STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555338	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Care Center	1836 N. Fair Oaks Ave Pasadena, CA 91103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on interview and record review, the facility failed to ensure two (2) of 2 sampled residents were treated with dignity and respect by failing to: 1. Ensure Resident 22's clothes and linen are clean and no food stains and debris on 12/9/2024 and 12/10/2024. 2. Ensure Resident 1 was assisted with feeding at an eye level. This deficient practice has the potential to affect the resident's self-worth and self-esteem. Findings: 1. During a review of Resident 22's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of muscle wasting (weakening, shrinking, and loss of muscle) and dementia (a progressive state of decline in mental abilities). During a review of Resident 22's History and Physical (H&P), dated 10/30/2024, indicated resident has the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated 11/11/2024, indicated resident is independent in cognitive (the functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision making. The MDS also indicated resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, lower body dressing, putting on/taking off footwear and required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing. The MDS indicated, Resident 22 also required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating, oral hygiene, and personal hygiene. (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 - Some	During a review of Resident 22's Care Plan with focus on resident requires assistance with Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily), dated 3/4/2022, indicated to assist with all ADL as needed and assist with dressing daily as needed. During a concurrent observation in Resident 22's room and interview on 12/9/2024 at 9:16 AM, Resident 22 was observed with orange stains on his shirt and bed linens. Certified Nursing Assistant 6 (CNA 6) stated it was food stains. During an interview on 12/10/2024 at 3:53 PM, Resident 22 stated the food stain on his shirt bothers him. During an interview on 12/11/2024 at 11:29 AM, Director of Staff Development (DSD) stated if a resident is alert, then the CNA would need to ask if the resident would want to be changed (clothes and bed linen) and provide some encouragement. DSD also stated keeping the resident with clean clothes and bed linen is for the resident's dignity. During an interview on 12/11/2024 at 12:58 PM, the Director of Nursing (DON) stated the CNAs should offer to change the resident and not wait for the resident to ask to be changed. The DON also stated it is a dignity issue if resident was left with soiled clothes and bed linen. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised 2/2021, indicated employees shall treat all residents with kindness, respect, and dignity. The P&P also indicated resident right to a dignified existence. 44636 2. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis), and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right hand. During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the upper extremity (shoulder, elbow, wrist, and hand). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for eating. During a concurrent observation and interview on 12/9/2024 at 12:41 PM in Resident 1's room, Certified Nursing Assistant (CNA 5) was standing and feeding Resident 1's on the resident's right-hand side while resident is in bed. CNA 5 stated she was standing and forgot to sit down to feed Resident 1. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 10:47 AM with the Director of Nursing (DON), the DON stated staff should be sitting down while feeding the residents. The DON stated when staff stood while feeding residents, it showed authority and can make the resident feel disrespected and feel not being treated with dignity. The DON stated it was more comfortable for the resident to see staff at an eye level while feeding. The DON also stated the residents would have to raise their heads while being feed which could also result in discomfort. During a record review of the facility's Policy and Procedure titled, Resident Rights, revised 2/2021, the policy indicated employees shall treat all residents with kindness, respect, and dignity.

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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** 42223 Based on observation, interview and record review, the facility failed to accommodate the needs of two of 21 (Residents 39 and 29) residents, by failing: 1. To ensure the call light (initial communication between staff and residents) was within reach of Resident 39 when the resident needed to call for help to ask for water on 12/11/2024. 2. To provide Resident 29 with a touch pad call light (with a gentle touch, it will signal to notify a caregiver that assistance is needed) which is appropriate for the resident condition/needs. This deficient practice has the potential to delay in the necessary care and services and/ or needs not being met for Resident 39 and 29. Findings: 1. During a review of Resident 39's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of dementia (a progressive state of decline in mental abilities) and depression (elevation or lowering of a person's mood). During a review of Resident 39's History and Physical (H&P), dated 3/1/2024, indicated resident is alert and orient to person and place. The H&P also indicated resident needs assistance with everything apart from feeding. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2024, indicated resident is severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated resident is dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. In addition, the MDS indicated, Resident 39 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, upper body dressing and personal hygiene and needs assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. During a review of Resident 39's care plan with focus on assistance with Activities of Daily Living (ADLs - activities such as bathing, dressing, and toileting a person performs daily) , revised 10/7/2021, indicated to assist with ADL's as needed and have call light within resident's reach. During an observation inside Resident 39's room on 12/11/2024 at 3:25 PM, Resident 39 was observed yelling and stating he needs water. Call light was observed to be placed behind the resident. During a concurrent observation in Resident 39 room and interview on 12/11/2024 at 3:30 PM, Certified Nursing Assistant 7 (CNA 7) stated Resident 39's call light is not within the resident's reach, and it should be within reach of the resident. CNA 7 also stated the call light was placed behi nd the head of the bed the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 4:12 PM, Director of Nursing (DON) stated the call light should be within reach so the resident can call the staff when the resident needs assistance. 2. During a review of Resident 29's admission record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of functional quadriplegia (complete immobility due to severe physical disability or frailty) and bullous pemphigoid (a rare skin condition that mainly affects older people). During a review of Resident 29's H&P, dated 11/14/2024, indicated resident is awake and would make eye contact. During a review of Resident 29's MDS, dated [DATE], indicated resident is severely impaired in cognitive skills for daily decision making. The MDS also indicated resident is dependent with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Resident required substantial/maximal assistance with eating and oral hygiene. During a review of Resident 29's care plan with focus ADL self-care performance deficit and limited physical mobility, revised 6/1/2023, indicated to encourage the resident to use bell to call for assistance. During an observation in Resident 29's room on 12/9/2024 at 10:49 AM, Resident 29 was observed with contracted hands and a call light that required a push of a button. During a concurrent observation and interview on 12/11/2024 at 8:48 AM, the DON stated it is not the right call light for Resident 29 because his hands are contracted, and the resident is unable to push the call light button when resident needs assistance or help. The DON stated Resident 29 needs a call light that is a touch pad call light so resident can use it to call for staff. During a review of the facility's Policy and Procedure titled, Resident Call System, dated 9/2022, indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The P&P also indicated if the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on interview and record review, the facility failed to ensure a comprehensive, resident-centered care plan was developed for five (5) of 21 sampled residents (Resident 126, 1, 37, 2, and 59) as indicated on the facility's policy: 1. Resident 126 did not have a care plan for the use of oxygen. 2. Resident 1 did not have a care plan for Restorative Nursing Assistant (RNA) services (provided by certified nursing assistants [CNAs] who specialize in rehabilitation and restorative care for residents with limited mobility.) 3. Resident 37 did not have a care plan for the refusal of RNA services. 4. Resident 59 did not have a care plan for Low Air Loss (LAL) mattress (operates using a blower-based pump that is designed to circulate a constant flow of air through the mattress, commonly used to heal pressure ulcers [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence]). 5. Resident 2 did not have a care plan for the use of an indwelling catheter (Foley catheter; a thin, flexible tube that is inserted into the bladder to drain urine). These deficient practices have the potential for a delay in the necessary care and services for Residents 126, 1, 37, 59, and 2, which could cause harm and complications resulting to negatively affecting the residents' overall wellbeing. Findings: 1. During a review of Resident 126's Admission Record, the Admission Record indicated resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of trigeminal neuralgia (a type of chronic pain disorder that involves sudden attacks of severe facial pain) and repeated falls. During a review of Resident 126's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2024, the MDS indicated resident was independent with cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated Resident 126 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bath self, upper body dressing, lower body dressing and putting on/taking off footwear. Resident required supervision or touching assistance (helper provides verbal cures and/or touching/steadying and/or contract guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) with eating, oral hygiene, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's Physician Orders, dated 12/8/2024, the Physician's order indicated oxygen at two (2) to four (4) liters per minute (LPM, volume of oxygen supplied over a period of time) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath/ wheezing keep oxygen saturation (SpO2, amount of oxygen in the blood or how well a resident is breathing) above 95%. During an observation on 12/9/2024 at 9:39 AM, Resident 126 was observed with oxygen via nasal cannula. During a concurrent review of Resident 126's care plans and interview with MDS Nurse on 12/11/2024 at 9:35 AM, MDS Nurse stated the resident did not but should have a care plan for the use of oxygen per physician's order. MDS Nurse also stated it was important to have a care plan for continuity of care and for the staff to follow interventions for the resident. During an interview on 12/11/2024 at 12:50 PM, Director of Nursing (DON) stated a resident who uses oxygen is required to have a care plan because the staff needs to follow the plan of care for the resident. DON also stated it is for the continuity of care and for the nurses to implement the interventions for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated for preparation of oxygen administration to review the resident's care plan to assess for any special needs of the resident. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, revised December 2016, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. P&P also indicated the care plan describe the services that are provided. 44636 2. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis), and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right hand. During a record review of Resident 1's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the upper extremity. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Physician Order Summary Report, dated 11/11/2024, the order indicated RNA for passive range of motion (PROM, the range that can be achieved by external means such as another person or a device) to bilateral upper extremities (BUE, both arms from shoulder to hands) three (3) sets of ten (10) all planes every day 5 times per week as tolerated every day shift. During a review of Resident 1's care plan indicating risk for functional decline and decline of range of motion, revised on 11/2/2024, did not include care plan interventions for PROM to Resident 1's BUE as indicated on the Physician Order Summary Report, dated 11/11/2024. During an interview on 12/9/2024 at 9:27 AM in Resident 1's room with Resident 1, Resident 1 stated he did not receive RNA services for upper extremities and only received RNA services for his lower extremities. During an interview on 12/11/2024 at 12:34 PM with MDS Nurse, MDS Nurse stated the care plans were interventions staff needed to do for the residents for continuity of care. MDS Nurse stated the care plans would allow nurses to anticipate what the residents' needs were while they were in the facility. During a concurrent interview and review of Resident 1's care plan on 12/11/2024 at 3:57 PM with Physical Therapist 1 (PT 1), PT 1 stated Resident 1 did not have care plan for RNA services for BUE. PT 1 stated there should be a care plan to make sure staff knew what services was to be provided for Resident 1 to make sure there was not decline in range of motion. During a concurrent interview and review of Resident 1's care plan on 12/12/2024 at 9:32 AM with Registered Nurse (RN 2), RN 2 stated Resident 1 did not have care plan for RNA services for BUE. 3. During a record review of Resident 37's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of encounter for surgical aftercare following surgery on the digestive system, ventral hernia (protrusion of intestine or other tissue through a weakness or gap in the abdominal wall), and metabolic encephalopathy. During a record review of Resident 37's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated Resident 37 had impairment on one side of the upper extremity and used a walker and wheelchair for mobility devices. The MDS indicated required partial/moderate assistance (helper does less than half the effort for toileting hygiene, shower/bathe self, lower body dressing, chair/bed-to-chair transfer, toilet transfer, walking 10 feet, and walking 50 feet with two turns. During a record review of Resident 37's Physician Order Summary Report, dated 6/11/2024, the orders indicated as follows: - RNA order for ambulation with front wheeled walker (FWW, a mobility aid designed to assist individuals with limited mobility by providing stability and support while walking) 50 to 150 feet or as tolerated every day five times per week or as tolerated, every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- RNA Program: Active assisted range of motion (AAROM, therapeutic exercises used to increase joint flexibility, muscular strength, and joint mobility) to BUE for every day 5 times per week for 3 sets of 10 reps or as tolerated in all available planes of motion within pain-free ROM, to maintain functional movement, every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday. During a record review of Resident 37's Restorative Orders, the orders indicated: - In October: Resident 37 refused RNA services seven times. - In November: Resident 37 refused RNA services 11 times. - In December: Resident 37 refused RNA services six times. During a record review of Resident 37's care plans, there were no care plan for Resident 37's refusal of RNA services. During an interview on 12/11/2024 at 12:34 PM with MDS Nurse, MDS Nurse stated the care plans were interventions staff needed to do for the residents for continuity of care. MDS Nurse stated the care plans would allow nurses to anticipate what the residents' needs were while they were in the facility. During a concurrent interview of record review of Resident 37's medical records on 12/12/2024 at 9:45 AM with RN 2, RN 2 stated Resident 37's RNA notes indicated Resident 37 had episodes of refusals for RNA services and were mostly due to discomfort and pain. RN2 stated Resident 37's refusals of RNA services since October 2024 was concerning. RN 2 stated in accordance with the Resident 37's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team) and care plans, Resident 37's physician had not been notified and an updated care plan had not been done. RN 2 stated a care plan should have been developed for Resident 37's refusals of RNA services. RN 2 stated with updated care plan comes interventions and goals which could allow other nurses to monitor the refusals more closely. RN 2 stated refusals could indicate other complications such as pain and depression. 48152 4. During a review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses that included contractures (stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right ankles, contractures of the left and right hands and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 59 needed substantial/maximal assistance (helper does more than half the effort needed to complete the activity) for oral and personal hygiene, rolling left and right and moving from lying to sitting or sitting to lying. The MDS also indicated Resident 59 was assessed as at risk for developing pressure ulcers/injuries with a treatment of pressure reducing device for bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's Order Summary, dated 12/12/2024, the Order Summary indicated an order for LAL mattress setting according to weight and comfort of the resident every shift. During a review of Resident 59's Treatment Administration Record (TAR), dated 12/2024, the TAR indicated may have LAL mattress for skin management & fragile skin, monitor for proper LAL Mattress setting every shift, ordered 11/5/2024. During an observation on 12/10/2024 at 8:15 AM at Resident 59's bedside, Resident 59 was observed lying in bed on LAL mattress therapy. During a concurrent observation, interview, and record review on 12/10/2024 at 4:23 PM with Treatment Nurse 1 (TN1), Resident 59 observed in bed on a LAL mattress therapy. Resident 59's medical chart including all care plans were reviewed. The medical chart did not indicate a care plan for Resident 59's LAL therapy. LVN 1 stated she was unable to locate a care plan that included Resident59's LAL therapy. LVN 1 stated it is required for Resident 59 to have a care plan for the LAL therapy because it is the plan that will be done by staff. LVN 1 stated this will ensure the care plan interventions are being followed as indicated to achieve the care plan goals for Resident 59. During a concurrent interview and record review on 12/10/2024 at 4:44PM with Registered Nurse 1 (RN1), Resident 59's medical chart including all care plans were reviewed. The medical chart did not indicate a care plan for Resident 59's LAL therapy. RN1 stated Resident 59 did not and should have a care plan for LAL therapy to ensure that there are specific goals set and that staff are monitoring the effectiveness of the LAL therapy. 48395 5. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Parkinson's disease (a progressive nervous system disorder that causes nerve cells in the brain to deteriorate, leading to movement problems) without dyskinesia (a movement disorder that involves involuntary muscle movements such as tics, tremors, shakes, or full-body movements) and schizophrenia (a chronic mental disorder that affects how a person things, feels and behaves). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe impairment (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 2 needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), and rolling left and right in bed and needed partial/moderate assistance (helper does less than half the effort) with upper and lower body dressing (the ability to dress and undress above and below the waist) and personal hygiene. Resident 2 was assessed with an indwelling catheter. During a review of Resident 2's Treatment Administration Record (TAR) dated December 2024, the TAR indicated an order for urinary catheter care every shift from 11/28/2024 to 12/11/2024 and another order to monitor for signs and symptoms (s/s) of infection: fever, sediments (the presence of specks, cells, or debris in urine that make it look cloudy), foul odor, change in color, hematuria (blood in urine) every shift for foley catheter care if present indicate letter. If not present not applicable (NA) from 11/28/2024 - 12/11/2024. (continued on next page)

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	555338	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Care Center	1836 N. Fair Oaks Ave Pasadena, CA 91103

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/9/2024 at 9:53 AM in Resident 2's room, Resident 2 was observed to have a Foley catheter hanging on the side of the bed in a dignity bag with thick cream-colored sediment in the Foley catheter tubing. During an observation on 12/10/2024 at 8:18 AM in Resident 2's room, Resident 2 was observed asleep in bed with a Foley catheter hanging on the side of the bed in a dignity bag with thick, cloudy cream-colored sediment in the Foley catheter tubing. During a concurrent interview and record review on 12/10/2024 at 4:29 PM with Registered Nurse 1 (RN 1), Resident 2's Care Plan dated December 2024 was reviewed. Resident 2 did not have a care plan for Foley catheter use. RN 1 stated the last Foley care plan Resident 2 had was on 7/10/2024 and was resolved and stated Resident 2 was discharged at that time from the facility and was recently readmitted . RN 1 stated there is no current Foley catheter care plan for the resident and that there should have been one initiated especially since a care plan's purpose is to help indicate and meet the goal for the resident by ensuring interventions are carried out. During an interview on 12/11/2024 at 12:34 PM with MDS Nurse, MDS Nurse stated the care plan ensures the facility staff and nurses are aware about the resident and are able to anticipate the resident's needs for continuity of care. MDS Nurse stated Resident 2's Foley catheter care plan should have been initiated the same day her Foley catheter was first put in or upon admission if she was admitted to the facility with a Foley catheter. MDS further stated, If there is no care plan for the resident having a Foley catheter then how will the staff know what care to provide for that specific resident? During an interview on 12/12/2024 at 2:04 PM with the Director of Nursing (DON), the DON stated there should be a care plan initiated for a resident with a Foley catheter so that facility staff are able to communicate the resident's plan of care and know the interventions that need to be done to care for that specific resident. The DON stated that if there is no care plan, the facility staff will not be able to know the problem the resident has or what kind of care they need or the interventions they need to implement to help eventually resolve the problem.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to coordinate with the primary physician and IDT and to collaborate with Hospice 1 regarding Resident 1's Responsible Party's (RP 1) request to place Resident 1 under hospice care (a program that gives special care to residents who are near the end of life and have stopped treatment to cure or control their disease) for one of 21 sampled residents (Resident 1). This deficient practice resulted in a delay or lack of coordination in delivery of hospice care and services to Resident 1. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of quadriplegia (paralysis of all four limbs), metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), and multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis). During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the upper extremity. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. During a record review of Resident 1's Hospice Informed Consent and Treatment Authorization, dated 10/11/2024, the Hospice Consent indicated RP 1 signed the consent for hospice care. During a record review of Resident 1's Skilled Nursing Facility and General In-Patient Agreement, dated 10/29/2024, the agreement indicated the Administrator has signed the hospice agreement with Hospice 1. The agreement indicated this was a legally binding agreement for the provision of arranged services. During a record review of Resident 1's Physician Order Summary Report for the month of November and December 2024, the order did not indicate for Resident 1 to receive hospice services. During a concurrent interview and record review on 12/12/2024 at 10:02 AM, Resident 1's hospice documents and physician's orders dated 10/29/2024 To 12/12/2024 was reviewed. RN 2 stated Resident 1 did not have any physician orders indicating to place Resident 1 on hospice. RN 2 stated, RN 2 was not aware what happened after residents signed a consent for hospice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/2024 at 10:13 AM with the Director of Nursing (DON), the DON stated an Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) Meeting should have been conducted to discuss the resident's condition with the responsible party/family when a resident signed a hospice agreement. The DON stated it had been over a month and a half after RP signed the agreement on 10/11/2024 and Resident 1 was not placed on hospice care. The DON stated she did not follow up with RP 1's hospice request for Resident 1, it was not coordinated with the IDT including Resident 1's primary physician so the physician's order was not obtained and the facility did not collaborate with Hospice 1. During the same concurrent interview and record review on 12/12/2024 at 10:26 AM with the DON, Resident 1's progress notes, IDT notes, care plans, and social service notes from October to December 2024 were reviewed. The DON stated there were no documented evidence that follow up was made with RP 1's request for hospice for Resident 1. The DON also stated, there was no documented evidence that the hospice care request was coordinated with IDT, Resident 1's primary physician and that the facility collaborated with Hospice 1. The DON stated hospice care services were for the resident and family by providing emotional and spiritual support and provision of additional care to the resident. The DON stated the facility did not and should have coordinated with the IDT including the resident's primary physician regarding RP 1's request for hospice care to ensure Resident 1's needs are being met. During an interview on 12/12/2024 at 11:10 AM with RP 1, RP 1 stated RP 1 signed the hospice contract and spoke with the DON and was under the impression that the hospice did not accept the contract. RP 1 stated RP 1 wanted Resident 1 placed in hospice in order to receive additional care. During a record review of the facility's Policy and Procedure titled, Hospice Program, revised 7/2020, the policy indicated the facility staff will collaborate with hospice representatives and coordinate facility staff participation in the hospice care planning process for residents receiving theses services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Residents 1 and 59) were provided necessary treatment and services to prevent formation of and promote healing of pressure injury (pressure ulcers, injury to the skin and underlying tissue resulting from prolonged pressure on the skin) in accordance with the facility's policy and procedure and physician's order by failing to ensure Resident 1 and 59's low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure sores designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings. This deficient practice had the potential to place Residents 1 and 59 at risk for skin integrity complications and to have worsening or recurrence of a pressure sore. Findings: 1. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of quadriplegia (paralysis of all four limbs), pressure ulcer of sacral (bone at the end of the spine) region stage 4 (deep pressure injury, reaching into muscle and bone and causing extensive damage), multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis), and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right hand, right ankle, and left ankle. During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the upper (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. The MDS also indicated Resident 1 had a stage 4 pressure ulcer/injury. During a record review of Resident 1's Physician Order Summary Report, the order indicated as follows: - On 10/31/2024: Sacrum (a triangular bone at the base of the spinal column that connects with or forms a part of the pelvis) pressure injury: cleanse with normal saline (NS, mixture of salt and water used to replenish fluid and electrolyte), pat dry, apply Collagen particles (used in wound treatment to stimulate new tissue growth), cover with bordered foam dressing (a soft absorbent foam pad surrounded by a waterproof or semi-permeable adhesive border) every day shift. - On 11/5/2024: May have LAL mattress for skin management, pressure injury, and fragile skin. Monitor for proper LAL mattress setting every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/10/2024: LAL mattress setting according to weight and comfort of the resident every shift. During a record review of Resident 1's care plan for pressure injury stage 4, dated 11/4/2024, the care plan did not indicate LAL mattress for skin management. During a record review of Resident 1's Braden Scale Assessment, dated 11/11/2024, the assessment indicated Resident 1 was at high risk for developing pressure ulcers. During a record review of Resident 1's Weights and Vital Summary, dated 12/4/2024, the weight summary indicated Resident 1's weight was 107 pounds (lbs., unit of measurement). During an observation on 12/9/2024 at 9:29 AM in Resident 1's room, Resident 1 was lying in bed with the LAL mattress setting at 5 (210 lbs.). Observed that there was a sticky note on the LAL machine with a red arrow pointing HERE to level three (3). During a concurrent observation and interview on 12/10/2024 at 3:35 PM in Resident 1's room with Resident 1, Resident 1 was lying on his back with the LAL mattress setting at 5. Resident 1 stated, My bed is hard, it is not comfortable, my back hurts. During a concurrent observation in Resident 1's room and interview on 12/10/2024 at 3:43 PM with Licensed Vocation Nurse (LVN 3), observed Resident 1's LAL mattress setting was set at 5. LVN 3 stated the LAL mattress setting should be set based on the resident's weight. LVN 3 stated Resident 1's LAL mattress setting was set at 5 for a weight of 210 lbs. LVN 3 stated Resident 1 complained about the resident's back hurting and the LAL setting needed to be adjusted because the resident's weight is 107 lbs. During an interview on 12/11/2024 at 9:18 AM with Treatment Nurse (TN 1), TN 1 stated Resident 1's LAL mattress should be set based on the resident's weight. TN 1 stated if the setting was higher than Resident 1's weight it would not be comfortable for the resident. TN 1 stated having a higher setting for the LAL mattress could cause pressure ulcer. TN 1 stated the mattress would not be effective to help with wound management since the mattress was too hard. During a record review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the policy indicated the comprehensive, person-centered care plan will aid in preventing or reducing decline in the resident's functional status and/or functional levels and reflect currently recognized standards of practice for problem areas and conditions. 48152 2. During a review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses that included contractures of the left and right ankles, contractures of the left and right hands and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 with severely impaired cognitive skills for daily decision making. The MDS indicated Resident 59 needed substantial/maximal assistance (helper does more than half the effort needed to complete the activity) for oral and personal hygiene, rolling left and right and moving from lying to sitting or sitting to lying. The MDS also indicated Resident 59 with a risk for developing pressure ulcers/injuries with a treatment of pressure reducing device for bed. During a review of Resident 59's Physician's Order date 11/5/2025, indicated may have LAL mattress for skin management and fragile skin. The order also indicated monitor for proper LAL mattress setting every shift. During an observation on 12/10/2024 at 8:15 AM at Resident 59's bedside, Resident 59 was observed lying in bed with LAL mattress weight setting of 130lbs - 180 pounds (lbs). During an observation on 12/10/2024 at 10:59 AM at Resident 59's bedside, Resident 59's LAL mattress was observed with a weight setting of 130lbs - 180 lbs. During an observation on 12/10/2024 at 3:30 PM at Resident 59's bedside, Resident 59 observed lying in bed with the LAL mattress weight setting of 130lbs - 180lbs. During a concurrent observation, interview and record review on 12/10/2024 at 4:23 PM with TN1, Resident 59 observed in bed with LAL mattress weight set at 130lbs - 180lbs. Resident 59's Weight Summary, dated, was reviewed. The weight summary indicated Resident 59 with a weight of 93lbs as of 12/4/2024 .TN 1 stated according to Resident 59's weight of 93lbs, the LAL mattress is on the wrong weight setting and needs to be set at 80lbs - 130 lbs. TN 1 stated 130lbs - 180lbs is not an appropriate setting because her weight is not in that range, the pressure is not appropriate for the resident and it may be too firm. TN1 stated the wrong weight setting could affect Resident 59 making the resident uncomfortable and may not effectively prevent pressure ulcers. During a concurrent interview and record review on 12/10/2024 with Registered Nurse 1 (RN1), Resident 59's Treatment Administration Record (TAR), dated 12/2024 was reviewed. The TAR indicated may have LAL mattress for skin management & fragile skin, monitor for proper LAL mattress setting every shift, ordered 11/5/2024. RN1 stated the proper setting for Resident 59 means the mattress setting is set according to Resident 59's weight of 93lbs and would need to be set between the 80lbs and 130lbs. RN1 stated the proper setting is important for Resident 59 to prevent skin issues and recurrence of pressure ulcers and if the LAL mattress is on the wrong setting the mattress will be too hard [firm] and create a risk for pressure ulcers instead of preventing them. During a review of the facility's Policy and Procedure (P&P) titled Low Air Loss Therapy, (undated), the P&P indicated it is the policy of the facility to utilize the low air loss therapy under the direction of the physician's order. During a review of the operation manual titled, Brand 1 4000DX/4600DX/5000DX system, (undated), the operation manual indicated: A. The system [pump unit, mattress, and optional cover sheet] intended to reduce the incidence of pressure ulcers while optimizing patient comfort. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. The product function of the press weight range is to press minus or plus buttons to select the correct patient weight [setting]. C. Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to provide Restorative Nursing Services (a program available in nursing homes to help residents maintain any progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) as ordered by the physician to increase, prevent, or maintain range of motion (ROM, full movement potential of a joint) for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for decline in physical functions and developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in the extremities (a limb of the body, such as the arm or leg) for not receiving the ordered exercises. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis), and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right hand. During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 had impairment on both sides of the upper extremity. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. During a record review of Resident 1's Physician Order Summary Report, dated 11/11/2024, the order indicated Restorative Nursing Assistant (RNA) for passive range of motion (PROM, the range that can be achieved by external means such as another person or a device) to bilateral upper extremities (BUE, both arms from shoulder to hands) three sets of ten (10) all planes every day, five (5) times per week as tolerated every day shift. During a record review of Resident 1's Joint Mobility Assessment, dated 1/5/2024, the assessment indicated Resident 1's left wrist had minimal (25% - 50%) mobility. During a record review of Resident 1's Joint Mobility Assessment, dated 11/11/2024, the assessment indicated Resident 1's left wrist had moderate (50% - 75%) mobility. During a record review of Resident 1's Rehab Progress Notes, dated 11/11/2024, the note indicated deterioration was noted in Resident 1's bilateral upper extremities contractions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Restorative Orders (a medical record used by healthcare providers to document the RNA interventions that help residents maintain their independence and safety) for the month of November 2024, the Restorative Orders did not include RNA services for the BUE. During a record review of Resident 1's Restorative Orders for the month of December 2024, the Restorative Orders did not include RNA services for the BUE. During a record review of Resident 1's risk for functional decline and decline of range of motion, revised on 11/2/2024, the care plan interventions did not include to provide PROM to the BUE. During an interview on 12/9/2024 at 9:27 AM in Resident 1's room, Resident 1 stated he did not receive RNA services to his upper extremities since November During an interview on 12/11/2024 at 2:52 PM with RNA 1, RNA 1 stated Resident 1 did not have physician orders for PROM on the upper extremities. RNA 1 stated Resident 1 right arm was positioned straight, and his left arm was contracted with his hand positioned on his chest. RNA 1 stated ROM was only performed on Resident 1's bilateral lower extremities (BLE, both legs from hip to foot) and non for BUE. RNA 1 stated Resident 1 needed range of motion (ROM, full movement potential of a joint) to be performed on the BLEs. RNA 1 stated Resident 1 never refused RNA services. During a concurrent interview and record review of Resident 1's Physician Order Summary Report on 12/11/2024 at 3:34 PM with Physical Therapist (PT 1), PT 1 stated on 11/12/2024 Resident 1 was started on PROM for BUE to be completed five times per week and was still ongoing. PT 1 stated when RNA services were not carried out for Resident 1, then his contractures could get worse and affect his mobility. During a concurrent interview and record review of Resident 1's physician orders dated 11/11/2024, on 12/12/2024 at 9:32 AM with Registered Nurse (RN 2), RN 2 stated Resident 1 had RNA orders for his upper extremities to be done 5 times per week. During a review of Resident 1's Restorative Orders for the month of November and December 2024, RN 2 stated there were no RNA services done for Resident 1's upper extremities for November and December. During a review of Resident 1's RNA weekly notes for November and December 2024 with RN 2, RN 2 stated RNA weekly notes were also not done and should have been completed weekly. RN 2 stated RNA weekly notes were done to review all the services that were provided and to review for any changes in condition for Resident 1. RN 2 stated muscular atrophy (wasting or thinning of muscle mass), decrease in quality of life, and depression could result if RNA services were not provided to Resident 1. During a record review of the facility's Policy and Procedure (P&P) titled, Restorative Nursing Services, revised 7/2022, the policy indicated restorative goals may include, but are not limited to supporting and assisting the resident in developing, maintaining, or strengthening his/her physiological and psychological resources and participating in the development and implementation of his/her plan of care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Care Center	1836 N. Fair Oaks Ave Pasadena, CA 91103

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 1 and 2) who had an indwelling urinary catheter (Foley Catheter, tube inserted into the bladder to drain urine into a drainage bag) received appropriate care and services as indicated in the physician's orders by failing to appropriately assess and document signs and symptoms (s/sx) of urinary tract infection (UTI, an infection in any part of the urinary system, the kidneys, bladder [organ that stores urine] or urethra [the tube through which urine leave the body]). These deficient practices resulted in delayed UTI identification, delayed treatment, and had the potential to lead to worsening infection. Findings: 1. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of benign prostatic hyperplasia (BPH, non-cancerous prostate gland enlargement that can cause urination difficulty), acute kidney failure (when the kidneys suddenly become unable to filter waste products from the body), calculus of kidney (kidney stone). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. The MDS also indicated Resident 1 had an indwelling catheter. During a record review of Resident 1's Physician Order Summary Report, dated 10/27/2024, the order indicated to monitor for s/sx of infection: [F] fever, [S] sediments (crystals, bacteria, or blood exit through the urine), [FO] foul odor, [C] change in color, [H] hematuria (blood in the urine) every shift for foley catheter care if present indicate letter. If not present, NA. During a record review of Resident 1's care plan, revised 11/2/2024, the care plan indicated Resident 1 was at risk for decline in bowel and bladder status related to calculus of kidney, nephrolithiasis (kidney stones), constipation, BPH, chronic kidney disease (CKD, long-term condition where kidneys gradually lose function and unable to filter blood properly). The care plan interventions for staff were to clean/change resident after each episode of incontinence and monitor for s/sx of UTI and report to physician. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's care plan, revised 7/28/2023, the care plan indicated Resident 1 was at risk for urinary elimination problem, urinary retention (condition that makes it difficult to empty the bladder, either partially or completely), acute pain, fluid volume deficit (body loses more fluids than it takes in), BPH. The care plan interventions for staff were to monitor for signs and symptoms of UTI such as hematuria, cloudy urine, burning sensation, foul smelling urine, flank pain (pain in the upper back, abdomen, or sides of the body), elevated temperature and notify the physician if present. During a record review of Resident 1's care plan, revised 10/27/2024, the care plan indicated Resident 1 had an indwelling catheter and was at risk for UTI, urethral irritation, discomfort/pain related to urinary retention. The care plan interventions for staff were to provide indwelling foley catheter care every shift and observe for s/sx of infection such as foul odor, blood in urine, sediments, etc. and refer to the physician accordingly. During a record review of Resident 1's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of December 2024, the MAR indicated there were no s/sx of infection present in the foley catheter and urinary catheter care was done. There was no indication the indwelling catheter contained sediments. During an observation on 12/9/2024 at 9:29 AM in Resident 1's room, Resident 1's indwelling catheter tubing had small reddish sediment. During an observation on 12/10/2024 at 3:34 PM in Resident 1's room, Resident 1's indwelling catheter tubing had a moderate amount of cloudy sediment. During an observation on 12/11/2024 at 11:26 AM in Resident 1's room, Resident 1's indwelling catheter tubing had a moderate amount of whitish sediment. During an interview on 12/11/2024 at 11:36 AM with Registered Nurse (RN 2), RN 2 stated staff needed to monitor urine for UTI by assessing the urine for color, amount, sediments, and hematuria. RN 2 stated the physician would need to be notified of the change of condition within the shift and followed up with the next shift if the physician did not respond. RN 2 stated UTIs could be life threatening for the residents and could be prevented by use of antibiotics. During an observation on 12/11/2024 at 11:49 AM in Resident 1's room with RN 2, RN 2 stated Resident 1 had a moderate amount of sediment noted in the indwelling catheter tube and the physician needed to be contacted. During a concurrent interview and record review on 12/11/2024 at 3:12 PM of Resident 1's Change of Condition/Situation, Background, Assessment, Request/Recommendation (COC/SBAR, tool used by health care professionals when communicating about critical changes in a resident's status) and Treatment Administration Record (TAR, a medical record used by healthcare providers to document the administration of a medication or treatment) with RN 2, RN 2 stated the physician had not been contacted regarding Resident 1's sediment in the indwelling catheter. RN 2 stated Resident 1's TAR was documented as N/A which meant there no were s/sx of infection present and it should have been documented as being present since Resident 1 had sediment in the indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure titled, Catheter Care, Urinary, revised 8/2022, the policy indicated to observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately: if urine has an unusual appearance (i.e., color, blood, etc.); if signs and symptoms of urinary tract infection or urinary retention occur. 48395 2. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Parkinson's disease (a progressive nervous system disorder that causes nerve cells in the brain to deteriorate, leading to movement problems) without dyskinesia (a movement disorder that involves involuntary muscle movements such as tics, tremors, shakes, or full-body movements) and schizophrenia (a chronic mental disorder that affects how a person things, feels and behaves). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe impairment with cognitive skills for daily decision making. Resident 2 needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), and rolling left and right in bed and needed partial/moderate assistance (helper does less than half the effort) with upper and lower body dressing (the ability to dress and undress above and below the waist) and personal hygiene. Resident 2 also needed an indwelling catheter. During a review of Resident 2's Treatment Administration Record (TAR), dated December 2024, the TAR indicated the following orders 11/28/2024 to 12/11/2024: A. Urinary catheter care every shift. B. Monitor for s/sx of infection: fever, sediments (the presence of specks, cells, or debris in urine that make it look cloudy), foul odor, change in color, hematuria (blood in urine) every shift for Foley Catheter care if present indicate letter. If not present not applicable (NA). During a concurrent observation and interview on 12/9/2024 at 9:53 AM with RN 1 in Resident 2's room, Resident 2 was observed to have a Foley Catheter hanging on the side of the bed in a dignity bag draining yellow urine with thick cream-colored sediment in the Foley Catheter tubing with the tubing touching the floor. RN 1 stated that Resident's 2's Foley Catheter was draining clear yellow urine with sediment in the Foley Catheter tubing and stated the tubing was also touching the floor. RN 1 stated that the Foley Catheter tubing should not be touching the floor due to infection control. During an observation on 12/10/2024 at 8:18 AM in Resident 2's room, Resident 2 wads observed asleep in bed with a Foley Catheter hanging on the side of the bed in a dignity bag draining yellow urine with thick, cloudy cream-colored sediment in the Foley Catheter tubing. During an observation on 12/10/2024 at 3:58 PM, Resident 2's Foley Catheter was observed hanging on the side of the bed draining clear yellow urine with beige colored cloudy sediment observed in the Foley Catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/2024 at 4:20 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when a resident has a Foley Catheter, they look to see if there is any sediment, hematuria (blood in urine) or foul odor in the urine as well as checking for any kinks in the tubing and making sure the urine is flowing correctly. LVN 1 stated depending on the order, they might have to flush the Foley Catheter if it's not flowing right. LVN stated that sediment looks like little rocks that look like sand that build up in the urine and if there is a lot of it observed in the tubing, they need to notify the resident's physician (MD). LVN 1 also stated that their documentation of monitoring of the resident's Foley Catheter can be found in the resident's treatment administration record (TAR) and further stated that it's important to notify the MD about sediments in the resident's Foley Catheter since it could be an indication of something wrong with the resident' kidneys such as the resident not getting enough fluid. During an interview on 12/10/2024 at 4:26 PM with RN 1, RN 1 stated when doing rounds, facility staff need to make sure that the resident's Foley Catheter has a date, order and tubing is not kinked. RN 1 stated facility staff need to check for the color and if there are sediments in the urine. RN 1 stated if they find any changes, they need to inform the MD since the resident could possibly have a UTI or is dehydrated. RN 1 also stated that sediments in the urine look like a white mucus plug (a thick jelly-like collection of mucus [clear, sticky, or slimy fluid that lines and protects many parts of the body]) in the Foley Catheter tubing which can indicate an infection or blockage. During a concurrent interview and record review on 12/10/2024 at 4:36 PM with RN 1, Resident 2's TAR and progress notes dated December 2024 were reviewed. Resident 2's progress notes indicated no documentation of Resident 2 having sediments in the urine and Resident 2's TAR indicated documentation for monitoring for signs and symptoms of infection for the resident's Foley Catheter on 12/9/2024 for all shifts (day, evening, and night) as NA meaning nothing was seen. RN 1 stated that for 12/9/2024 it should have been documented to indicate that there were sediments found in the urine. RN 1 also stated that the MD should have been notified to potentially receive an order to flush the resident's Foley Catheter and also because sediments in the urine could potentially indicate an infection and since Resident 2 is only alert to herself, she is unable to inform the staff if she is having discomfort. During an interview on 12/11/2024 with Infection Preventionist (IP), IP stated that a resident's Foley Catheter should not be touching the floor since anything on the floor could potentially enter the resident's open site which is where the Foley Catheter enters the urethra and is a risk for infection. During an interview on 12/12/2024 at 2:04 PM with Director of Nursing (DON), the DON stated it is expected of the facility nurses to check the urine in the resident's Foley Catheter for any sediments, color and consistency. DON stated sediments are the white stuff in the Foley Catheter tubing and if it is found, the MD should be notified and from there the MD could potentially order a urinalysis (UA; a simple examination of a urine sample that involves checking its appearance, concentration and content) or other laboratory tests and to continue monitoring the resident for s/s of UTI. DON also stated that the Foley Catheter tubing should not be touching the floor for infection control. During a review of the facility's policy and procedure (P&P) titled Catheter Care, Urinary revised August 2022, the P&P indicated its purpose to prevent urinary catheter-associated complications, including urinary tract infections. The P&P also indicated: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Infection Control a. Be sure the catheter tubing and drainage bag are kept off the floor. D. Complications a. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately: i. If urine has an unusual appearance (in example (i.e.), color, blood, etc.). ii. If signs and symptoms of urinary tract infection or urinary retention occur. E. Documentation a. The following information should be recorded in the resident's medical record: i. All assessment data obtained when giving catheter care. ii. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for four (4) or six (6) sampled residents (Residents 1, 16, 231, and 279) in accordance with the facility policy by failing to ensure: 1. a. Resident 1's nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril) was properly placed in the nostrils. b. Resident 1's nebulizer (a drug delivery device used to deliver drugs in the form of inhalation into the lungs) face mask and tubing were changed weekly and stored in a bag when not in use. c. Resident 1's NC tubing was changed weekly. 2. Resident 16 was not provided with a new humidifier (a device for keeping the oxygen moist) when it was empty. 3. Resident 231 had an oxygen order priro to oxygen therapy administration. 4. Resident 279's oxygen nasal cannula (NC; a small flexible tube with two prongs that fit into your nostrils, used to deliver supplemental oxygen directly into your nose, allowing one to breathe in additional oxygen when needed) tubing was properly stored in a plastic bag and the tubing connector from the oxygen concentrator (a medical device that provides supplemental oxygen) to the humidified water container was changed within seven (7) days per the facility's policy and procedure. These deficient practices have the potential for delay in the necessary respiratory care and services for Residents1, 16, 231, and 279 and for the residents to develop a respiratory infection, cause complications, associated with oxygen therapy, and result in the spread of diseases and infection. Findings: 1. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs), multiple sclerosis (an autoimmune disease that affects the brain and spinal cord with symptoms ranging from numbness and tingling to blindness and paralysis), and metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function). During a record review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 11/8/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and rolling to the left and right of the bed. The MDS also indicated Resident 1 received oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Physician Order Summary Report, dated 10/27/2024, the order indicated as follows: - Oxygen at two (2) to 4 liters per minute (LPM, volume of oxygen supplied over a period of time) via nasal cannula every shift for shortness of breath and wheezing (a high-pitched, lung sound produced by airflow through an abnormally narrowed or compressed airway), keep oxygen saturation (SpO2, amount of oxygen in the blood or how well a resident is breathing) above 95%. - Albuterol Sulfate Nebulization Solution (medication administered by oral inhalation with the aid of a nebulizer to open the airways in lung diseases where spasm may cause breathing problems) 2.5 milligram (mg, unit of measurement)/three (3) milliliter (ml, unit of volume) 0.083%: 3 ml inhale orally via nebulizer every 6 hours as needed for shortness of breath and congestion. During a record review of Resident 1's care plan, revised 1/27/2024, the care plan indicated Resident 1 was at risk for shortness of breath for oxygen desaturation (a decrease in the amount of oxygen in the blood) and having crackles (abnormal breath sounds that are discontinuous, explosive, and nonmusical) in the lungs. The staff interventions included were to administer Albuterol Sulfate Nebulization Solution 3 ml inhale orally via nebulizer every 6 hours as needed for shortness of breath and congestion, monitor for episodes of shortness of breath, and administer oxygen as ordered 2 LPM via nasal cannula as needed to keep O2 saturation greater than 92%. During an observation on 12/9/2024 at 9:29 AM in Resident 1's room, Resident 1's NC was on the resident's left cheek while the oxygen was on at 2 LPM. The NC tubing was observed not labeled. Resident 1's nebulizer was placed on top of a shampoo bottle lying on the nightstand. Resident 1's nebulizer tubing was observed not labeled. During a concurrent observation and interview on 12/9/2024 at 9:33 AM with Treatment Nurse (TN 1), TN 1 stated Resident 1's NC was placed on the resident's left cheek. TN 1 stated Resident 1 was not able to readjust the NC and the NC needed to be positioned in the nostrils to receive the ordered oxygen. TN 1 stated there was no label and there should be a label with a date on the NC tubing. TN 1 stated Resident 1's nebulizer was placed on top of the shampoo bottle on the nightstand and was not and should have been stored in a plastic bag. TN 1 stated the nebulizer tubing was also not labeled with the date and should be labeled. During an interview on 12/12/2024 at 10:50 AM with the Director of Nursing (DON), the DON stated the NC tubing and nebulizer tubing were supposed to be changed once a week. The DON stated the tubing and storage bags were supposed to be dated to ensure they were being changed weekly. The DON stated the NC and nebulizer were supposed to be stored in a plastic storage bag when not in use to prevent infection. The DON stated there were virus and bacteria that could cause an infection to the residents when the NC and nebulizer were not stored in the plastic bags. 42223 2. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of dementia (a progressive state of decline in mental abilities) and anxiety (a feeling of fear, dread, and uneasiness). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 9/19/2024, the MDS indicated resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated Resident 16 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, and putting on/taking off footwear. Resident 16 also required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 16's physician orders, dated 2/8/2024, the physician's order indicated may administer oxygen at 2 LPM via nasal cannula as needed for oxygen less than 92% in room air. May titrate to 5l/min via mask to maintain oxygen saturation at more than 92%. During a concurrent observation and interview on 12/9/2024 at 9:54 AM, Restorative Nursing Assistant 1 (RNA 1) stated there is no water in humidifier bottle and it needs to be replaced. During an interview on 12/11/2024 at 3:33 PM, Licensed Vocational Nurse 4 (LVN 4) stated there should be water in the humidifier bottle and if not, it needs to be replaced with a new one. LVN 4 also stated it was to keep the oxygen moist when the resident receives it. During an interview on 12/11/2024 at 4:11 PM, Director of Nursing (DON) stated there should be water in the humidifier bottle and the purpose was to moisten the oxygen for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated to check the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. During a review of the facility's P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, the P&P indicated to check water levels of any pre-filled reservoir every 48 hours and to change the pre-filled humidifier when the water level becomes low. P&P also indicated to use distilled water for humidification per facility protocol. 48152 3. During a review of Resident 231's Admission Record, the Admission Record indicated Resident 231 was admitted to the facility on [DATE] with diagnoses that included dependence on supplemental oxygen (a treatment that provides extra oxygen), pneumonia (PNA- an infection/inflammation in the lungs) and bacteriemia (infection of the blood). During a review of Resident 213's MDS, dated [DATE], the MDS indicated Resident 231 with intact cognitive skills for daily decision making. The MDS indicated Resident 231 needed supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating, oral and personal hygiene, and partial/moderate assistance (helper does less than half the effort needed to complete the activity) with toileting. The MDS also indicated Resident 231 with a continuous oxygen therapy treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 231's care plan care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) titled, Resident at Risk of Shortness of Breath, dated 12/4/2024, the staff intervention included was for medications to be given as ordered. During a concurrent observation and interview with Resident 231 on 12/9/2024 at 10:55AM at Resident 231's bedside, Resident 231 was observed sitting on the wheelchair while receiving 2.5 liters (L- a unit of measurement) of oxygen through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 231 stated he gets oxygen therapy all the time at the facility and needs to receive it because of his PNA. During a concurrent observation and interview on 12/9/2024 at 11:16 AM with Infection Preventionist Nurse (IP) at Resident 231's bedside, Resident 231 was observed receiving 2.5L oxygen therapy through a nasal cannula. IPN stated Resident 231 is receiving oxygen because of his PNA diagnosis. During a concurrent interview and record review on 12/12/2024 at 4:10 PM with the DON, Resident 231's medical chart was reviewed. The chart did not indicate a physician's order for oxygen therapy from 12/4/2024 to 12/12/2024. DON stated there was no order for oxygen administration and per facility policy, there needs to be on order before oxygen therapy is administered to the resident. DON stated oxygen is a medication and Resident 231 should not receive oxygen without a physician's order because the oxygen therapy can have a negative effect on the resident. During a review of the facility's P&P titled Oxygen Administration, revised 10/2010, the P&P indicated the purpose is to provide guidelines for safe oxygen administration and staff are to verify there is a physician's order for oxygen administration. During a review of the facility undated P&P titled, Medication Administration, the P&P indicated medications are administered in accordance with the written orders of the attending physician. 48395 4. During a review of Resident 279's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked) and muscle weakness (a condition where your muscles lack strength, making it difficult to move normally). During a review of Resident 279's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/29/2024, MDS indicated the resident was cognitively intact (ability to think, remember, and reason). Resident 279 was dependent (helper does all of the effort) with going from lying to sitting on the side of the bed, rolling left and right in bed and putting on and taking off footwear, needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing (the ability to dress and undress below the waist), needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist) and personal hygiene and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. Resident 279 was on oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 279's Order Summary Report, dated December 2024, the Order Summary Report indicated an order on 11/23/2024 for resident to be on oxygen 2 liters (a unit of measurement) / minute (min) via (by) nasal cannula every shift for shortness of breath (SOB) and wheezing (a high pitched whistling or rattling sound that occurs when the airways in the lungs are narrowed or blocked) keep oxygen (O2) saturation (the percentage of hemoglobin [a protein in red blood that carries oxygen from the lungs to the body's tissues and organs) in the blood that carries oxygen) above 95% (percent). During a review of Resident 279's Care Plan, dated 11/23/2024, the Care Plan indicated resident is at risk for shortness of breath with interventions including oxygen at 2-4 liters/min via nasal cannula as needed for SOB and wheezing keep O2 saturation above 95%. During a review of Resident 279's Order Summary Report dated December 2024, the Order Summary Report indicated an order from 11/23/2024 to monitor oxygen saturation every shift for as needed (PRN) oxygen use. During a concurrent observation and interview with Infection Preventionist (IP) on 12/9/2024 at 10:45 AM in Resident 279's room, Resident 279's tubing connector from the oxygen concentrator to the humidified water container was observed with a label dated 11/28/2024. Resident 279's oxygen nasal prongs were sitting on top of the wheelchair seat. IP verified that Resident 279's oxygen nasal prongs were sitting on top of the wheelchair seat and the tubing connector from the oxygen concentrator to the humidified water was dated 11/28/2024. IP stated when oxygen NC tubing is not in use, it should be stored in a plastic bag labeled with the resident's name and date it was changed and since Resident 279's oxygen connector tubing was dated for 11/28/2024, it was not changed as scheduled (12/5/2024) since the connector tubing should be changed weekly. IP further stated not properly storing the NC tubing and not changing the oxygen connector tubing weekly can pose a risk for infection. During an observation on 12/10/2024 at 9:10 AM in Resident 279's room, Resident 279 was observed lying down with oxygen being administered to him via NC. During an interview on 12/12/2024 with Director of Nursing (DON), the DON stated that oxygen NC tubing should be stored in a plastic bag when not in use to prevent contamination and that the connector tubing from the oxygen concentrator to the humidified water should be dated properly and changed every 7 days as needed due to infection control. During a review of the facility's policy and procedure (P&P) titled Departmental (Respiratory Therapy) - Prevention of Infection revised November 2011, the P&P indicated, The purpose of this procedure is to guides prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff, and under the Infection Control Considerations Related to Oxygen Administration, the P&P indicated to: change the oxygen cannula and tubing every seven (7) days, or as needed, and to, keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48152 Based on observation, interview and record review, the facility failed to administer medications per facility policy for two (2) of four (4) sampled residents (Resident 228 and 223) observed during medication administration by failing to: 1. Administer Resident 228's aspirin (a type of nonsteroidal anti-inflammatory drug [NSAID] that can treat pain, inflammation, and lowers risk of stroke or blood clots) with food as indicated on the physician's order. 2. Administer Resident 223's Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate- used to treat increased pressure in the eye) between 8AM and 10AM. These failures had the potential risk of adverse effects (an undesired harmful effect resulting from a medication or other intervention) for Residents 228 and 223. Findings: 1. During a review of Resident 228's Admission Record, the Admission Record indicated Resident 228 was admitted to the facility on [DATE], with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells), atherosclerosis of aorta (a condition where plaque builds up in the walls of the aorta [the main artery that carries oxygenated blood from the heart to the body]) and generalized muscle weakness. During a review of Resident 228's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2024, the MDS indicated Resident 228 with intact cognitive skills for daily decision making. The MDS indicated Resident 228 needed supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with oral and personal hygiene and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. During a review of Resident 228's Order Summary Report, dated 12/12/2024, the Order Summary Report indicated aspirin oral tablet 325 milligrams (mg, unit of mass) give one (1) tablet by mouth two (2) times a day for cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply) prophylaxis (PPX- to prevent or control the spread of a disease or infection) take with food. During an observation on 12/11/2024 at 9:48 AM at Resident 228's bedside, Licensed Vocational Nurse 2 (LVN 2) was observed administering 325 mg of aspirin to Resident 228 without offering and giving Resident 228 food prior to or with medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/11/24 at 10:56 AM with LVN 2, Resident 228's Medication Administration Record (MAR), dated 12/1/2024 to 12/31/2024, the MAR indicated Aspirin oral tablet 325 mg, give 1 tablet by mouth 2 times a day for CVA PPX take with food. LVN 2 stated they did not and should have offered any food or check to see when Resident 228 last ate before administering the aspirin medication because it is indicated in the physician's order to give with food. LVN 2 stated it is important to follow the order and administer aspirin with food because aspirin is an NSAID that can cause stomach irritation and taking it with food can help prevent the stomach irritation for Resident 228. 2. During a review of Resident 223's Admission Record, the Admission Record indicated Resident 223 was admitted to the facility on [DATE] with diagnoses that included glaucoma (damage to the optic nerve leads to progressive, irreversible vision loss), anemia, neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve) and neuritis (inflammation of one or more nerves). During a review of Resident 223's Order Summary Report, dated 12/10/2024, the Order Summary Report indicated Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate) instill one drop in both eyes 2 times a day for glaucoma. During an observation on 12/11/2024 at 10:35 AM with LVN 2 at Resident 223's bedside, LVN 2 administered Brinzolamide - Brimonidine Tartrate 1 drop in both of Resident 223's eyes. During a concurrent interview and record review on 12/11/24 at 10:56 AM with LVN 2, Resident 228's Medication Administration Record (MAR), dated 12/1/2024 - 12/31/2024, the MAR indicated Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate) instill 1 drop in both eyes 2 times a day for glaucoma at 9 AM and 5 PM. LVN 2 stated the medication was given late and should have been given between 8 AM and 10 AM. LVN 2 stated the facility policy for medication administration time is to administer up to an hour before and an hour after the prescribed time. LVN 2 stated it is important to administer medications within the indicated time to prevent any adverse effects and to ensure the medication does what it is intended to do. During an interview on 12/12/2024 at 1:02 PM with Director of Nursing (DON), the DON stated per facility policy, all medications should be given as ordered and during the indicated administration time. DON stated when giving medications, staff need to ensure the right resident, time, route, medication, and indication before administering. The DON stated it is important to follow the physician's order and facility policy when administering medications to prevent the residents from having adverse reactions. During a review of the facility's undated Policy & Procedure (P&P) titled, Medication Administration, the P&P indicated medications are administered in accordance with the written orders of the attending physician, medications are to be administered within 1 hour before or one 1 hour after the prescribed time and to give NSAIDs with food or antacids and fluids.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, yielded a facility medication rate of 8% for two (2) of four (4) sampled residents (Resident 228 and Resident 223) observed during medication administration (med pass). The medication errors were as follows: 1. Administer Resident 228's aspirin (a type of nonsteroidal anti-inflammatory drug [NSAID] that can treat pain, inflammation, and lowers risk of stroke or blood clots) with food as indicated on the physician's order. 2. Administer Resident 223's Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate- used to treat increased pressure in the eye) between 8AM and 10AM. These failures had the potential risk of adverse effects (an undesired harmful effect resulting from a medication or other intervention) for Residents 228 and 223. Findings: 1. During a review of Resident 228's Admission Record, the Admission Record indicated Resident 228 was admitted to the facility on [DATE], with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells), atherosclerosis of aorta (a condition where plaque builds up in the walls of the aorta [the main artery that carries oxygenated blood from the heart to the body]) and generalized muscle weakness. During a review of Resident 228's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2024, the MDS indicated Resident 228 with intact cognitive skills for daily decision making. The MDS indicated Resident 228 needed supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with oral and personal hygiene and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. During a review of Resident 228's Order Summary Report, dated 12/12/2024, the Order Summary Report indicated aspirin oral tablet 325 milligrams (mg, unit of mass) give one (1) tablet by mouth two (2) times a day for cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply) prophylaxis (PPX- to prevent or control the spread of a disease or infection) take with food. During an observation on 12/11/2024 at 9:48 AM at Resident 228's bedside, Licensed Vocational Nurse 2 (LVN 2) was observed administering 325 mg of aspirin to Resident 228 without offering and giving Resident 228 food prior to or with medication administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/11/24 at 10:56 AM with LVN 2, Resident 228's Medication Administration Record (MAR), dated 12/1/2024 to 12/31/2024, the MAR indicated Aspirin oral tablet 325 mg, give 1 tablet by mouth 2 times a day for CVA PPX take with food. LVN 2 stated they did not and should have offered any food or check to see when Resident 228 last ate before administering the aspirin medication because it is indicated in the physician's order to give with food. LVN 2 stated it is important to follow the order and administer aspirin with food because aspirin is an NSAID that can cause stomach irritation and taking it with food can help prevent the stomach irritation for Resident 228. 2. During a review of Resident 223's Admission Record, the Admission Record indicated Resident 223 was admitted to the facility on [DATE] with diagnoses that included glaucoma (damage to the optic nerve leads to progressive, irreversible vision loss), anemia, neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve) and neuritis (inflammation of one or more nerves). During a review of Resident 223's Order Summary Report, dated 12/10/2024, the Order Summary Report indicated Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate) instill one drop in both eyes 2 times a day for glaucoma. During an observation on 12/11/2024 at 10:35 AM with LVN 2 at Resident 223's bedside, LVN 2 administered Brinzolamide - Brimonidine Tartrate 1 drop in both of Resident 223's eyes. During a concurrent interview and record review on 12/11/24 at 10:56 AM with LVN 2, Resident 228's Medication Administration Record (MAR), dated 12/1/2024 - 12/31/2024, the MAR indicated Simbrinza Ophthalmic Suspension 1-0.2 percent (%) (Brinzolamide - Brimonidine Tartrate) instill 1 drop in both eyes 2 times a day for glaucoma at 9 AM and 5 PM. LVN 2 stated the medication was given late and should have been given between 8 AM and 10 AM. LVN 2 stated the facility policy for medication administration time is to administer up to an hour before and an hour after the prescribed time. LVN 2 stated it is important to administer medications within the indicated time to prevent any adverse effects and to ensure the medication does what it is intended to do. During an interview on 12/12/2024 at 1:02 PM with Director of Nursing (DON), the DON stated per facility policy, all medications should be given as ordered and during the indicated administration time. DON stated when giving medications, staff need to ensure the right resident, time, route, medication, and indication before administering. The DON stated it is important to follow the physician's order and facility policy when administering medications to prevent the residents from having adverse reactions. During a review of the facility's undated Policy & Procedure (P&P) titled, Medication Administration, the P&P indicated medications are administered in accordance with the written orders of the attending physician, medications are to be administered within 1 hour before or one 1 hour after the prescribed time and to give NSAIDs with food or antacids and fluids.

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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** 48395 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for one (1) of two (2) medication carts (Medication Cart 2) as indicated in the facility policy by failing to ensure Resident 47's: a. open vial of Humalog (brand name for insulin lispro a fast-acting insulin [a hormone that helps regulate blood sugar levels and metabolism]) was labeled with an open date. b. 2 unopened Humulin N (brand name for NPH insulin which is an intermediate-acting insulin) KwikPens (brand name for a prefilled, disposable insulin pen that can be used to deliver insulin) were stored in the refrigerator. This deficient practice had the potential for adverse reaction in the event that these medications were administered to Resident 47. Findings: During a review of Resident 47's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of chronic kidney disease (CKD; a condition where the kidneys are damaged and can't filter blood properly) stage three (moderate loss of kidney function that occurs when your kidneys are working at 45-59% of their normal capacity) and type 2 diabetes mellitus (a chronic condition in which the body does not use insulin [a hormone produced by the pancreas (organ in the abdomen that regulates hormone production) that regulates blood sugar levels] properly or does not produce enough insulin) with diabetic chronic kidney disease (a type of chronic kidney disease (CKD) that occurs when diabetes damages the kidneys). During a review of Resident 47's Minimum Data Set (MDS - resident assessment tool), dated 11/13/2024, MDS indicated the resident was cognitively intact (ability to think, remember, and reason). Resident 47 was dependent (helper does all of the effort) for tub/shower transfers (the ability to get in and out of a tub/shower) and chair/bed-to-chair transfers (the ability to transfer to and from a bed to a chair or wheelchair), needed substantial/maximal assistance (helper does more than half the effort) with lying to sitting on the side of the bed, rolling left and right in bed, and lower body dressing (the ability to dress and undress below the waist) and needed partial/moderate assistance (helper does less than half the effort) with personal hygiene and eating. During a review of Resident 47's Order Summary Report, dated December 2024, the Order Summary Report indicated an order for the following medication: a. Humulin N subcutaneous (beneath the skin) suspension (a liquid with small particles of medicine) 100/unit (unit of measurement)/milliliters (ml) inject 10 unit subcutaneously two times a day for type 2 Diabetes Mellitus. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Insulin Lispro Injection 100 unit/ml inject as per sliding scale: if 70-150 = 0; 151-200 = 2; 201-250 = 4; 2511-300 = 6; 301-350 = 8; 351-400 = 10; 401-450 = 12 and call MD, subcutaneously before meals for Diabetes Mellitus. During a concurrent observation and interview at 12/12/2024 at 10:52 AM with Registered Nurse 2 (RN 2) in the facility hallway in front of Medication Cart 2, the following were observed inside Medication Cart 2: a. Resident 47's Humalog was observed to be opened and had no label indicating opened date. b. 2 of Resident 47's Humulin N KwikPens were observed unopened and stored in the cart drawer. The label on the Humulin N Kwikpen indicated the medication needed to be refrigerated. RN 2 stated Resident 47's Humalog was opened and had no label indicating opened date. RN 2 stated that she opened the vial yesterday but did not write it down. RN 2 also stated Resident 47's 2 Humulin N KiwkPens were in the cart drawer unopened and unopened insulin needs to be stored in the refrigerator. During an interview on 12/12/2024 at 12:25 PM with RN 2, RN 2 stated insulin needs to be dated with an open date because it is only good for a certain amount of time, about 2 - three (3) weeks and if it goes past the open date then a new insulin vial would be needed. RN 2 also stated that she should have dated the Humalog vial should have been dated when she first opened it. RN 2 further stated that unopened insulin needs to be stored in the refrigerator per instructions. During an interview on 12/12/2024 at 2:12 PM with Director of Nursing (DON) DON stated that once a medication is opened, it needs to be dated with the open date so that it could be easily communicated to the rest of the staff when the medication was opened, and the expiration date needs to be checked prior to administration. DON stated insulin is only good for 28 days and if it goes past its expiration date it could affect its efficacy (the ability to produce the maximal response for a particular drug) and if given to the resident after 28 days it might not work effectively. DON further stated that unopened insulin should be stored in the refrigerator and not in the medication cart. During a review of the facility's policy and procedure (P&P) titled Drug Storage and Labeling (undated), the P&P indicated: a. Drugs and biologicals (substances made from living organisms or their products that are used in medicine to prevent, diagnose, treat, or relieve symptoms of disease) will be stored in a safe, secure, and orderly fashion, and will be accessible only to licensed nursing or pharmacy personnel. a. Drugs stored under refrigeration will be stored between 36 degrees Fahrenheit (a temperature scale used to measure how hot or cold something is) and 46 degrees Fahrenheit. b. Medications Requiring Notation of Date Opened - All medications requiring an open date will be dated immediately upon opening. Date will be applied using a Date Open label OR written directly on the packaging by the charge nurse. a. The following expiration periods are based on currently accepted standards of practice and/or the manufacturer's recommendations. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Expires 28 days after opening: All insulins, purified protein derivative (PPD; a solution used in the tuberculin skin test [TST; a simple and safe way to determine if someone has tuberculosis] to diagnose tuberculosis [TB]) solutions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review, the facility failed to ensure residents' meals were palatable (refers to the taste and/or flavor of the food) for one of two sampled residents (Resident 34) in accordance with the facility policy. This failure had the potential to result in dissatisfaction, decreased food intake and place Resident 34 at risk for unplanned weight loss. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of type two (2) diabetes mellitus (a chronic condition in which the body does not use insulin [a hormone produced by the pancreas (organ in the abdomen that regulates hormone production) that regulates blood sugar levels] properly or does not produce enough insulin) with diabetic neuropathy (a complication of diabetes that occurs when high blood sugar levels damage nerves throughout the body) and gastroesophageal reflux disease (GERD; a digestive disorder that occurs when stomach contents flow backward into the esophagus). During a review of Resident 34's History and Physical Examination (H&P), dated 9/16/2024, H&P indicated resident has the capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/6/2024, MDS indicated the resident was independent with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 34 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with walking 10 feet, transfers (how resident moves to and from bed, chair, wheelchair, standing position), and lower body dressing (the ability to dress and undress below the waist) and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with upper body dressing (the ability to dress and undress above the waist), personal hygiene and eating. Resident 34 also needed a therapeutic (a meal plan that is customized to meet a resident's nutritional needs and address a medical condition) diet. During a review of Resident 34's Order Summary Report, dated December 2024, the Order Summary Report indicated a diet order on 9/15/2024 for Controlled Carbohydrate (a small sugar molecules) diet (CCHO), regular texture (no modifications), thin liquids consistency. During a review of Resident 34's Care Plan dated 12/7/2024, the Care Plan focus indicated resident is at risk for nutritional imbalance due to medical diagnoses with interventions including to honor resident's reasonable food preferences. During an interview on 12/10/2024 at 9:15 AM with Resident 34, Resident 34 stated he does not like the food and stated, It is really [NAME] and that the alternatives were not any better. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the test tray on 12/11/2024 at 12:45 PM with Dietary Supervisor (DS), a CCHO tray was sampled with a baked fish filet, mashed potatoes, and chopped carrots. The mashed potatoes were tasted and were very bland with no flavor. DS also tasted the sample tray & stated the mashed potatoes tasted bland and dehydrated and that the mashed potatoes were served to all the residents in the facility. DS also stated the chopped carrots tasted bland and needed flavor. DS further stated that he prefers the food that he serves to have flavor and that the menu for today was not that great. During an interview on 12/11/2024 at 4:40 PM with Resident 34, Resident 34 stated the lunch was okay and that the fish on the tray was alright but did not bother trying the mashed potatoes or carrots on the tray because he never liked the vegetables that the facility serves since they were always bland. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services Staff, revised October 2017, the P&P indicated food will be palatable, attractive, and served in a timely manner at proper temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: a. Label foods in the kitchen with item name and 'use by' date (the last date recommended for the use of the product) and/ or open date. b. Discard expired food items in the kitchen. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization . Findings: During a concurrent observation in the kitchen and interview with the Dietary Supervisor (DS) on [DATE] at 7:40 AM, the kitchen was observed with food items not labeled to indicate the food item names and use by date. The DS stated all food items were supposed to be labeled with food item name, use by date, and food must be discarded when expired. DS stated. the following were found in the kitchen's cooking station, dry storage, refrigerator and/or freezer: a. One (1) gallon bottle of teriyaki sauce with mold noted inside with no open and/ or use by date. b. A chunk of ham in a clear container not labeled with item name and/ or use by date. c. A clear pitcher of dark juice not labeled with item name and/ or use by date. d. Six (6) peanut butter sandwiches with expiration date of [DATE]. e. Twenty- nine (29) cups of prepared Jello with expiration date of [DATE]. f. An open bag of double acting baking powder with expiration date of [DATE]. g. One (1) gallon bottle of salad oil with no open and use by date. h. One (1) gallon bottle of sesame oil with no open and use by date. i. Three and a half (3.5) L clear container with white powder (instant potato flakes) with no item name or use by date. j. One (1) pound clove ground with expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. A large frozen bag of meat not labeled with item name and/ or use by date. DS stated the teriyaki sauce, ham, juice, salad oil, sesame oil, and instant potato flakes items were opened but was not and should have been labeled with the name of the food item and dated the item with an open or use by date. DS stated all expired food items and moldy items should have been thrown away. DS stated all food items should have been labeled with the item name along with a use by date to know when the food items were going to expire. DS stated the importance of having an expiration date on the food items was to prevent serving expired foods to the residents. DS stated serving expired food items to the residents would get the residents sick by causing food poisoning. During a review of the facility's Policy and Procedure (P&P) titled Labeling and Dating of Foods, dated 2023, the policy indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. During a review of the facility's P&P titled, Freezer Storage, dated 2023, the policy indicated all frozen food should be labeled and dated. A review of the 2022 FDA 2022 Food Code 2022, ,d+[DATE].18 titled, Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, indicated time/temperature control safety refrigerated foods must be consumed, sold, or discarded by the expiration date. https://www.fda.gov/media/164194/download?attachment

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview and record review, the facility failed to observe infection control measures as indicated on the facility policy and procedure (P&P) when the facility failed to ensure: 1. Facility staff changed their N95 respirator (a respiratory protective device designated to achieve a very close facial fit and very efficient filtration of airborne particles) after leaving Resident 280's room which was a respiratory isolation room (known as an airborne infection isolation room [AIIR] that isolates residents with airborne infectious diseases [bacteria or viruses that are most commonly transmitted through small respiratory droplets]) due to Resident 280's positive (+) Coronavirus (COVID, a disease caused by coronavirus characterized mainly by fever and cough and can progress to severe symptoms) test. 2. Five (5) linen carts in the hallway were not contaminated by Resident 33 taking linen on their own. 3. Facility staff wore N95 masks while in the hallways while the facility was under COVID outbreak (a sudden increase in the number of cases of a disease or medical condition in a specific location or population over a given time period). 4. Resident 126's nasal cannula was not on the floor 5. Resident 59's suction equipment was clean, labeled, and stored. 6. Facility Staff did not use required personal protective equipment (PPE, equipment worn to minimize exposure to hazards) before entering Resident 47's room, which was a droplet isolation (used to prevent the spread of illnesses from residents to others through respiratory droplets) room. These failures had the potential to result in the spread of bacteria and virus to other residents in the facility. Findings: 1. During a review of Resident 280's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of ulcerative chronic (long-term) pancolitis (a type of inflammatory bowel disease [IBD, a chronic disease that occurs when the body's immune system attacks healthy cells in the intestines, causing inflammation and damage] that causes chronic inflammation and ulcers throughout the entire colon [the longest part of the large intestine: a tube-shaped organ in the digestive system that removes water and nutrients from food]) and enterocolitis (a condition that involves inflammation of both the small intestine [a long, tube-like organ in the digestive system that connects the stomach to the large intestine] and the colon) due to Clostridium Difficile (C.diff; a type of bacteria that can cause diarrhea and inflammation of the colon). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 280's Minimum Data Set (MDS - resident assessment tool), dated 12/7/2024, MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 280 needed substantial/maximal assistance (helper does more than half the effort) with going from a sitting to a standing position, putting on/taking off footwear, and lower body dressing (the ability to dress and undress under the waist). Resident 280 needed partial/moderate assistance (helper does less than half the effort) with walking 10 feet, chair/bed-to-chair transfers (the ability to transfer to and from a bed to a chair or wheelchair), going from lying down to sitting on the side of the bed, upper body dressing (the ability to dress and undress above the waist including fasteners, and personal hygiene. Resident 280 also needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 280's Order Summary Report dated December 2024, the Order Summary Report indicated resident on novel respiratory isolation due to + COVID test. During a review of Resident 280's COVID Symptoms Care Plan, dated 12/5/2024, the COVID Symptoms Care Plan indicated Resident 280 had COVID like symptoms present including chills and cough and was positive for COVID on 12/4/24. The Care Plan also indicated an intervention to observe COVID isolation precaution as indicated by Centers for Disease Control and Prevention (CDC; the nation's leading science-based, data-drive, service organization that protects the public's health) guideline. During an observation on 12/9/2024 at 9:06 AM outside of Resident 280's room. A Novel Respiratory Isolation sign was observed outside of their door. During an observation on 12/10/2024 at 4:10 PM in the hallway outside of Resident 280's room, Registered Nurse 1 (RN 1) was observed stepping out of Resident 280's room and did not change her N95 mask. During an observation on 12/11/2024 at 8:17 AM in the hallway outside of Resident 280's room, Certified Nursing Assistant 1 (CNA 1) was observed rolling a bin of dirty linen out of Resident 280's room, doffed (to take off) her PPE. During a concurrent observation and interview on 12/11/2024 at 8:20 AM with CNA 1 in the hallway outside of Resident 280's room, CNA 1 was observed leaving Resident 280's room. CNA1 doffed her PPE but did not change her mask. CNA 1 stated she did not change her mask when she left Resident 280's room. During a review of the facility's daily assignment dated 12/11/2024 for the 7AM to 3 PM shift, the facility's daily assignment indicated CNA 1's assignment of three rooms with three residents. Two of the residents were on Novel Respiratory Isolation precautions for confirmed COVID and one resident was on Airborne precautions for shingles (a painful rash caused by the same virus that causes chickenpox [highly contagious viral disease that causes an itchy rash or fluid-filled blisters that eventually scab over]). During an interview on 12/11/2024 at 3:20 PM with Infection Preventionist (IP), IP stated any staff leaving a COVID isolation room should doff all his/her PPEs inside the room before exiting. IP stated the N95 mask also needs to be changed since the isolation resident's bacteria could get onto the mask while caring for the resident. IP added if the staff member continues to wear the same mask, then there's a risk of transferring the infection to another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 2:09 PM with Director of Nursing (DON), the DON stated the expectation of staff leaving a COVID isolation room is that they remove all PPE, perform hand hygiene and need to change their mask since the mask could be contaminated and is a risk for spreading infection to other residents if it is not changed. During a review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Using Personal Protective Equipment, revised September 2022, the P&P indicated, When caring for a resident with suspected or confirmed SARS-COV-2 infection: Disposable respirators are removed and discarded after exiting the resident's room or care area and closing the door. During a review of the facility P&P titled Isolation - Categories of Transmission-Based Precautions (a set of guidelines that healthcare workers use to prevent the spread of infection to patients who may be infected with certain infection agents) revised September 2022, the P&P indicated, Transmission-based precautions are initiated when a resident develops signs and symptoms of transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The P&P further indicated, Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. 2. During a review of Resident 33's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of chronic obstructive pulmonary disease (a long-term lung disease that makes it difficult to breathe) and unspecified hearing loss (a general term for hearing loss that occurs when there is no clear cause). During a review of Resident 33's MDS, dated [DATE], MDS indicated the resident had intact cognitive skills for daily decision making. Resident 33 needed partial/moderate assistance with walking 10 feet and putting on and taking off footwear, needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance with resident) with chair/bed-to-chair transfers, upper body dressing and personal hygiene and needed setup or clean-up assistance with eating. During a concurrent observation and interview on 12/11/2024 at 9:32 AM with CNA 2 in the hallway, Resident 33 was observed going down the hallway in her wheelchair and grabbed linen from 5 different linen carts. CNA 2 stated that Resident 33 always does that and that they know it is wrong but that is what the resident likes. CNA 2 also stated that Resident 33 always goes around grabbing linens, gowns, and towels from the carts. During a concurrent observation and interview on 12/11/2024 at 9:40 AM with Restorative Nursing Assistant 1 (RNA 1), Resident 33 was observed going down the hallway in her wheelchair and grabbed linen from 5 different linen carts. RNA 1 stated that Resident 33 does it when she needs it especially when staff are too busy to help her. During an interview on 12/12/2024 at 8:55 AM with IP, IP stated residents should not be going to the linen carts and grabbing linen from them themselves because their hands might be dirty and could potentially contaminate the clean linen. IP also stated that she was not aware of Resident 33's behavior of grabbing linen herself from the clean linen carts in the hallways. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 2:09 PM with DON, the DON stated that residents should not be taking linen out of the linen carts themselves due to possibly contaminating the clean linen. During a review of the facility's P&P titled Departmental (Environmental Services) - Laundry and Linen revised January 2019, the P&P indicated it's purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen, with the general guidelines under standard precautions indicating to, wash hands after handling soiled linen and before handling clean linen. During a review of the facility's P&P titled Policies and Practices - Infection Control revised July 2014, the P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections. The P&P also indicated: a. The facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, [NAME] or veteran status, or payor source. b. The objectives of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 3. During an observation on 12/9/2024 at 9:45 AM at the front entrance of the facility, a sign was observed indicating that the facility currently had COVID positive residents who were currently residing within the facility. During an observation on 12/9/2024 at 2:22 PM by Nurses' Station 1, CNA 8 and CNA 9 were observed walking down the hallway to Nurses' Station 1 then proceeded to Nurses' Station 2 without wearing a mask. During an interview on 12/11/2024 at 3:20 PM with IP, IP stated staff should be putting on N95 once they enter the facility and walking through the facility hallways because if they walk in without wearing a mask, they are then susceptible to infection especially since the facility was in a COVID outbreak. During an interview on 12/12/2024 at 2:09 PM with DON, the DON stated staff should be wearing an N95 mask from the entrance of the building especially since the facility was under COVID outbreak and that staff could potentially be asymptomatic (showing no symptoms) and could be carrying COVID and possibly further spread the infection. During an observation on 12/12/2024 at 3:39 PM in the hallway next to Nurses' Station 1, CNA 3 and CNA 4 were observed sitting in the charting area across from the COVID isolation rooms not wearing their N95 masks which were observed hanging around their necks. During a concurrent observation and interview on 12/12/2024 at 3:55 PM with CNA 3 and CNA 4 in the hallway next to Nurses' Station 1, CNA 3 and CNA 4 were observed sitting in the charting area across from the COVID isolation rooms not wearing their N95 masks which were observed hanging around their necks. CNA 3 and CNA 4 both stated they should have been wearing their masks for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the P&P titled Coronavirus Disease (COVID-19) - Using Personal Protective Equipment revised September 2022, the P&P indicated, Alternatively if community transmission is high the facility may implement: a. Universal use of NIOSH-approved particulate respirators with N95 filters or higher for staff during all resident care encounters or in specific units or areas of the facility at higher risk for SARS-COV-2 transmission. During a review of the facility's P&P titled Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures revised September 2022, the P&P indicated, This facility follows infection prevention and control (IPC) practices recommended by the Centers for Diseases Control and Prevention to prevent the transmission of COVID-10 within the facility, by implementing universal use of PPE for staff and following current environment and infection prevention and control recommendations. During a review of the facility's P&P titled Coronavirus Disease (COVID-19) - Occupational Health revised September 2021, the P&P indicated, Facility practices are in place to protect healthcare personnel from exposure to COVID-19 to the extent possible in accordance with Occupational Health and Safety Administration (OSHA) and Center for Disease Control and Prevention (CDC) recommendations. The P&P also indicated, Safe work practices are measures that staff are asked to comply with in order to reduce their exposure, for example, hand hygiene, proper donning (putting on) and removal of PPE, handling waste and potentially infection material, and complying with all infection prevention and control practices. During a review of the facility's P&P titled, Coronavirus Disease (COVID-19) - Education and Training revised December 2021, the P&P indicated information is provided to staff, presented in a language and at a literary level that the employee understands includes: a. Reinformed of standard and transmission-based precaution procedures (including hand hygiene, respiratory hygiene, and proper use and disposal of personal protective equipment). b. Policies and procedures implemented to prevent the spread of COVID-19 in the workplace (proper use of PPE, cleaning, and disinfection, etc.) 42223 4. During a review of Resident 126's Admission Record, the Admission Record indicated Resident 126 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of trigeminal neuralgia (a type of chronic pain disorder that involves sudden attacks of severe facial pain) and repeated falls. During a review of Resident 126's MDS, dated [DATE], the MDS indicated resident had an intact cognitive skill for daily decision making. MDS also indicated Resident 126 required substantial/maximal assistance with toileting hygiene, shower/bath self, upper body dressing, lower body dressing and putting on/taking off footwear. Resident 126 required supervision or touching assistance (helper provides verbal cures and/or touching/steadying and/or contract guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating, oral hygiene, and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/9/2024 at 9:39 AM, Resident 126 was observed with oxygen via nasal cannula. During an observation on 12/9/2024 at 11 AM, Resident 126's nasal prongs (part that enters the nose) of the nasal cannula tubing was observed on the floor. During an observation on 12/9/2024 at 11:10 AM, Physical Therapy Assistant (PTA) was observed picking up Resident 126's nasal cannula off the floor and set it on Resident 126's bed. During an observation on 12/9/2024 at 11:20 AM, PTA was observed putting Resident 126's nasal cannula behind the wheelchair without a bag. During a concurrent observation and interview on 12/9/2024 at 11:25 AM, PTA was observed to give oxygen to Resident 126 as needed. PTA stated he was about to administer the oxygen as needed. PTA also stated it was on the floor and the nasal cannula should have been discarded and replaced with a new one and put in a bag. During an interview on 12/11/2024 at 12:21 PM, Infection Preventionist Nurse (IP) stated if the nasal cannula was on the floor, it should be discarded and replaced because it has been contaminated and can lead to the resident having an infection. IP also stated the nasal cannula should be placed in a bag when it is not in use. During a review of the facility's Policy and Procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of infection, revised 11/2011, the P&P indicated the purpose is to prevent infection associated with respiratory therapy tasks and equipment. P&P also indicated keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. During a review of the facility's P&P titled, Infection Control, revised 7/2014, the P&P indicated to prevent infections in the facility. P&P also indicated to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. During a review of the facility P&P titled, Cleaning and Disinfection of Resident-Care Equipment, revised 5/15/2022, indicated semi-critical items such as respiratory therapy equipment are free from all microorganisms. 48152 5. During a review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), gastro-esophageal reflux disease (GERD- chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 with severely impaired cognitive skills for daily decision making. The MDS indicated Resident 59 needed substantial/maximal assistance with oral and personal hygiene, eating assessment was not attempted due to medical condition or safety concerns and Resident 59 was dependent (helper does all effort needed to complete activity) with toileting and bathing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/10/2024 at 9:16 AM with Licensed Vocational Nurse 2 (LVN 2) and IP, at Resident 59's bedside, a suction machine, yankauer (a suction device used to maintain an open airway and improve oxygenation by removing secretions and foreign material from the mouth and throat) with connection tubing labeled with a date of 9/4/2024 and suction collecting canister labeled with a date of 9/3/2024 was filled with approximately 150 cubic centimeter (cc, unit of volume) of fluid was observed. The suction collecting canister and suction machine were also observed with dried brown spots. LVN 2 stated the suction machine is dirty and should have been cleaned once it became dirty. LVN 2 stated the suction equipment was dated 9/3/2024 and 9/4/2024 and should have been discarded and changed weekly or when needed per facility protocol. LVN 2 also stated it is important to make sure staff are changing and cleaning the suction tubing and canister to prevent Resident 59 from respiratory infections caused by bacteria from the dirty equipment. During an interview with IP on 12/12/2024 at 11:12 AM, IP stated the suction collection canister is changed as needed, when full or visibly soiled. IP stated all [suction] equipment should be changed weekly and labeled with the date it was changed. IP also stated it is important to make sure the suction equipment is changed because it can get contaminated over time, and if it is used on a resident, it can cause respiratory infections. During an interview with DON on 12/12/2024 at 3:12 PM, the DON stated the suction equipment including tubing and collection canister are changed every seven (7) days, as needed or daily after use. The DON stated after equipment is changed, it needs to be labeled with the date of first use. The DON also stated it is important to ensure the suction tubing and canister are being changed per policy because mold and bacteria that can develop in the equipment, causing the risk of infections to the residents. During a review of the facility's P&P titled, Suctioning, revised 8/2014, the P&P indicated to discard suction connecting tubing between resident's use and to discard disposable collecting canisters after single resident use. The P&P also indicated when suction equipment is designated for extended use, the suction collecting canister should be cleaned and flushed as necessary when secretions are present, emptied and cleaned daily and changed as necessary. 6. During a review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was originally readmitted to the facility on [DATE] with diagnoses that included pneumonia (PNA- an infection in your lungs caused by bacteria, viruses or fungi), chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) and type 2 diabetes mellitus (DM2 - a chronic metabolic disease that occurs when the body doesn't produce enough insulin or can't use it properly). During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 with intact cognitive skills for daily decision making. The MDS indicated Resident 47 needed partial/moderate assistance with eating, oral and personal hygiene, and substantial/maximal assistance with toileting and bathing. During a review of Resident 47's Order Summary Report, dated 12/12/2024, the order summary indicated resident is placed on droplet isolation for pneumonia. During an observation on 12/12/2024 at 9:32 AM, CNA 10 observed donning a gown and gloves before entering Resident 47's room. CNA 10 did not apply a face shield or goggles prior to entering the room. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 12/12/2024 from 9:32 AM through 9:46 AM inside Resident 47's room, CNA 10 observed without wearing required face shield or goggles. CNA 10 was observed next to the head of the bed (right side), repositioning Resident 47 and assisting Resident 47 with putting on socks. Resident 47 observed talking to CNA 10 throughout the entire observation. During an interview with Infection Preventionist Nurse (IP) on 12/12/2024 at 11:02 AM with, IP stated droplet precautions are used for residents with PNA and other certain respiratory viruses. IPN stated staff and visitors who enter droplet isolation rooms must wear the required PPE of a face shield or goggles and gloves. IP stated CNA 10 should have been wearing a face shield or goggles while in the Resident 47's room, assisting with care. IP stated it is important to follow PPE protocols to prevent cross contamination and transmission of infectious microorganisms from that resident to other residents, visitors and/or staff. During an interview with CNA 10 on 12/12/2024 at 12:55 PM, CNA 10 stated when she was assisting Resident 47 earlier in the day [12/12/2024 from 9:32 AM through 9:46 AM], she did not wear the required PPE of a face shield or goggles because she did not see the signage that Resident 47 was on droplet precautions. CNA 10 stated she saw the PPE cart at the door but did not use the PPE. CNA 10 stated it is important to wear all required PPE to protect the residents from the spread of infections. During a review of the facility's Policy and Procedure (P&P) titled, Isolation- Categories of Transmission-Based Precautions, revised 9/2022, the P&P indicated droplet precautions are implemented for residents with microorganisms transmitted by droplets, generated by the individual coughing, sneezing, or talking. The P&P also indicated masks are worn when entering the room, gloves, gown, and goggles are worn if there is risk of spraying of respiratory secretions. 44636