STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555348	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granada Post Acute	3565 E Imperial Hwy Lynwood, CA 90262

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) assessments for three of 19 sampled residents (Residents 23, 19, and 24) were completed and documented accurately. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Residents 23, 19, and 24's health status. This deficient practice also created the potential for Residents 23, 19, and 24 to not receive the care and interventions needed to reach their highest practicable physical and psychosocial well-being. Findings: 1. During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE]. Resident 23's admitting diagnoses included oropharyngeal phase dysphagia (swallowing problems occurring in the mouth and/or the throat). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 23 had mild cognitive impairment (a condition where memory and thinking problems are noticeable but not severe enough to interfere with daily activities). The MDS indicated Resident 23 required substantial to maximal assistance from staff to roll from left to right while in bed. The MDS did not indicate Resident 23 had any dental concerns, including broken natural teeth or fragments of teeth. During an observation on 3/25/2025 at 9:43 a.m., Resident 23 was observed with foul mouth odor and poor/missing dentition. The teeth present were black in color and appeared broken and/or fragmented. During an interview on 3/26/2025 at 10:48 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated one of the purposes of the MDS assessment was to assist with care planning and to ensure residents received the care they needed. The MDSN stated that the MDS identifies the care areas that need to be addressed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 3/26/2025 at 10:54 a.m., with the MDSN, Resident 23's MDS Section L, dated 3/6/2025, was reviewed. The MDSN stated she completed Resident 23's MDS dated [DATE], and stated the MDS did not indicate Resident 23 had any dental concerns. The MDSN stated Resident 23's current dental status met the MDS criteria for obvious or likely broken teeth and stated Resident 23's MDS was not accurate. The MDSN stated the MDS assessment should be accurate and stated an inaccurate MDS assessment could lead to Resident 23 not receiving necessary dental care. 51684 2. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including dysphagia (difficulty swallowing), dementia (progressive state of decline of mental abilities), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently) and muscle weakness. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognitive skills was intact. The MDS indicated Resident 24 required maximum assistance from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves.) During concurrent observation and interview on 3/24/2025 at 11:13 a.m., in Resident 24's room, Resident 24 was observed sitting up in bed with no upper and lower teeth. Resident 24 stated she did not have any natural teeth and oft or puree foods. During a concurrent interview and record review on 3/25/2025 at 3:05 p.m., with the MDSN, Resident 24's MDS, dated [DATE] was reviewed. The MDSN stated Resident 24's MDS oral/dental assessment was coded incorrectly and did not reflect the resident's actual oral and/or dental status. The MDSN stated because Resident 24 did not have natural teeth, and the MDS should have been coded correctly. The MDSN stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. 3. During a review of Resident 19's Admission Record, the facility admitted Resident 19 on 9/28/2023 and readmitted Resident 19 on 1/14/2025 with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness (loss of muscle strength), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and anxiety (feeling of fear). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 19 required maximum (helper does more than half the effort) assistance from staff for ADL's. During a telephone interview on 3/24/2025 at 2:59 p.m., with Resident 19's responsible party (RP 1), RP 1 stated Resident 19 did not have any natural teeth and was on a pureed diet (foods that have been blended or mashed into a smooth, pudding-like consistency). During an observation on 3/26/2025 at 9:40 a.m., in the facility's dining room, Resident 19 was observed sitting up in wheelchair eating pureed food with no upper and lower teeth. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/26/2025 at 9:46 a.m., with the MDSN, Resident 19's MDS, dated [DATE] was reviewed. The MDSN stated she was aware of Resident 19 not having any natural teeth. The MDSN stated Resident 19's MDS oral/dental status assessment was coded incorrectly and did not reflect the resident's actual oral and/or dental status. The MDSN stated because Resident 19 did not have natural teeth, the MDS should have been coded correctly. The MDSN stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. During a review of the facility's policy and procedure (P&P) titled Certified Accuracy of the Resident Assessments, revised on 11/2019, the P&P indicated any person completing a portion of the Minimum Data Set must sign and certify the accuracy of that portion of the assessment. The P&P also indicated the information captured on the resident assessment should reflect the status of the resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure an accurate Level I Preadmission Screening and Resident Review (PASRR, a screening tool that helps identify possible serious mental illness [SMI], and if the resident requires specialized services) was submitted for one of four sampled residents (Resident 74). This deficient practice placed Resident 74 at risk of not receiving recommended or required treatments for diagnosed SMIs, or appropriate placement in a facility to meet Resident 74's needs. Findings: During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was admitted on [DATE] and was most recently readmitted on [DATE]. Resident 74's admitting diagnoses included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and anxiety disorder (a group of mental health conditions characterized by excessive and persistent fear or worry, often interfering with daily life). During a review of Resident 74's Minimum Data Set (MDS, a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 74 did not have any cognitive impairments (difficulties with thinking, learning, remembering, and making decisions). The MDS indicated Resident 74 required substantial to maximal assistance from staff for bed mobility. During a review of Resident 74's Level I PASRR assessment, dated 1/15/2025, the Level I PASRR assessment indicated the individual completing the assessment was to indicate whether the resident had a diagnosed SMI. Resident 74's Level I PASRR did not reflect his SMI diagnoses of psychosis, depression, or anxiety disorder. During a review of Resident 74's PASRR determination letter, dated 1/15/2025, the determination letter indicated Resident 74 did not require a Level II PASRR Mental Health Evaluation because the Level I PASRR indicated Resident 74 did not have any SMIs. During an interview on 3/26/2025 at 1:22 p.m., with the Social Services Director (SSD), the SSD stated that the Level I PASRR was completed by the hospital, prior to the resident's admission to the facility. The SSD stated she reviewed the Level I PASRR's upon the resident's admission to the facility. The SSD stated that if the Level I PASRR was not completed accurately by the hospital staff, she completed a new Level I PASRR for submission to the required agencies. During a concurrent interview and record review, on 3/26/2025 at 1:26 p.m., with the SSD, Resident 74's Level I PASRR, dated 1/15/2025, was reviewed. The SSD stated the Level I PASRR did not reflect Resident 74's SMIs of psychosis, depression, and anxiety disorder. The SSD stated a new and accurate Level I PASRR should have been completed and submitted but was not. The SSD stated the purpose of the PASRR assessment was to ensure residents received mental health services and recommendations, and an inaccurate assessment prevented the resident from receiving those services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Preadmission Screening and Resident Review, dated 4/2017, the P&P indicated all residents admitted to the facility were to have a Level I PASRR completed to identify residents with serious mental illness (SMI) and ensure those residents received the services they required for their SMI, and in the appropriate setting.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure care plans (a document that outlines a resident's care needs, diagnosis, and treatment goals) were developed and/or implemented for two of 19 sampled residents (Residents 288 and 191) when: 1. Resident 288 did not have padding on her siderails. 2. Resident 191, who was receiving oxygen, did not have an oxygen sign posted outside her doorway. These deficient practices placed Resident 288 at risk for physical harm and injury and had the potential to delay necessary monitoring and safety interventions (actions nurses take to help residents achieve their care plan goals) related to Resident 191's oxygen administration. Findings: 1. During a review of Resident 288's Admission Record, the admission record indicated Resident 288 was admitted to the facility on [DATE]. Resident 288's admitting diagnoses included epilepsy (a neurological condition characterized by recurrent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 288's Minimum Data Set (MDS, a resident assessment tool), dated 3/8/2025, the MDS indicated Resident 288 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily functioning and daily living). The MDS indicated Resident 288 had impairments to her lower extremities (legs) on both sides of her body and was dependent for staff for mobility while in and out of bed. During a review of Resident 288's care plan titled High risk for trauma/injuries related to: Seizure Disorder, dated 3/6/2025, the care plan indicated staff were to apply padding to both siderails while the resident was in bed. During an observation on 3/24/2025 at 2:29 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed with metal siderails to both sides of her bed. No padding was applied to either siderail. During an observation on 3/25/2025 at 1:38 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed with metal siderails to both sides of her bed. No padding was applied to either siderail. During an interview on 3/26/2025 at 2:52 p.m., with Registered Nurse Supervisor (RN) 1, RN 1 stated that when a resident has a diagnosis of seizure disorder, staff were to apply padding to the siderails 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 - Few	During a concurrent interview and record review on 3/26/2025 at 2:54 p.m., with RN 1, Resident 288's care plan titled High risk for trauma/injuries related to: Seizure Disorder, dated 3/6/2025, was reviewed. RN 1 stated the care plan indicated Resident 288 had a diagnosed seizure disorder and the care plan interventions indicated Resident 288 was to have padding on both of her siderails. RN 1 stated the purpose of padding the siderails was to prevent injury if Resident 288 were to have a seizure while in bed. During a concurrent observation and interview, 3/26/2025 at 2:56 PM, at Resident 288's bedside, with RN 1, Resident 288 was observed lying in bed with her head leaning against the siderail on the right side of her bed. RN 1 stated there was no padding to either of Resident 288's siderails. RN 1 stated Resident 288 was at risk for injury and could hurt herself if she were to have a seizure. 48131 2. During an observation on 3/24/2025 at 10:05 a.m., in Resident 191's room, observed Resident 191 lying in bed receiving supplemental oxygen via a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at three liters per minute. Observed Resident 191's room did not have an oxygen sign posted outside of the room's doorway. During a review of Resident 191's Admission Record, the admission record indicated Resident 191 was initially admitted on [DATE] and readmitted on [DATE]. The admission record indicated the following diagnoses which included Parkinson's (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), dependence on supplemental oxygen, pneumonia (an infection/inflammation in the lungs), congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 191's History and Physical (H&P), dated 2/5/2025, the H&P indicated Resident 191 did not have the capacity to understand and make decisions. During a review of Resident 191's MDS, dated [DATE], the MDS indicated Resident 191's cognition was severely impaired. The MDS indicated Resident 191 was dependent (helper does all the effort) on staff for oral hygiene, toileting and bathing. During a review of Resident 191's Order Summary Report dated 3/26/2025, the order summary report indicated an order for oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 2 liters per minute (LPM) every shift for hypoxia. During a review of Resident 191's care plan titled, Congestive Heart Failure, undated, the care plan indicated Resident 191 had potential shortness of breath (difficulty breathing), chest pains, irregular pulse (heart rate), and elevated blood pressure (the force of your blood pushing against the walls of your blood vessels (like the tubes that carry blood) as your heart pumps) related to compromised cardiac (heart) function. The care plan interventions indicated to administer continuous oxygen at 2 LPM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/26/2025 at 12:40 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 191's care plans were reviewed. LVN 3 stated she could not find a care plan regarding Resident 191's oxygen administration. LVN 3 stated an oxygen care plan was important because it would have oxygen parameters, when to call the doctor and how to use the oxygen safely. LVN 3 stated the MDS Nurse (MDSN) usually initiates a care plan upon admission, or any licensed nurse can initiate the oxygen care plan. LVN 3 stated if Resident 191's oxygen was started after admission, a change of condition should have been initiated along with an oxygen care plan. During an interview on 3/26/2025 at 12:48 p.m. with the MDSN, the MDSN stated the use of oxygen should be care planned. The MDSN stated the admitting nurse should have updated the care plans. The MDSN stated Resident 191's oxygen care plan should have been restarted when she was readmitted to the facility. The MDSN stated without a care plan there are no interventions (the actions a nurse takes to help residents achieve their health goals) on how to monitor Resident 191's oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) and when to call the doctor. The MDSN stated without an oxygen care plan, Resident 191's oxygen therapy was not being monitored and there were no goals or outcomes of when to discontinue the resident's oxygen. During an interview on 3/27/2025 at 10:03 AM with the Director of Nursing (DON), the DON stated there should be a care plan for oxygen therapy. The DON stated moving forward, the facility would ensure an oxygen care plan was done for all residents receiving oxygen so that the nursing staff would know the parameters, when to call the doctor, when to change the tubing and apply the oxygen signage. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the care plan described the services staff were to provide to allow the resident to achieve their highest practicable physical, mental, and psychosocial well-being. During a review of the facility's P&P titled Bed Safety and Bed Rails, revised 8/2022, the P&P indicated additional safety measures were to be implemented for residents identified as having a higher than usual risk for injury. During a review of the facility's P&P titled, Resident Assessment: Care Planning - Interdisciplinary Team, undated, the P&P indicated the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized care plan for each resident and the care plan is based on the resident's comprehensive assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure interventions to prevent the development or worsening of pressure ulcers (PU, localized damage to the skin and/or underlying tissue usually over a bony prominence) were implemented for four of seven sampled residents (Residents 288, 74, 23, and 191) when: 1. Low-air-loss-mattress (LALM, a mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) settings were incorrect for Residents 288, 74, and 191. 2. Resident 23 was not provided with a LALM as ordered by the resident's physician. 3. Resident 191's LALM was labeled with the wrong resident's name and weight settings. These deficient practices placed Residents 288, 74, 23, and 191 at risk for the development or worsening condition of existing pressure ulcers. Findings: 1. During an interview on 3/26/2025 at 9:15 a.m., with the Treatment Nurse (TN), the TN stated LALMs created air flow to stabilize pressure within the mattress, and relieved pressure placed on the resident's skin. The TN stated the LALM settings were based on the residents' weight, and stated the higher the weight setting, the more firm the mattress. The TN stated she, or any licensed nurse, could adjust the settings on the LALM to ensure that the settings were accurate to the resident's weight. The TN stated that if the LALM settings were not correct, there was the potential for a new PU to develop or for existing PUs to worsen. a. During a review of Resident 288's Admission Record, the Admission Record indicated Resident 288 was admitted to the facility on [DATE]. Resident 288's admitting diagnoses included generalized muscle weakness and other symptoms and signs involving the musculoskeletal system. During a review of Resident 288's Minimum Data Set (MDS, a resident assessment tool), dated 3/8/2025, the MDS indicated Resident 288 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily functioning and daily living). The MDS indicated Resident 288 had impairments to her lower extremities (legs) on both sides of her body and was dependent for staff for mobility while in and out of bed. The MDS indicated Resident 288 was at risk for developing PUs. During a review of Resident 288's active physician order, dated 3/6/2025, the order indicated Resident 288 was to have a low air loss mattress (LALM) for wound management, at the 150-pound (lb., a unit of measuring weight) setting. During a review of Resident 288's weekly weight record, dated 3/25/2025, the record indicated Resident 288 weighed 154 lbs. on 3/25/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/24/2025 at 2:18 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed on a LALM. The mattress settings were set at the 350-lb. setting. During an observation on 3/25/2025 at 12:45 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed on a LALM. The mattress settings were set at the 350-lb. setting. During an observation on 3/26/2025 at 8:40 a.m., at Resident 288's bedside, Resident 288 was observed lying in bed on a LALM. The mattress settings were set for the 350-lb. setting. During a concurrent interview and record review, on 3/26/2025 at 9:19 a.m., with the TN, Resident 288's LALM physician order dated 3/6/2025, and weight measurement record dated 3/25/2025, were reviewed. The TN stated the physician order indicated Resident 288's LALM was to be set at the 150-lb. setting, and stated Resident 288's most recent weight was 154 lbs. During a concurrent observation and interview, on 3/26/2025 at 9:20 a.m., at Resident 288's bedside, with the TN, the TN stated Resident 288's LALM was set for the 350-lb. setting, and stated this was not the correct setting. b. During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 74's admitting diagnoses included generalized muscle weakness, Stage 3 PU (full-thickness loss of skin, dead and black tissue may be visible) to the tailbone region, and Stage 4 PU (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) to the left hip, and Stage 2 PU (partial-thickness loss of skin, presenting as a shallow open sore or wound) to an unspecified buttock. During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74 did not have any cognitive impairments. The MDS indicated Resident 74 required substantial to maximal assistance from staff to roll left and right while in bed. The MDS indicated Resident 74 had unhealed PUs and was at risk for developing additional PUs. During a review of Resident 74's active physician order, dated 1/24/2025, the order indicated Resident 74 was to have a LALM for wound management. During a review of Resident 74's monthly weight record, dated 3/3/2025, the record indicated Resident 74 weighed 140 lbs. on 3/3/2025. During an observation on 3/25/2025 at 8:56 a.m., at Resident 74's bedside, observed Resident 74's LALM set for the 280-lb. setting. During a concurrent observation and interview on 3/25/2025 at 10:31 a.m., with Resident 74, at Resident 74's bedside, observed Resident 74's LALM set for the 280-lb. setting. Resident 74 stated the LALM was for his wounds, and stated that he would like for the mattress to be softer. Resident 74 stated the mattress was very firm, that when he woke up every morning his back hurt. Resident 74 stated the LALM was supposed to be set for his weight, and asked if the mattress could be softer. During an observation on 3/26/2025 at 8:47 a.m., at Resident 74's bedside, observed Resident 74's LALM set for the 250-lb. setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 3/26/2025 at 9:24 a.m., with the TN, Resident 74's LALM physician order dated 1/24/2025, and weight measurement record dated 3/3/2025, were reviewed. The TN stated Resident 74 had orders for a LALM, and stated Resident 74's most recent weight was 140 lbs. The TN stated Resident 74's LALM settings should be set according to Resident 74's weight. During a concurrent observation and interview on 3/26/2025 at 9:25 a.m., at Resident 74's bedside, with the TN, observed Resident 74's LALM set for the 250-lb. setting. The TN stated this was not the correct setting for the resident and stated it should be set for the 150-lb. setting. 2. During a review of Resident 23's Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE]. Resident 23's admitting diagnoses included symptoms and signs involving the musculoskeletal system and osteonecrosis (a condition where bone tissue dies due to a loss of blood supply) to his left arm. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 had mild cognitive impairment. The MDs indicated Resident 23 required substantial to maximal assistance from staff to roll from left to right while in bed. The MDS indicated Resident 23 was at risk for developing PUs. During a review of Resident 23's active physician order, dated 2/28/2025, the order indicated Resident 23 was to have a LALM for wound management. During an observation on 3/25/2025 at 9:12 a.m., at Resident 23's bedside, Resident 23 was observed lying in bed. Resident 23 did not have an LALM mattress in place. During an observation on 3/25/2025 at 12:50 p.m., at Resident 23's bedside, Resident 23 was observed lying in bed. Resident 23 did not have an LALM mattress in place. During an observation on 3/26/2025 at 8:44 a.m., at Resident 23's bedside, Resident 23 was observed lying in bed. Resident 23 did not have an LALM mattress in place. During a concurrent interview and record review, on 3/26/2025 at 9:27 a.m., with the TN, Resident 23's active physician orders were reviewed. The TN stated Resident 23 had orders for a LALM. During a concurrent observation and interview on 3/26/2025 at 9:27 a.m., at Resident 23's bedside, with the TN, the TN stated Resident 23 did not have a LALM mattress as ordered by the physician. The TN stated she could not state why Resident 23 did not have a LALM mattress. 48131 3. During an observation on 3/24/2025 at 10:05 a.m., Resident 191's room, observed Resident 191 lying in bed on a LALM. The LALM control indicated the bed was set at 130 lbs. The LALM control was labeled with another resident's name and indicated the LALM should be set to 80 lbs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granada Post Acute	3565 E Imperial Hwy Lynwood, CA 90262

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 191's Admission Record, the admission record indicated Resident 191 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 191's diagnoses iincluded Parkinson's (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right and left lower legs, congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), sepsis (a life-threatening blood infection), and chronic kidney disease (damaged kidneys that cannot filter blood properly over a long period). During a review of Resident 191's History and Physical (H&P), dated 2/5/2025, the H&P indicated Resident 191 did not have the capacity to understand and make decisions. During a review of Resident 191's MDS, dated [DATE], the MDS indicated Resident 191's cognition was severely impaired. The MDS indicated Resident 191 was dependent (helper does all the effort) on staff for oral hygiene, toileting and bathing. During a review of Resident 191's Order Summary Report dated 3/26/2025, the order summary report indicated Resident 191 was ordered a LALM every shift for wound management on 3/14/2025. During a review of Resident 191's Order Summary Report dated 3/26/2025, the order summary report indicated Resident 191 was ordered a LALM set to 120 lbs. per the resident's weight of 115 lbs. every shift for wound management on 3/26/2025. During a review of Resident 191's care plan titled, Alteration in Skin Integrity: Actual Pressure Sore, undated, the care plan indicated Resident 191 had an unstageable (a type of full-thickness skin and tissue loss where the wound bed is covered by dead tissue making it impossible to determine the true depth or stage) PU to the coccyx (tailbone). The care plan goal indicated Resident 191's PU would decrease in size in the next 30 days and the risk for further skin breakdown would be reduced every day for three months. The care plan interventions indicated to use a LALM as ordered. During a review of Resident 191's care plan titled, Resident is incontinent (the inability to control the bladder [the organ that stores urine] or bowels [the organ responsible for digesting food and eliminating waste]) of Bowel and Bladder, undated, the care plan indicated Resident 191 was at risk for skin impairment and pressure sores. The care plan goal indicated Resident 191 would minimize the risks for skin impairments related to incontinence in the next three months. The care plan interventions indicated to use a pressure reducing mattress if necessary. During a review of Resident 191's Weight and Vitals Summary record, dated 3/26/2025, the Weights and Vitals Summary record indicated Resident 191 weighed 115 lbs. on 3/18/2025 and 3/25/2025. During a review of Resident 191's Braden Scale (measures the risk for development of a pressure sore) dated 3/21/2025, the Braden Scale indicated Resident 191 was chairfast (cannot walk safely and confined to a chair or wheelchair), had very limited (unable to make frequent or significant changes in position independently) mobility and was at high risk of developing PUs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/24/2025 at 10:25 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 191's LALM controls were observed. LVN 2 stated the LALM was for the wrong resident. LVN 2 stated the name and setting on the label was for a different resident and should not have been placed on Resident 191's LALM. LVN 2 stated having the wrong label on Resident 191's LALM could lead to confusion and an inaccurate weight setting. LVN 2 stated an inaccurate weight setting on Resident 191's LALM would cause the bed to not be therapeutic and cause skin issues if not set to the correct setting of 130 lbs. but labeled for at 80 lbs. LVN 2 stated the LALM was for the wrong patient and was not the right label or setting for Resident 191. LVN 2 stated having the wrong label and wrong LALM may have an inaccurate weight and could cause confusion. LVN 2 stated instead of being therapeutic for the resident it can cause more skin issues if it was not at set at the correct setting. During a concurrent interview and record review on 3/26/2025 at 10:29 a.m. with the TN and the Quality Assurance Nurse (QAN), Resident 191's weight was reviewed. The QAN stated Resident 191's weight was 115 lbs. and the LALM for the resident should have been set according to the resident's weight. The TN stated the LALM was administered to the wrong resident and the LALM was not set to the correct setting for Resident 191. The TN stated if Resident 191's LALM was not set according to the resident's weight, the resident's PU could worsen. The QAN stated the licensed nurse assigned to Resident 191 was responsible for ensuring the LALM was set according to the resident's weight and that the bed was labeled correctly. The QAN stated the licensed nurse did not double check to make sure Resident 191 was in the right bed. During an interview on 3/27/2025 at 10:08 a.m. with the Director of Nursing (DON), the DON stated the LALM was used to distribute airflow based on the resident's weight to prevent skin break down. The DON stated the licensed nurses should have made rounds to ensure Resident 191's LALM was set according to her weight. During a review of the facility's policy and procedure (P&P) titled Air Mattress, undated, the P&P indicated the purpose of using special air mattresses was to decrease pressure from the resident's weight in bed, and to promote the healing of or the prevention of pressure ulcers. The P&P further indicated to monitor the mattress to assure that it is functioning properly, and that air level assures that the resident's body does not touch the bed. During a review of the facility document titled Treatment Nurse Job Description, undated, the document indicated the treatment nurse was required to administer treatments as prescribed and implement interventions as indicated and as ordered by the physician. During a review of the facility's document titled, Drive: Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operating Manual, undated, the document indicated to determine the resident's weight and set the control knob to that weight setting on the control unit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure safety was maintained for one of two sampled residents (Resident 288) by failing to pad Resident 288's siderails. This deficient practice placed Resident 288 at risk for harm and injury. Findings: During a review of Resident 288's Admission Record, the admission record indicated Resident 288 was admitted to the facility on [DATE]. Resident 288's admitting diagnoses included epilepsy (a neurological condition characterized by recurrent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 288's Minimum Data Set (MDS, a resident assessment tool), dated 3/8/2025, the MDS indicated Resident 288 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily functioning and daily living). The MDS indicated Resident 288 had impairments to her lower extremities (legs) on both sides of her body and was dependent for staff for mobility while in and out of bed. During a review of Resident 288's care plan titled High risk for trauma/injuries related to: Seizure Disorder, dated 3/6/2025, the care plan interventions indicated staff were to apply padding to the siderails on both sides of the resident's bed while the resident was in bed. During an observation on 3/24/2025 at 2:29 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed with metal siderails to both sides of her bed. No padding was applied to either siderail. During an observation on 3/25/2025 at 1:38 p.m., at Resident 288's bedside, Resident 288 was observed lying in bed with metal siderails to both sides of her bed. No padding was applied to either siderail. During an interview on 3/26/2025 at 2:52 p.m., with Registered Nurse (RN) 1, RN 1 stated that when a resident has a diagnosis of seizure disorder, staff were to apply padding to the siderails of the resident's bed. During a concurrent interview and record review on 3/26/2025 at 2:54 p.m., with RN 1, Resident 288's care plan titled High risk for trauma/injuries related to: Seizure Disorder, dated 3/6/2025, was reviewed. RN 1 stated the care plan indicated Resident 288 had a diagnosed seizure disorder and the care plan interventions indicated Resident 288 was to have padding on both of her siderails. RN 1 stated the purpose of padding the siderails was to prevent injury if Resident 288 were to have a seizure while in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, 3/26/2025 at 2:56 PM, at Resident 288's bedside, with RN 1, Resident 288 was observed lying in bed with her head leaning against the siderail on the right side of her bed. RN 1 stated there was no padding to either of Resident 288's siderails. RN 1 stated Resident 288 was at risk for injury and could hurt herself if she were to have a seizure. During a review of the facility's policy and procedure (P&P) titled Bed Safety and Bed Rails, revised 8/2022, the P&P indicated additional safety measures were to be implemented for residents identified as having a higher than usual risk for injury.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to place oxygen signage at the room door entrance indicating oxygen was in use for one of six sampled residents (Resident 191) receiving oxygen therapy. This deficient practice had the potential to place all residents' and staff's safety at risk. Findings: During an observation on 3/24/2025 at 10:05 a.m., in Resident 191's room, observed Resident 191 lying in bed receiving supplemental oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at three (3) liters per minute (LMP). Observed Resident 191's room did not have an oxygen sign posted outside of the doorway. During a review of Resident 191's Admission Record, the admission record indicated Resident 191 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 191's diagnoses included Parkinson's (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), acute respiratory failure with hypoxia (when the lungs suddenly fail to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), dependence on supplemental oxygen, pneumonia (an infection/inflammation in the lungs), congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 191's History and Physical (H&P), dated 2/5/2025, the H&P indicated Resident 191 did not have the capacity to understand and make decisions. During a review of Resident 191's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 191's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 191 was dependent (helper does all the effort) for oral hygiene, toileting and bathing. During a review of Resident 191's Order Summary Report dated 3/26/2025, the order summary report indicated an order for oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 2 LPM every shift for hypoxia. During a review of Resident 191's care plan titled, Congestive Heart Failure, undated, the care plan indicated Resident 191 had potential shortness of breath (difficulty breathing), chest pains, irregular pulse (heart rate), and elevated blood pressure (the force of your blood pushing against the walls of your blood vessels (like the tubes that carry blood) as your heart pumps) related to compromised cardiac (heart) function. The care plan interventions indicated to administer continuous oxygen at 2 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/24/2025 at 10:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 observed that there was no oxygen signage posted outside of Resident 191's room. LVN 2 stated Resident 191 should have an oxygen sign posted for safety because the resident was receiving oxygen. LVN 2 stated the admitting nurse, or any staff member assigned to the resident should have made sure an oxygen sign was posted. LVN 2 stated all signs should have been posted upon admission of the resident or when the oxygen was started. LVN 2 stated the oxygen sign was important to prevent fires. During an interview on 3/27/2025 at 10:03 a.m. with the Director of Nursing (DON), the DON stated oxygen signage should have been placed on the doorway of Resident 191's room. The DON stated moving forward, the facility would ensure an oxygen care plan was done for all residents receiving oxygen so that the nursing staff would know the parameters, when to call the doctor, and to apply the oxygen signage for safety. During a review of the facility's policy and procedure (P&P) titled, Respiratory - Oxygen Administration, undated, the P&P indicated to place an Oxygen in Use sign on the outside of the room entrance door.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure their medication error rate was less than five percent (%) when Licensed Vocational Nurse (LVN) 1 failed to administer one of four randomly selected residents' (Resident 4) medications timely and as ordered by Resident 4's physician. The outcome was six medication errors out of 32 opportunities for errors, with resulted in a Medication Administration Error Rate of 18.75%, based on the following: 1. Resident 4 received six medications, Lidocaine cream (medication applied to the skin to prevent or treat pain), empagliflozin (hypoglycemic medication used to lower blood sugar levels), benztropine (anti-tremor medication), primidone (anticonvulsant medication used to treat seizure disorders [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), carbidopa-levodopa (anti-tremor medication), and docusate sodium (a stool softener), more than one hour after the permitted administration time. 2. LVN 1 applied the Lidocaine cream on Resident 4's right knee instead of Resident 4's left knee. These deficient practices had the potential for Resident 4 to experience pain, increase in tremors, low blood pressure, low blood sugar, constipation, diarrhea, and increase in seizure activity due to Resident 4's medications being administered incorrectly and outside of the scheduled time. Findings: During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscle rigidity, and slow, imprecise movements), type 2 diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), and convulsions (also known as seizures). During a review of Resident 4's Minimum Data Set ([MDS], a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 4's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 4 was dependent on staff's assistance with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 4 received hypoglycemic (low blood sugar) and anticonvulsant medication. During a review of Resident 4's History and Physical (H&P), dated 10/13/2024, the H&P indicated Resident 4 could make needs known but could not make medical decisions. During a review of Resident 4's Order Summary Report, active orders as of 3/26/2025, the Order Summary Report indicated to give: 1. Benztropine 1 milligram (mg, a unit of dose measurement), by mouth, in the morning for Parkinson's disease. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Carbidopa-levodopa 25-100 mg, by mouth, four times a day for Parkinson's disease. 3. Docusate sodium 100 mg, by mouth, two times a day for bowel management. Hold for loose stool or diarrhea. 4. Empagliflozin 25 mg, by mouth, in the morning for DM type 2. 5. Lidocaine cream 5%, apply to the left knee two times a day for pain management. 6. Primidone 50 mg, give 1.5 tablet, by mouth, two times a day for seizure disorder. During a concurrent observation and interview on 3/25/2025 at 11:10 a.m., in Resident 4's room, with Licensed Vocational Nurse (LVN) 1, LVN 1 checked Resident 4's blood sugar. LVN 1 stated Resident 4 did not require any insulin at that time. During a concurrent observation and interview on 3/25/2025 at 11:25 a.m., in Resident 4's room. LVN 1 reentered Resident 4's room and checked Resident 4's heart rate and blood pressure. LVN 1 stated Resident 4's blood pressure and heart rate did not meet the ordered parameters (specific instructions that dictate whether the medication is safe to administer) and she would not administer Resident 4 her blood pressure medication. LVN 1 stated she had to prepare the rest of Resident 4's medications. During a concurrent observation and interview on 3/25/2025 at 11:35 a.m., outside of Resident 4's room, LVN 1 prepared a total of six medications for Resident 4. After dispensing the medications, LVN 1 confirmed a total of five oral medications and one cream were to be administered to Resident 4. During a concurrent observation and interview on 3/25/2025 at 11:46 a.m., in Resident 4's room, LVN 1 reentered Resident 4's room and administered the five oral medications with lemonade. The five oral medications were benztropine, carbidopa-levodopa, docusate sodium, empagliflozin, and primidone. LVN 1 applied the lidocaine cream to Resident 4's right knee and after application, LVN 1 was notified of the incorrect application. LVN 1 stated the lidocaine cream was supposed to be applied to Resident 4's left knee. During a review of Resident 4's Medication Administration Audit Report, dated 3/25/2025, the Audit Report indicated Resident 4's Lidocaine cream, empagliflozin, benztropine, primidone, carbidopa-levodopa, and docusate sodium were scheduled to be administered at 9 a.m., but were administered by LVN 1 at 11:47 a.m. The Audit Report indicated Resident 4 was administered her second dose of carbidopa-levodopa at 1:10 p.m., less than two hours after the first dose administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2025 at 2:15 p.m., with LVN 1, LVN 1 stated Resident 4's medications administered at 11:46 p.m. were scheduled for 9 a.m. LVN 1 stated medications had to be administered within the time permitted which was between an hour before and an hour after the scheduled time. LVN 1 stated each medication affected the body in their own way and administering them late could cause unwanted reactions. LVN 1 stated Resident 4 received the carbidopa-levodopa and benztropine late, which could cause an increase in Resident 4's tremors and shaking. LVN 1 stated she administered Resident 4's second dose of carbidopa-levodopa around 1 p.m. but the time in between the first and second dose were too close together. LVN 1 stated administering the two doses of carbidopa-levodopa too close together put Resident 4 at risk for increased confusion. LVN 1 stated Resident 4 received the empagliflozin late, which could cause a drop in Resident 4's blood sugar. LVN 1 stated Resident 4's primidone was administered late, which could cause an increase in preventable seizure activity. LVN 1 stated Resident 4's docusate sodium was administered late, which could potentially cause loose stool and diarrhea if the two doses were administered too close together. LVN 1 stated Resident 4's Lidocaine cream was administered late and initially onto the incorrect knee, which could cause Resident 4 to experience preventable pain. During an interview on 3/26/2025 at 2:52 p.m., with the Director of Nursing (DON), the DON stated residents' medications must be administered according to their physician's order. The DON stated medications could be administered an hour before and an hour after the scheduled administration time. The DON stated medications administered after the permitted time placed the resident at risk of experiencing adverse effects and symptoms the medications were used to treat. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 7/2024, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The P&P indicated, Medications must be administered in accordance with the orders, including at required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to provide a daily menu and offer alternative menu options for one of eight sampled residents (Resident 3). This deficient practice had the potential to impact Resident 3's nutritional status, quality of life and result in food dissatisfaction leading to insufficient food intake. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decreased size of a body part, cell, organ or tissue), dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak) following cerebral infarction (stroke - loss of blood flow to a part of the brain), and severe protein-calorie malnutrition (inadequate intake of protein, calories and other essential nutrients). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/5/2025, the MDS indicated Resident 3 was cognitively intact (the ability to think, remember and reason). The MDS indicated Resident 3 supervision (helper provides verbal cues and/or touching to assist resident) with eating and was dependent (helper does all the effort) on staff for toileting and bathing. During a review of Resident 3's Progress Notes Summary, dated 3/4/2025, the Progress Notes Summary indicated Resident 3 was oriented to person, place, and time and although non-verbal, Resident 3 was capable of effectively communicating her needs through a digital device. During a review of Resident 3's care plan titled, Altered Nutritional Needs, undated initiated, the care plan goal indicated Resident 3 would consume greater than 75% of each meal and would eat to desire and tolerance. The care plan interventions indicated to encourage Resident 3 to eat 75-100% of each meal. During a review of Resident 3's Order Summary Report, dated 3/26/2025, the order summary report indicated an active order starting 2/24/2025 for a Regular diet, pureed (foods that have been blended, mashed, or strained to a smooth, pudding-like consistency) texture, regular consistency (normal, everyday foods of various textures). During a concurrent observation and interview on 3/24/2025 at 10:51 a.m. with Resident 3, Resident 3 was observed lying in bed alert and oriented. There was no menu posted near the bed or on the nightstand. Resident 3 was unable to speak but used a tablet for communication. Resident 3 stated via tablet that she had difficulty swallowing and was on a pureed diet. Resident 3 stated the pureed meals were inedible and made her want to puke. Resident 3 stated she received the same meal every day. Resident 3 stated she had been in the facility for three weeks and had not received a menu. Resident 3 stated she complained about the food to the nursing staff and asked if she could have something with flavor such as chicken or beef. Resident 3 stated she was never offered alternatives even though she barely ate her meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555348	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granada Post Acute	3565 E Imperial Hwy Lynwood, CA 90262

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/25/2025 at 12:38 p.m. with Resident 3, observed Resident 3 while eating lunch. Resident 3's lunch plate consisted of 3 scoops of food and 2 bowls, one consisting of a clear liquid and the other with a white creamy substance. Resident 3 pointed to her tray and wrote on her tablet, What is this? Resident 3 stated she would only attempt to eat the meals served to prevent her from being hungry by midnight. Observed Resident 3 take a spoonful from the scoops of food on her lunch tray. Resident 3 wrote, I cannot eat this, it makes my stomach hurt and makes me want to vomit. During an interview on 3/25/2025 at 1:45 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 3 ate 25 to 50 percent (%) of her lunch meal. CNA 1 stated when a resident eats less than 50% of their meal, it is reported to the charge nurse and the resident would be offered an alternative. CNA 1 stated she did not offer Resident 3 an alternative for her lunch meal because she was on a pureed diet, and she was feeling sick. CNA 1 stated she did not ask Resident 3 why she felt sick. CNA 1 stated if Resident 3 was not on a pureed diet she would have offered her something else to eat. During a concurrent observation and interview on 3/25/2025 at 2 p.m. with Licensed Vocational Nurse (LVN) 2 and Resident 3, in Resident 3's room, LVN 2 searched for Resident 3's menu. LVN 2 stated Resident 3 did not have a menu in her room. LVN 2 stated all residents should have a menu posted in the room so that they can get a supplement meal ordered in advance if they do not like what is being served for that meal. LVN 2 stated if a resident ate less than 50% of their meal, she would offer the resident something else to eat or a nutritional shake. LVN 2 stated without a menu, Resident 3 was not able to see what was served and was unable to choose something she preferred. LVN 2 stated Resident 3 could have been served an alternative meal based on her diet. LVN 2 asked Resident 3 if she like her lunch? Resident 3 shook her head and stated No. LVN 2 stated she offered Resident 3 a nutritional shake but did not offer her an alternative lunch even though she was aware Resident 3 ate less than 50% of her meal. LVN 2 stated once she knew Resident 3 ate less than 50% of her meal, she should have asked the resident if she wanted something else and gone to the kitchen to order her an alternative lunch. LVN 3 stated Resident 3 could have weight loss and malnutrition from eating less than 50 percent of the food every day. LVN 2 stated Resident 3's meals should have been something that she enjoyed. During an interview on 3/25/2025 at 3:15 p.m. with the Dietary Services Supervisor (DSS), the DSS stated Resident 3 could get any item on the alternative menu served pureed or within the diet order. The DSS stated Resident 3 should have a menu in her room posted on the wall or on her nightstand. The DSS stated the Activities Department was responsible for providing the menu to the residents. During an interview on 3/27/2025 at 9:57 a.m. with the Director of Nursing (DON), the DON stated the Dietary Department was responsible for providing menus to the residents and not the Activities Department. The DON stated he would in-service his dietary supervisor regarding who was responsible for providing the menus to the residents and in-service the nursing staff that resident on pureed diets should also be offered alternatives. During a review of the facility's Policy and Procedure (P&P) titled, Nutrition Care - Resident/Patient Food Preferences, dated 2011, the P&P indicated the following: 1. If records indicate a food or beverage is routinely refused this should be documented on the Resident's profile card and tray card as a dislike. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Appropriate substitutions will be offered for individual resident dislikes. 3. All residents must be offered a substitute food item when an item they dislike is on the menu. 4. Ethic food preferences should be taken into consideration for all residents and ethnic food should be made available. During a review of the facility's policy and procedure (P&P0 titled, Menus, dated 2011, the P&P indicated the menus will be posted in the resident's dining room or other resident accessible areas. The P&P indicated menus will be written or available at least one week in advance of preparation and shall be posted in the facility at least one week in advance of service.