STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555395	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Encanto Healthcare Center	555 South El Encanto Road City of Industry, CA 91745

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure the resident's call light was within reach for two of two sampled residents (Residents 20 and 27). These deficient practices had the potential for Residents 20 and 27 not to receive necessary care or received delayed services to meet the residents' needs. Findings: a. During a review of Resident 20's Admission Records (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a brain condition caused by a chemical imbalance in the blood) and Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) During a review of Resident 20's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/9/2024, the MDS indicated Resident 20 had severely impaired cognition (ability to understand) and required maximal assistance (helper does more than half the effort) with oral and toileting hygiene, shower, and upper body dressing. During a review of Resident 20's untitled Care Plan (CP), dated 8/2/2023, the CP indicated Resident 20 was at risk for decline in activities of daily living (ADL)/range of motion (ROM), skin breakdown, falls and injury. The CP interventions included to keep Resident 20's call light within reach and answer promptly. During an observation on 6/18/2024 at 10:30 am inside Resident 20's room, Resident 20 could not pull his call light. Resident 20's call light was hanging on the side of the bed and the cord was caught in between the bed and the bedrails. During an interview on 6/18/2024 at 10:45 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the resident's call light should be reachable and accessible to the resident to call help and for the staff to meet the resident's needs. b. During a review of Resident 27's AR, the AR indicated Resident 27 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a long term joint disease that causes the cartilage within a joint to break down over time) and history of falling. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's untitled CP, dated 6/19/2019, the CP indicated Resident 27 was at risk for injury from falls as evidenced by history of falls at home prior to hospitalization , impaired cognition with episodes of forgetfulness and history of cerebrovascular accident (CVA, also called stroke, damage to the brain from interruption of blood supply). The CP goal was to maintain functional mobility to minimize injury from falls for Resident 27. The CP interventions included to assist Resident 27 in all transfers and mobility and keep the resident's call light within reach and answer promptly. During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27 had intact cognition and required moderate assistance (helper does less than half the effort) with toileting and shower. During a review of Resident 27's Fall Risk Assessment (FRA) dated 5/7/2024, the FRA indicated Resident 27 had a score of 8 indicating Resident 27 was moderately at risk for fall related to the resident's balance problems, requiring assistive devices. During an observation on 6/18/2024 at 11:00 am inside Resident 27's room, Resident 27 was standing on her own and Resident 27's call light was on the floor by the wall. During an interview on 6/19/2024 at 11:50 pm with LVN 4, LVN 4 stated, Resident 27's call light should be placed next to the resident in bed, on the table or close to the resident's hands so the resident could call when the resident needed help, and the staff would assist and address the resident's needs immediately. LVN 4 stated Resident 27's call light should not be on the floor or stuck in between the bed and the bedrails where the resident could not pull or reach it. During an interview on 6/19/2024 on 12:00 pm with the Director of Nursing (DON), the DON stated call light should be placed where the residents could reach it and have access to it when they need it, so the residents could call the staff and the staff could address the residents' needs. During a review of the facility's undated Policy and Procedure (P&P) titled, Call Lights, the P&P indicated, All residents will have a call light in place at all times. Reposition call light within resident's reach to assure resident can call for help.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to ensure the resident's Advance Directive/Preferred Intensity of Care Documentation form (AD, a written instruction, recognized under State law relating to the provision of health care when the individual becomes incapacitated [lacking the ability to meet essential requirements for physical health, safety, or self-care]) was in the resident's medical record for two of two sampled residents (Resident 35 and 2). These failures had the potential for staff to provide care and services against the resident's will. Findings: a. During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was admitted to the facility on [DATE] with diagnoses that included dependence of renal dialysis (treatment for kidney failure [loss of kidney function] that removes unwanted toxins, waste products and excess fluids by filtering the blood) and fracture (broken bone) of the lower leg. During a review of Resident 35's AD form dated [DATE], the AD form indicated Resident 35 chose no resuscitation (to revive from apparent death or from unconsciousness) and no tube feeding (nutrition through a flexible tube that goes in through the nose or directly into the stomach). During a review of Resident 35's Minimum Data Set (MDS, a resident assessment and care screening tool), dated [DATE], the MDS indicated Resident 35 had clear speech, had an ability to understand others and had the ability to make self-understood. The MDS indicated Resident 35's cognition (ability to understand) was intact. During an interview and concurrent record review on [DATE] at 12:26 pm with the Admission Coordinator (AC), the AC stated, there was no AD and AD form in Resident 35's medical record. The AC stated, Resident 35's AD form needed to be in the resident's medical record for easy access during an emergency. The AC stated, without the AD form, staff would not know Resident 35's treatment and staff would provide care and services against the resident's will. 42781 b. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on [DATE] with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), essential hypertension (elevated blood pressure without a known cause) and type 2 diabetes mellitus 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2 's cognition for daily decision making was severely impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review of Resident 2's medical record on [DATE] at 11:51 am, together with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated LVN 1 did not find Resident 2 AD Acknowledgement Form in Resident 2's medical record. LVN 1 stated, the AD Acknowledgement Form needed to be in Resident 2's medical record for easy access. During an interview and record review of Resident 2's medical record on [DATE] at 12:12 pm, together with the facility's Case Manager (CM), the CM stated, CM was unable to find Resident 2's AD Acknowledgement Form in Resident 2's chart. The CM stated AD Acknowledgment Form needed to be in Resident 2's clinical records to determine Resident 2's wishes and medical preferences in case of an emergency. During an interview on [DATE] at 10:10 am, with the facility's Director of Nursing (DON), the DON stated the AD Acknowledgment Form needed to be in the resident's chart to guide the staff in case of an emergency and honor the resident's wishes. During a review of the facility's Policy and Procedure (P&P) titled Advance Directive Policy/Procedure, revised ,d+[DATE], the P&P indicated, To promote a resident's right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive. Further, the facility's policy is to record the resident's wishes in the medical record and to follow those wishes to the extent practicable and allowable under State law. Upon admission, all residents and their representatives are presented with written information about their rights to accept or refuse medical or surgical treatment and their right to formulate an advance directive (if the resident has capacity to do so). This information is found in the resident rights portion of the admission packet and in the Preferred Intensity of Care and Advance Directive Acknowledgement forms.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to ensure a quarterly Minimum Data Sets (MDS - a comprehensive standardized assessment and screening tool) was timely completed within the required time frame for one of one sampled resident (Resident 4). This deficient practice had the potential to negatively affect the provision of necessary care for Resident 4. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated the facility admitted Resident 4 on 9/16/2022, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and malnutrition. During a review of Resident 4's MDS dated [DATE], the MDS indicated the MDS was a quarterly MDS assessment and was not yet completed as of 6/8/2024. During a review of the Center for Medicare and Medicaid Services (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) Submission Report, the report indicated Resident 4's Quarterly MDS was completed late. The report indicated the assessment completion date was more than 14 days after the assessment reference date. During a concurrent interview and record review on 6/19/2024 at 12:03 pm with the MDS Coordinator (MDSC), the MDSC stated MDS report needed to be submitted and completed on 6/8/2024. MDSC stated, MDSC missed to complete the quarterly MDS for Resident 4. MDSC stated, it was important to complete and submit the quarterly MDS to CMS as required to provide accurate information timely. During a review of the facility's undated Policy and Procedure titled, MDS and Resident Assessment Instrument Process, the P&P indicated, all other assessments must be submitted within 14 days of the MDS Completion Date. P&P indicated, quarterly assessment is due every quarter unless the resident is no longer in the facility

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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** 40438 Based on observation, interview, and record review, the facility failed to develop a specific and individualized person-centered care plan to meet the resident's needs for one of one sampled resident (Resident 20) who was assessed with hearing difficulty. This deficient practice had the potential for Resident 20 not to receive the necessary care, treatment, and services. Findings: During a review of Resident 20's Admission Records (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a brain condition caused by a chemical imbalance in the blood) and Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) During a review of Resident 20's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/9/2024, the MDS indicated Resident 20 had severely impaired cognition (ability to understand) and required maximal assistance (helper does more than half the effort) with oral and toileting hygiene, shower, and upper body dressing. The MDS indicated Resident 20 had hearing difficulty. During a concurrent observation and interview on 6/20/2024 at 10:10 am inside Resident 20's room with Licensed Vocational Nurse 6 (LVN 6), LVN 6 was talking full-voiced (strong, powerful voice) to Resident 20. Resident 20 was pointing to his right ear. Resident 20 nodded when asked by LVN 6 if he could not hear on his right ear. LVN 6 stated Resident 20 speaks mostly Cantonese and minimal use of the English language. LVN 6 stated LVN 6 needed to talk louder to Resident 20 to be understood. During a concurrent observation and interview on 6/20/2024 at 10:53 am with Licensed Vocational Nurse 5 (LVN 5), Resident 20 was pointing to his ears while LVN 5 was talking to him in Cantonese. Resident 20 stated Resident 20 could not hear well on both ears. During a review of Resident 20's Care Plans (CP) and clinical record on 6/20/2024 at 10:30 am, there was no care plan initiated and developed to address Resident 20's difficulty of hearing. During an interview on 6/21/2024 at 11:09 am with the Minimum Data Set Coordinator (MDS C), MDS C stated a care plan needed to be developed on admission, quarterly, annually and during changes of condition and revised as needed. During an interview on 6/21/2024 at 11:21 am with the Director of Nursing (DON), the DON stated the care plan would guide the staff to provide care, treatment, and services to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P), the P&P indicated, It is the policy of the facility to identify the resident's need and provide a data base for resident's health assessment that begins on the day the resident is admitted in the facility. The care plans are person-centered and are used to assist the resident to reach his/her highest to reach his/her highest practicable level of physical, mental and psychosocial well-being. The facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and time-oriented objectives to meet the residents' medical, nursing, mental and psychosocial needs that are identified from a thorough assessment that includes, but not limited to the Minimum Data Base (MDS).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure residents were provided with a communication device in a language that the resident understood for two of three sampled residents (Residents 20 and 34). These deficient practices had the potential to affect Residents 20 and 34's communication with the staff and had the potential for the delay of the provision of care, treatment, and services to the residents. Findings: a. During a review of Resident 20's Admission Records (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a brain condition caused by a chemical imbalance in the blood) and Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) During a review of Resident 20's untitled Care Plan (CP), dated 8/2/2023, the CP indicated Resident 20 spoke another language/dialect. Resident 20 spoke Cantonese/Mandarin and was at risk for social isolation and unmet needs. The CP interventions included to translate /interpret other language /dialect speaking staff as needed and to use communication board (a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves) as needed to facilitate understanding. During a review of Resident 20's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/9/2024, the MDS indicated Resident 20 had severely impaired cognition (ability to understand) and required maximal assistance (helper does more than half the effort) with oral and toileting hygiene, shower, and upper body dressing. During a concurrent observation and interview on 6/18/2024 at 10:45 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 20's room, Resident 20 was pointing to his right ear while LVN 2 was talking to him. LVN 2 stated LVN 2 did not know if Resident 20 had difficulty hearing. LVN 2 stated LVN 2 communicated to Resident 20 by sign language and by pointing to LVN 2's body in reference to Resident 20's body parts. LVN 2 stated Resident 20 had no communication board inside the room. LVN 2 stated Cantonese/Mandarin speaking staff were not always available in the facility. LVN 2 stated an effective communication method was important to communicate better to the residents and ensure the needs of the residents were met. During an interview on 6/19/2024 at 11:50 am with LVN 4, LVN 4 stated all non-verbal, but alert and oriented residents and non-English speaking residents needed to have a communication board at bedside with pictures and description of their spoken language so the residents would communicate their needs and be understood and for the staff to address the resident's needs promptly. (continued on next page)

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F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 6/19/2024 at 12:00 pm with the Director of Nursing (DON), the DON stated all non-English speaking residents needed to have a communication board so the residents would express their needs and the staff would address the resident's needs appropriately.

During a review of the facility's undated Policy and Procedure (P&P) titled, Communication Boards, the P&P indicated, To ensure nonverbal and non-native speaking residents always have communication boards available at bedside to use in their communication with staff and for the staff to use o communicate with residents.

40037

b. During a review of the Resident 34's AR, the AR indicated Resident 34 was admitted to the facility on [DATE], with diagnoses that included muscle weakness and pulmonary hypertension (high blood pressure in the blood vessels that supply the lungs).

During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34's preferred language was Mandarin (Chinese language). The MDS indicated Resident 34 had clear speech, usually understood others, and usually made self-understood. The MDS indicated Resident 34 required supervision for eating and partial/moderate assistance (helper does less than half the effort) for upper body dressing and personal hygiene.

During an observation on 6/18/2024 at 10:47 am, in Resident 34's room, Resident 34 was lying in bed awake, there was an English-Chinese communication board on top of Resident 34's night stand. During a concurrent interview of Resident 34 by Surveyor 1 (Mandarin speaking surveyor), Resident 34 stated Resident 34 spoke Mandarin and it was hard to communicate with staff due to language barrier. Resident 34 stated the communication board had limited choices and staff normally used body language to communicate.

During an interview on 6/20/2024 at 10:54 am, Licensed Vocational Nurse 3 (LVN 3) stated, the facility did not have communication services other than the communication board to non-English speaking residents. LVN 3 stated, it was hard to communicate and understand residents that English was not their primary language. LVN 3 stated, the communication board for Resident 34 did not cover all care areas and resident needs. LVN 3 stated, the facility needed to have other interpretation services in place to use when there was a language barrier between staff and residents. LVN 3 stated, staff would not be able to provide quality care and meet the needs of the resident if staff would not understand the residents.

During an interview on 6/20/2024 at 11 am, Certified Nursing Assistant 1 (CNA1) stated it was difficult to communicate with Resident 34 due to language barrier. CNA1 stated CNA1 used communication board and body language to communicate with Resident 34. CNA1 stated, it was very hard to determine Resident 34's specific needs. CNA1 stated, the facility did not have other communication method to provide translation services. CNA1 stated, residents would feel frustrated and get upset when staff do not understand the residents, affecting the resident's quality of life.

During an interview on 6/20/2024 at 11:29 am, Social Service Assistant (SSA) stated the facility did not have other communication methods for non-English speaking residents except the communication board. The SSA stated, residents would get anxious if they were not able to communicate with staff effectively.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled Communication Boards Policy/Procedure, the P&P indicated When rare occasion arises that a resident needs an interpreter, Social Services and/or Nursing will locate the interpreter when available to translate information and verbal interventions to the appropriate native language.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to label and date the Intravenous (IV-administered into a vein) site consistent with professional standards of practice for one of one sampled resident (Resident 93). This deficient practice had the potential to result in infection and worsen Resident 93's medical condition. Findings: During a review of Resident 93's Admission Record (AR), the AR indicated Resident 93 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and malignant neoplasm of the lung (lung cancer). During a review of Resident 93's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 6/13/2024, the MDS indicated Resident 93 had moderately impaired cognition (ability to understand). The MDS indicated Resident 93 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for personal hygiene, toileting and rolling left and right. During a review of Resident 93's Physician Orders (PO) for infusion therapy dated 6/16/2024, the PO indicated for Resident 93 to receive continuous infusion for 0.9% NS at the rate of 60ml/hr for 24 hours. During a review of Resident 93's Intravenous Therapy Medication Record (ITMR) dated 6/16/2024, the ITMR indicated Resident 93's peripheral line (IV access) was inserted on 6/16/2024 at 11:20 pm to Resident 93's left hand. During an observation on 6/18/2024 at 11:20 am, in Resident 93's room, Resident 93 had ongoing IV fluid of Normal Saline (NS) 0.9% (percent, 0.9 gram of salt [NaCl] per 100ml of solution) flowing at 60 milliliter per hour (ml/hr). Resident 93's IV access was located at the back of Resident 93's left hand. There was no label on the IV dressing of the date of insertion. During an interview on 6/18/2024 at 11:38 am with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 93's IV site was not labeled. The MDSC stated IV site needed to be labeled with date of insertion so that staff would know when to change the IV site, for infection control purposes. The MDSC stated, IV access should be changed every 72 hours after insertion. The MDSC stated, Resident 93's IV was inserted on 6/16/2024. During a review of the facility's Policy and Procedure titled Short Peripheral Catheter Insertion, revised 5/1/2015, the P&P indicated label dressing with date and time, catheter gauge and length, nurse's initials.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48905 Based on observation, interview, and record review, the facility failed to post actual nurse staffing data at the beginning of each shift daily for two of two sampled locations (lobby and nursing station) on 6/18/2024 and 6/20/2024. These failures had the potential to result in not providing nurse staffing information to residents and visitors and had the potential to affect the quality of care to the residents. Findings: During an observation on 6/18/2024 at 10:24 am in the lobby of the facility and nursing station, the Posted Nurse Staffing Information (PNSI) form did not have the actual number of nursing staff present for the morning shift of 6/18/2024. During an interview on 6/20/2024 at 11:32 am with the Director of Nursing (DON), the DON stated the PNSI form should be filled out at the beginning of each shift. The DON stated if the PNSI was not filled out, residents or visitors would not be able to know the actual number of staff who worked. During a concurrent observation and interview on 6/20/2024 at 11:35 AM with Registered Nurse Supervisor 1 (RN Sup 1), the PNSI form for 6/20/2024 in the nursing station did not have the actual number of staff working. RN Sup 1 stated RN supervisors were responsible for updating the form with actual number of staff working. RN Sup 1 stated the PNSI form was in the nursing station and at the lobby entrance. The RN Sup 1 stated the PNSI form should be completed at the beginning of the shift and stated RN Sup 1 did not complete the form for 6/20/2024. RN Sup 1 stated the PNSI form needed to be updated so that residents and family members would be aware of the facility's staffing. During a review of the facility's Policy and Procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers revised 8/2022, the P&P indicated within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The P&P indicated the charge nurse posts the staffing information in the locations designated by the administrator.

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NAME OF PROVIDER OR SUPPLIER El Encanto Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 555 South El Encanto Road City of Industry, CA 91745	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48905 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with the facility's Policy and Procedure (P&P) on dating open food containers, refrigerated food storage labeling and dating and hair net policy, for one of one facility kitchen, by failing to: A. Label one bottle of salad dressing, one carton of milk, one canister of chopped onion seasoning, one canister of garlic herb cayenne pepper, and one canister of chicken flavor base, with the open date. B. Discard one tray of nourishments that contained yogurt, prunes, and cottage cheese from the refrigerator dated 6/12/2024. C. Wear a beard net for two staff members who had facial hair while working in the facility's kitchen area on 6/19/2024. These failures had the potential to result in food contamination and food borne illnesses (illness from ingesting contaminated food). Findings: During an observation on 6/18/2024 at 9:50 am in the kitchen, one bottle of salad dressing, one carton of milk, one canister of chopped onion seasoning, one canister of garlic herb cayenne pepper, and one canister of chicken flavor base was opened with no open date label. One tray of nourishments that contained yogurt, prunes, and cottage cheese dated 6/12/2024 was observed to be in the kitchen refrigerator. During an interview on 6/18/2024 at 3:49 pm with the Dietary Supervisor (DS), the DS stated foods that are opened should be labeled with the opened date. The DS stated the risk of not labeling foods with the open date was that staff would not know when the food was opened. During an interview on 6/19/2024 at 11:47 am with [NAME] 1, [NAME] 1 stated foods should be thrown away after three days. [NAME] 1 stated nourishments that were dated 6/12/2024 should have been thrown away on 6/15/2024. [NAME] 1 stated the risk of having opened food past three days in the refrigerator was that the resident could get a foodborne illness if food was left in the refrigerator for too long and served to the residents. During a concurrent observation and interview on 6/19/2024 at 12:10 pm with the DS in the kitchen, the DS and [NAME] Aide (CA) 1 did not have beard nets on while in the kitchen. The DS stated, DS and CA 1 did not have beard nets on and stated a beard net should be worn because hair could fall into the resident's food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled, Dating Open Food Containers the P&P indicated all opened or prepared food items must be clearly marked with the date of opening which applies to all potentially hazardous foods such as, prepared salads, cooked meats, opened canned goods, cut produce, dairy products, and spices and seasonings. During a review of the facility's undated P&P titled, Refrigerated Food Storage, Labeling, and Dating the P&P indicated to discard any food items past the three-day use by date. During a review of the facility's undated P&P titled, Hair Net Policy for Kitchen Workers the P&P indicated kitchen workers with facial hair, such as, beards or mustaches must wear beard nets to cover facial hair.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to ensure its binding arbitration agreements included selection of a venue convenient to both facility and resident/resident responsible party for three of three sampled residents (Residents 16, 20 and 35). These deficient practices placed Residents 16, 20 and 35 at risk for unjust arbitration and delayed arbitration hearing in an event of an arbitration dispute. Findings: a. During a review of Resident 16's Admission Record (AR), the AR indicated the facility admitted Resident 16 on 5/6/2024 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), essential hypertension (elevated blood pressure without a known cause) and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/13/2024, the MDS indicated Resident 16 's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 16 required maximum assistance with upper body dressing and personal hygiene. During an observation on 6/18/2024 at 10:41 am, Resident 16 was lying in bed and was communicative. During a concurrent interview and record review on 6/20/2024 at 3:55 pm with the Admission Coordinator (AC), the binding arbitration agreement for Resident 16 was reviewed. The facility's arbitration agreement form titled Arbitration Agreement (AA) indicated it was signed by Resident 16's responsible party on 5/15/2024. The signed Arbitration Agreement of Resident 16 did not include information regarding selection of a neutral arbitrator and a venue convenient to both facility and resident/resident responsible party. During a review of the facility's Policy and Procedure (P&P) titled Binding Arbitration Agreements, dated 11/2023, the P&P indicated for arbitration agreements, provide for the selection of a venue that is convenient to and suitably meets the needs of both parties. The P&P indicated the venue will be agreed upon by both parties. The P&P indicated when selecting a venue for consideration, convenience for the resident (or representative) may be determined but his or her ability to get to the venue. 40438 b. During a review of Resident 20's AR, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a brain condition caused by a chemical imbalance in the blood) and Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait). (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review Resident 20's History and Physical (H&P), dated 8/1/2023, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 6/20/2024 at 3:55 pm with the AC, the binding arbitration agreement for Resident 20 was reviewed. Resident 20's Arbitration Agreement (AA) dated 8/8/2023 indicated Resident 20 signed the agreement. The signed AA did not include information regarding the selection of a neutral arbitrator and a venue convenient to both the facility and the resident or the resident's responsible party. 40037 c. During a review of Resident 35's AR, the AR indicated Resident 35 was admitted to the facility on [DATE] with diagnoses that included dependence of renal dialysis (a treatment for people whose kidneys are failing) and fracture (broken bone) of lower leg. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35 had clear speech, had an ability to understand others and had the ability to make self-understood. The MDS indicated Resident 35 was cognitively intact. During a review of Resident 35's AA signed on 4/11/2024, the AA did not provide for the selection of a venue that was convenient to both parties.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48905 Based on observation, interview, and record review, the facility failed to follow the its Policy and Procedure (P&P) on Enhanced Barrier Precaution (EBP, precautions that include the use of a gown and gloves during high contact resident care activities for residents) to prevent the spread of infections for one of five sampled residents (Resident 35) for infection control when Licensed Vocational Nurse 7 (LVN 7) did not don (put on) personal protective equipment (PPE, equipment worn to minimize exposure to hazards) before taking the blood pressure of Resident 35 in an EBP room. This failure had the potential to result in transmission of multidrug-resistant organisms (MDRO, bacteria that is resistant to antibiotics) to other residents in the facility. Findings: During a concurrent observation and interview on 6/19/2024 at 9:41 am with LVN 7, an EBP sign was noted outside of Resident 35's door. LVN 7 entered Resident 35's EBP room without donning on PPE and took Resident 35's blood pressure. LVN 7 stated LVN 7 did not have a gown on when taking Resident 35's blood pressure and stated LVN 7 should have worn gloves and a gown because LVN 7 was in close contact with Resident 35. LVN 7 stated LVN 7 did not follow EBP precautions and stated the risk of not following PPE precautions for an EBP room was that MDRO's can be transmitted to other residents in the facility. During an interview on 6/20/2024 at 9:22 am with the Infection Prevention Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated EBP was used to reduce the transmission of MDRO's. The IPN stated an EBP sign was posted outside the resident's door for residents who have open wounds, gastrostomy tubes (G-tube, surgical insertion of a tube, creating an artificial external opening into the stomach for medication/nutritional support), foley catheter (indwelling catheter placed into the bladder to drain urine), and residents who are on dialysis (process of removing excess waste material from the blood). The IPN stated staff needed to don PPE before entering the room if staff needed to be in close contact with the resident on EBP. The IPN stated taking Resident 35's blood pressure who was inside an EBP room was considered close contact activity. The IPN stated, MDRO's can be transferred to other residents if staff do not use proper PPE. During a record review of the facility's undated P&P, titled Enhanced Barrier Precaution, the P&P stated staff are to wear gowns and gloves while performing tasks that are associated with the greatest risk for MDRO contamination of health care providers (HCP) hands, clothes, and the environment, such as, any care activity where close contact with the resident is expected to occur.