygen through a tube and into your nose) continuously every shift. During a concurrent observation and interview on 1/8/2025 at 1:17 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 143's room, Resident 143 had oxygen therapy at 3 liters. LVN 1 stated Resident 143 oxygen therapy should be set at 2 liters. LVN 1 stated the physician orders were not being followed. LVN 1 stated having the oxygen therapy set at 3 liters could be dangerous since the resident had COPD. LVN 1 stated the oxygen at 3 liters continuously could be uncomfortable due to it being greater than 2 liters and could cause oxygen poisoning (occurs when someone breathes in too much oxygen). (continued on next page)

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F 0711 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, Oxygen Administration, dated 10/2010, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P indicated verify that there is a physician's order for this procedure and review the physician's orders or facility protocol for oxygen administration.

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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** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure blood pressure medication was administered in a timely manner for one of 7 sampled residents (Resident 36). This deficient practice had the potential to result in high blood pressure, dizziness, and a stroke. Findings: During a review of Resident 36's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 36 was originally admitted on [DATE] with a readmitted [DATE]. The face sheet indicated Resident 36 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm), atherosclerotic heart disease (a condition where plaque builds up in the arteries, narrowing them and reducing blood flow) and hypertensive heart disease (a group of heart problems that develop over time due to high blood pressure). During a review of Resident 36's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 36 cognitive skills were moderately impaired. The MDS also indicated Resident 36 was dependent on staff for toileting hygiene, showering, and upper/lower body dressing. During a review of Resident 36's physician orders, Resident 36 had an order for Metoprolol (a medication that lowers your blood pressure and heart rate) 25 milligrams MG- a measure of weight) once a day for hypertension (high blood pressure) with a start date of 10/31/2024. During a concurrent interview and record review, on 01/08/2025, at 8:51 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the time frame for administering medications was one hour before and/or one hour after scheduled time. LVN 1 stated Resident 36's Metoprolol was scheduled to be administered at 7:30 a.m. LVN 1 stated Resident 36's blood pressure medication was considered late. LVN 1 stated the risk of not administering medication in a timely manner could result in a drop or rise in blood pressure, especially if not administered on time. During an interview, on 01/10/2025, at 4:03 p.m., with the Administrator (ADM), the ADM stated medication could be given one hour before or one hour after its scheduled time. The ADM stated Resident 36's medication was administered late. The ADM stated the risk of not administering medication in a timely manner could result in adverse side effects and not being consistent with a resident's medication regimen. (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 review of the facility's policy and procedures, titled Medication Administration, dated 8/18/2022, indicated Medications shall be administered in accordance with the orders, including any required time frame and Medications shall be administered, as soon as possible but no more than one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure the medication error rate was less than 5% for two of 2 sampled residents (Resident 36 and resident 148). This deficient practice had the potential to affect the efficacy and side effects of the medications. Findings: During observation of medication administration with Cart 1 and Cart 2, the combined medication error rate was 6.67% with 2 mediation errors out of 30 opportunities. a. During a review of Resident 36's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 36 was originally admitted on [DATE] with a readmitted [DATE]. The face sheet indicated Resident 36 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm), atherosclerotic heart disease (a condition where plaque builds up in the arteries, narrowing them and reducing blood flow) and hypertensive heart disease (a group of heart problems that develop over time due to high blood pressure). During a review of Resident 36's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 36 cognitive skills were moderately impaired. The MDS also indicated Resident 36 was dependent on staff for toileting hygiene, showering, and upper/lower body dressing. During a review of Resident 36's physician orders, Resident 36 had an order for Metoprolol 25mg (a medication that lowers your blood pressure and heart rate) once a day for hypertension with a start date of 10/31/2024. During a concurrent observation and interview, on 01/08/2025 at 8:51 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 36's Metoprolol was scheduled to be administered at 7:30 a.m. LVN 1 stated Resident 36's blood pressure medication was considered late. LVN 1 stated the risk of not administering medication in a timely manner could result in medication errors and a drop or rise in blood pressure, chest pain or heart attack. b. During a review of Resident 148's face sheet, the face sheet indicated Resident 148 was admitted to the facility on [DATE]. The face sheet indicated Resident 148 had diagnoses which included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), dementia (a progressive state of decline in mental abilities), urinary tract infection (UTI- an infection in the bladder/urinary tract) and dehydration (a dangerous loss of body fluid caused by illness, sweating, or inadequate intake. (continued on next page)

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Kei-Ai South Bay Healthcare Center	15115 S Vermont Ave Gardena, CA 90247

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 148's Minimum Data Set (MDS), the MDS indicated Resident 148 cognitive skills was severely impaired. The MDS also indicated Resident 148 was dependent on staff for toileting hygiene, showering, and upper/lower body dressing. During a concurrent observation and interview, on 01/08/2025, at 9:15 a.m., with LVN 2, LVN 2 stated Resident 148's Depakote (a medication used to treat aggression) medication was not available in the medication cart nor the facility. LVN 2 stated the medication was not ordered. LVN 2 stated he called the pharmacy at 9:07 a.m. and Resident 148's medication was to be delivered to the facility later during the day on 1/2/2025. LVN 2 stated the risk of not administering a scheduled medication could result in medication errors and aggressive behaviors. During an interview on 1/08/2025 at 2:53 p.m., with LVN 2, LVN 2 stated the medication was delivered at 2:45 p.m. During a review of the facility's policy and procedures, titled Medication Administration, dated 8/18/2022, indicated Medications shall be administered in accordance with the orders, including any required time frame and Medications shall be administered, as soon as possible but no more than one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders. During a review of the facility's policy and procedures, titled Medication Administration (General), dated 8/18/2022, indicated If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and document the applicable code for specific situation as indicated on the eMAR, and document the reason why the drug is withheld, refused, or given at a time other than the scheduled prescribed time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure medication was ordered from the pharmacy for one of 8 sampled residents (Resident 148). This deficient practice resulted in Resident 148 missing 9 doses and had the potential to result in resident exhibiting physical aggression, restlessness, and manic behavior. Findings: During a review of Resident 148's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 148 was admitted to the facility on [DATE]. The face sheet indicated Resident 148 had diagnoses which included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), dementia (a progressive state of decline in mental abilities), urinary tract infection (UTI- an infection in the bladder/urinary tract) and dehydration (a dangerous loss of body fluid caused by illness, sweating, or inadequate intake). During a review of Resident 148's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 148 cognitive skills was severely impaired. The MDS also indicated Resident 148 was dependent on staff for toileting hygiene, showering, and upper/lower body dressing. During a concurrent observation and interview, on 01/08/2024, at 9:15 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 148's Depakote (a medication used to treat aggression) medication was not available in the facility. LVN 2 stated the medication was should had been delivered to the facility on [DATE]. LVN 2 stated he called the pharmacy on 01/08/2025 at 9:10 a.m. regarding Resident 148's medication but the pharmacy stated they never received a faxed order for Depakote. During a concurrent interview and record review, on 01/08/2024, at 9:56 a.m., with LVN 2, LVN 2 stated Resident 148 had not received his Depakote medication since 1/3/2025. LVN 2 stated Resident 148 missed 9 doses of Depakote from 1/3/25 to 1/8/25. LVN 2 stated the risk of not having the medication in the facility could result in an unsafe environment and Resident 148 could become aggressive to other residents. During an interview, on 01/10/24, at 4:03 p.m., with the Administrator (ADM), the ADM stated the licensed staff was to call and fax any new physician orders to the pharmacy. The ADM stated the pharmacy could deliver medication on the same day as a new order was faxed or deliver the following day if the medication was prescribed late during the day. The ADM stated there was no reason on why Resident 148's medication was not ordered and filled. The ADM stated, The residents are here to get taken care of. If we don't have the medications they need, we aren't taking care of them the way we should. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures, titled Medication Administration (General), dated 8/18/2022, indicated If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and document the applicable code for specific situation as indicated on the eMAR, and document the reason why the drug is withheld, refused, or given at a time other than the scheduled prescribed time. Cross-reference F759.

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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** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure Tylenol suppositories (a rectal medication used to relieve mild to moderate pain from headaches or muscle aches and to reduce a fever) stored in a clear, Ziplock bag was labeled and dated in the Station 1 Medication Storage room. This deficient practice had the potential to result in medication errors. Findings: During a concurrent observation and interview, on [DATE], at 9:17 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 observed an unlabeled and undated clear Ziplock bag with 52 rectal Tylenol suppositories stored in the medication fridge. LVN 3 stated the Ziplock bag should had been labeled and dated with an open date and expiration date. LVN 3 stated the risk of storing an unlabeled bag of medication in the medication refrigerator could result in medication errors. LVN 3 stated there was no label on the bag. LVN 3 stated We don't know if the medication is expired, if it belongs to a resident or what the medication is. During an interview, on [DATE], at 4:03 p.m., with the Administrator (ADM), the ADM stated all medication in the medication storage room was to be labeled and dated with open dates and expiration dates. The ADM stated the risk of having unlabeled medication in the medication storage refrigerator could result in medication errors. The ADM stated, We wouldn't know if the medication belongs to a resident or if it's a house medication. We also wouldn't know if the medication is expired. It could result in bad consequences if given to the wrong resident. During a review of the facility's policy and procedures, titled Storage of Medications, dated ,d+[DATE], indicated Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview, and record review, the facility failed to: 1. Ensure dental services were provided for one of 7 sampled residents (Resident 35). This deficient practice had the potential to result in a delay in necessary dental care and services. Findings: During a review of Resident 35's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 35 was originally admitted to the facility on [DATE] with a readmitted [DATE]. The face sheet indicated Resident 35's had diagnoses which included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), atrial fibrillation (an irregular and often very rapid heart rhythm), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 35's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 35 cognitive skills was severely impaired. The MDS also indicated Resident 35 was dependent on staff with toileting hygiene, showering and upper/lower body dressing. During an interview, on 01/07/2025, at 11:20 a.m., with Resident 35's son, Resident 35's son stated the facility's dental services, Golden Age Dental Care, visited residents monthly. Resident 35's son stated Resident 35's upper dentures had been loose for the past year. Resident 35's son stated Resident 35's upper dentures was supposed to be realigned for a better fit and was not. During an interview, on 01/10/2025, at 11:00 a.m., with Social Services Director (SSD), the SSD stated the facility's dental service visited all residents every month. The SSD stated Resident 35's last dental appt with Golden Age was 11/1/2024. SSD stated Resident 35 needed a realignment of her upper dentures. The SSD stated the Social Services department was responsible for following up with dental services for residents. The SSD stated there was no follow up with dental services for Resident 35. The SSD stated the risk of not following up on dental services could result in a resident not being able to eat, pain and discomfort. During an interview, on 01/10/2025, at 11:31 a.m., with the SSD, SSD stated she had called Golden Age at 11:25 a.m. on 01/10/2025 and received an approval to have Resident 35's dentures fixed. During an interview, on 1/10/2025, at 4:03 p.m., with the Administrator (ADM), the ADM stated Social Services was responsible for setting appointments, follow ups, transportation, and reimbursements of dental services. The ADM stated Resident 35's upper dentures should had been followed up on. The ADM stated the risk of not following up with dental services could result in weight loss, not eating and being uncomfortable. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures, titled Dental Services, revised 12/2016, indicated Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation and interview the facility failed to change oxygen tubing in seven days for one out of five Residents (Resident 66). This deficient practice placed Resident 66 at risk for infection. Findings: During a review of Resident 66's Admission Record (Face Sheet), the Face Sheet indicated Resident 66 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 66's diagnoses included chronic obstructive pulmonary disease (a medical condition that cause airflow blockage and breathing-related problems), heart failure (a medical condition that develops when the heart does not pump enough blood for your body's needs), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood). During a review of Resident 66's History and Physical (H&P), dated 12/7/2023, the H&P indicated Resident 66 does not have the capacity to understand and make decisions. During a review of Resident 66's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 12/7/2023, the MDS indicated Resident 66's cognition (ability to learn, reason, remember, understand, and make decisions) to recall information when ask to repeat information with some cueing (giving a signal or reminding member to do a task). The MDS indicated Resident 66 activities of daily living (ADL) dependent assistance with toileting, showering, and dressing. During an observation on 12/26/2023 at 9:43a.m. in Resident 66's room there was oxygen tubing (a device that gives additional oxygen through your nose) infusing to Resident 66 at 2 liters per unit attached to a humidifier (a device for keeping the atmosphere moist) unit with the date of 12/18/2023. During an interview on 12/28/2023 at 9:30a.m. with Licensed Vocational Nurse (LVN) 1. LVN 1 stated oxygen tubing is changed once a week. LVN 1 stated the humidity () build up in the oxygen tubing and can get in the lungs of Resident 66 if the oxygen tubing is not changed every 7 days. LVN 1 stated it is important to change the oxygen tubing once a week to prevent infection. During an interview on 12/28/2023 at 1:20p.m. with Assistant Director of Nursing (ADON) 1. ADON 1 stated oxygen tubing is changed once a week. ADON 1 stated the oxygen tubing needed to be changed for Resident 66 to prevent infection. During an interview on 12/28/2023 at 1:32p.m. with Infection Preventionist Nurse (IPN) 1. IPN 1 stated 1oxygen tubing should be changed every seven days. IPN 1 stated If the oxygen tubing is not changed it can put Resident 66 at risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated 6/2021, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Policies and procedures reflect the current infection prevention and control standards of practice .Updating or supplementing polices and procedures as needed . Assessment of staff compliance with existing policies and regulations. During a review of facility's policy and procedure titled, Respiratory Therapy-Prevention of Infection, dated 11/2023, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .Change the oxygen cannula and tubing every seven days.