STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555429	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Gardens Health Care Unit	842 East Villa Street Pasadena, CA 91101

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 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** 45099 Based on interview and record review, the facility failed to follow its Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) policy to inform and provide a written information regarding the right to formulate an advance directive for one (1) of two (2) sampled residents (Resident 26). This deficient practice had the potential to cause conflict in carrying out Resident 26's wishes regarding health care decisions during an emergency. Findings: During a review of Resident 26's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) and thrombocytopenia (a condition where a person has a lower-than-normal number of platelets in their blood). During a review of Resident 26's History and Physical (H&P), dated 2/27/2024, the H&P indicated Resident 26 had fluctuating capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a federally mandated assessment tool), dated 9/2/2024, the MDS indicated Resident 26 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 26 was dependent (helper does all the effort) with toileting, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 26 required substantial assistance (helper does more than half the effort) with shower and partial assistance (helper does less than half the effort) with upper body dressing and personal hygiene. During a review of Resident 26's Physician Orders for Life-Sustaining Treatment (POLST, a portable medical order form that records resident's treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration) prepared on 1/17/2024, the form did not indicate what was discussed with the resident. The POLST form did not indicate whether Resident 26 had an advance directive, had an advance directive but not available, or there was no advance directive. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Villa Gardens Health Care Unit	842 East Villa Street Pasadena, CA 91101

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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	During a concurrent interview and record review on 10/3/2024 at 5:26 PM, Licensed Vocational Nurse 5 (LVN 5) stated the advance directives acknowledgement form should be in the chart to make sure Resident 26 was notified of the choice to formulate an advance directive if she does not have one. LVN 5 verified Resident 26 did not and should have an advance directives acknowledgement form. During an interview on 10/4/2024 at 10:56 AM, the Social Services Director (SSD) stated the advance directives acknowledgement form should be in the chart. The SSD also stated the advance directives acknowledgement serves as an indicator that facility have had a conversation with the resident about having an advance directive. The SSD stated if the resident did not have one then the facility could provide information about having to formulate a health care directive. The SSD further stated the advance directives acknowledgement form would contain the information whether the resident has an advance directive or not. During a review of the facility's Policy and Procedure (P&P) titled, Advanced Directive, revised March 2024, the P&P indicated that upon admission to the community, social services staff or designee will inform and provide written information to the resident concerning their right to formulate an advanced directive. The policy also indicated that an acknowledgement for advanced directive form will be completed, signed, and placed in the resident's medical record. The policy further indicated that information about whether the resident has executed an advanced directive shall be displayed prominently in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Villa Gardens Health Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 842 East Villa Street Pasadena, CA 91101	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48152 Based on interview and record review, the facility failed to prevent falls (move downward, typically rapidly and freely without control, from a higher to a lower level) for one (1) of two (2) sampled residents (Resident 35) by failing to identify causative factors of the resident's fall, and revise the care plan with new resident-specific interventions (programs or activities that are designed to address the specific needs of the resident to ensure their well-being) to prevent further falls. On 7/14/2024 at 8:24 AM, Resident 35 was found sitting on the floor at 6:15 AM awake, very confused, and soaking wet with urine, there was no documented evidence of interventions provided to address resident's confusion and incontinence (involuntary loss of bowel and bladder control). This failure resulted in Reisdent 35 had six (6) falls incidents (8/5/2024, 9/9/2024, 9/10/2024, 9/23/2024 at 1:45 AM and 2:30 AM, and 9/29/2024) with the potential for injuries. On 9/23/2024, the resident sustained forehead laceration and skin tear to her left elbow after the second fall (2:30 AM). Findings: During a review of Resident 35's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 35 was admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of a facility's form titled Patient Diagnoses Information, dated 10/4/2024, the form indicated Resident with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) with dyskinesia (uncontrolled, involuntary muscle movements ranging from shakes, tics and tremors to full-body movements), dementia (a progressive state of decline in mental abilities) and repeated falls. During a review of Resident 35's Minimum Data Set (MDS- a federally mandated assessment tool), dated 9/9/2024, the MDS indicated Resident 35 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 35 was partial/moderate assistance (helper does less than half the effort needed to complete the activity) with toileting hygiene, supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with bathing, toilet transfers (the ability to get on and off a toilet or commode), dressing, putting on/taking off footwear and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating, oral and personal hygiene. During a review of Resident 35's Fall Risk Assessment, dated 9/9/2024, the Fall Risk assessment indicated some of Resident 35's fall risk factors to include diagnoses of Parkinson's, dementia, bowel incontinence (inability to control bowel movements), previous falls, unsteady gait and disoriented (confused and unable to think clearly) times two (2) (only able to recall 2 elements of the four: person, place, time, and situation). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Bowel and Bladder assessment dated [DATE], the assessment indicated Resident 35 as occasionally incontinent (usually 2 or more times per week but not daily) with bladder [urination], and functionally incontinent (unable to get to toilet without assistance) with bladder [urination]. The assessment also indicated Resident 35 has episodes of confusion, uses a walker, and needs extensive assistance with transfers. During a review of Resident 35's Fall Risk care plan, revised 9/30/2024, the care plan indicated Resident 35 had the following falls: a. Actual fall on 7/5/2024 b. Alleged fall on 7/14/2024 c. Actual fall 8/25/2024 (at 11:35 PM) d. Unwitnessed fall on 9/9/2024 e. Actual fall on 9/10/2024 f. Actual fall 9/23/2024 at 1:45 AM and 2:30 AM g. Actual fall on 9/29/2024. The care plans also indicated Resident 35 is at risk for falls related to history of falls, impaired mobility, lack of safety awareness, psychoactive med use, unsteady gait, urinary frequency, and weakness, with a goal of no injuries related to falls over the next quarter [12/4/2024]. The care plans dated from 7/14/2024 to 9/29/2024 did not include interventions to address the resident's incontinence at night and confusion. During a review of Resident 35's Progress Notes, dated 7/1/2024 through 10/4/2024, the circumstances for Resident 35 falls were as follows: a. Progress Notes dated 7/14/2024 at 8:24 AM indicated Resident 35 was found sitting on the floor at 6:15 AM awake, very confused, and soaking wet with urine. Resident 35 stated she did not know where she was and is wet because of water from the ceiling. b. Progress Notes dated 9/13/2024 at 1:24 PM indicated Resident 35 had a fall on 9/9/2024 attempting to reach for something and a fall on 9/10/2024 due to Resident 35 ambulating unassisted from bed, trying to get something from her closet. This fall resulted in a laceration to her right temple and multiple discolorations to both arms. c. Progress Notes dated 9/23/2024 at 3:54 AM indicated Resident 35 was found at 1:45 AM sitting on [floor] left side of the bed, stating she was in her apartment with her spouse, being robbed. d. Progress Notes dated 9/23/2024 at 4:09 AM indicated Resident 35 was found sitting on the floor around 2:30 AM sitting by her bed with a superficial laceration to forehead and skin tear to left elbow. Resident 35 stated she did not know what happened and her pants were observed halfway down, The note also indicated after fall, Resident 35 wanted to be taken to the toilet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Progress Notes dated 9/24/2024 at 11:33 AM indicated Resident had two falls on 9/23/2024, an unwitnessed at 1:45 AM and was found on the floor again at 2:35 AM. During a review of Resident 35's SBAR Communication Form, dated 8/25/2024 at 11:35 PM, the SBAR indicated Resident 35 stated she was putting the bedsheet on the floor for sleeping when she lost balance and fell . During a review of Resident 35's SBAR Communication Form, dated 9/23/2024, the SBAR indicated Resident 35 had two fall incidents, the first Resident 35 stated robber was in her apartment and the second fall, Resident 35 jumped out of her bed. The SBAR also indicated Resident 35's fall resulted in a forehead laceration and skin tear to her left elbow. During an interview on 10/4/2024 at 10:12 AM with Licensed Vocational Nurse 2 (LVN2), LVN 2 stated Resident has a history of falls, unsteady gait and is incontinent during the nighttime. During a concurrent record review and interview with the Director of Nursing (DON) on 10/4/2024 at 3:19 PM, Resident 35's fall history and revised fall risk care plan interventions were reviewed. The revised interventions were as follows: a. Fall on 7/5/2024, revised intervention added a night light leading to the bathroom. b. Fall on 7/14/2024, revised intervention added to remind Resident 35 not to close [room] door and/or wander at night. c. Fall on 8/25/2024, revised intervention added, Resident 35 moved closer to nurses' station. d. Fall on 9/10/2024, revised intervention added to remind Resident 35 to use the call light. e. Both falls on 9/23/2024, revised intervention of added floor mat (a pad that provides a cushioned land during a fall that reduces that chance of injury from a fall) on the side of Resident 35's bed at night. The DON stated Resident 35 has a history of falls including a fall with injury at previous facility and this facility. The DON also stated Resident 35 does not use call light even if reminded to do so because of forgetfulness and confusion. During a concurrent review of Resident 35's medical record and interview on 10/4/2024 at 6:18 PM with the DON and Administrator (ADM), the DON was unable to provide documented implemented interventions that address Resident 35's incontinence at night. ADM stated facility needs to continue to assess the plan, interventions and get creative as an interdisciplinary team (IDT - a coordinated group of experts from several different fields) to ensure Resident 35 is safe in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Post Fall Assessment, revised 12/14/2022, the P&P indicated Nursing should consider initiating immediate interventions during the same shift the fall occurred and based on the fall circumstances with given examples including increased toileting with specific times, increased assistance or supervision at specific high-risk times and increased monitoring using sensory devices. The P&P also indicated the care plan will be reviewed and updated with interventions to prevent further falls or injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Falls Prevention and Management Program, revised 12/14/2022, the P&P indicated: a. The falls prevention and management program serves to improve or maintain the quality of life for residents. Staff will properly assess a resident's risk for falling, provide adequate interventions to minimize that risk and try to prevent a resident from falling, and then evaluate the effectiveness of those interventions. b. Nursing being able to identify causative factors should a fall occur, and then accelerate the care plan with new interventions to prevent further falls; c. Consider using purposeful rounding to proactively address resident needs on a scheduled basis. A member of the care team rounds on the residents at an individually structured time such as hourly from 6 am to 10 pm and every two hours at night except for high-risk residents every hour. This could include scheduled and prompted toileting. It includes anticipating resident needs rather than responding to a call light.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility staff failed to follow its manual catheter irrigation (a procedure that uses sterile fluid to flush a blocked or clogged indwelling catheter [a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage]) policy when Licensed Vocational Nurse 5 (LVN 5) failed to cap the drainage tube of the indwelling catheter with a sterile protective sheath during irrigation for one (1) of one sampled Resident (Resident 18) as indicated in the facility's policy and procedure (P&P). This deficient practice had the potential for Resident 18 to develop urinary tract infection (UTI- an infection in the bladder/urinary tract). Findings: During a review of Resident 18's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 18 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH- when the prostate and surrounding tissue expands), chronic systolic congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 18's History and Physical Examination (H&P), dated 11/20/2023, the H&P indicated Resident 18 did not have the capacity to understand and make decisions. During a review or Resident 18's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/4/2024, the MDS indicated Resident 18 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 18 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, lower body dressing, and sit to stand. Resident 18 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) with shower/bathe self, personal hygiene, and toilet transfer. Resident 18 had an indwelling catheter. During a review of Resident 18's Physician's Order, dated 10/1/2024, the Physician's Order indicated an order to flush foley catheter (indwelling catheter- a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) with 50 cubic centimeter (cc-unit of measurement) normal saline (NS-a saltwater solution) every shift and as needed (PRN) to keep foley catheter patent/for sediments/or hematuria (blood in urine) or clogged. During a concurrent observation and interview with Resident 18, on 10/1/2024, at 1:46 PM, Resident 18 was sitting on his wheelchair in his room. Resident 18 stated he was waiting for LVN 5 to flush (irrigate) his indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 5, on 10/2/2024, at 2:29 PM, LVN 5 stated Resident 18's indwelling catheter was manually flushed every shift due to the presence of sediments (a buildup of various materials in the catheter that can cause blockage or encrustation) in the resident's indwelling catheter tubing. During an observation of Resident 18's foley catheter irrigation, on 10/4/2024, at 10AM, LVN 5 cleansed the connection site around the catheter and the drainage tubing with an alcohol pad and disconnected the catheter from the drainage tubing. LVN 5 placed the drainage tubing on the clean disposable absorbent pad that was placed on top of Resident 18's abdomen. LVN 5 did not cap or cover the drainage tubing before placing it on top of the disposable absorbent pad. LVN 5 flushed the catheter slowly with 50 cc of normal saline and disconnected the syringe from the catheter. LVN 5 cleansed the connection site and the drainage tubing with an alcohol pad and reconnected the catheter to the drainage tubing. During a concurrent review of the facility's Policy and Procedure (P&P) titled, Catheter, Manual Irrigation, revised on 8/2019 and interview with LVN 5 on 10/4/2024, at 12:11 PM, LVN 5 stated the P&P indicated to Carefully disconnect tubing from catheter, holding the catheter upright, cap the drainage tube with a sterile protective sheath. Secure drainage tubing close to resident on the bed. LVN 5 stated she did not cap or cover Resident 18's drainage tubing with a sterile protective sheath after it was disconnected from the catheter. LVN 5 stated the drainage tubing should be capped with a sterile sheath to prevent bacteria and germs from entering. LVN 5 stated Resident 18 can get an infection if bacteria or gems enter the drainage tubing. During a concurrent review of the facility's Policy and Procedure (P&P) titled, Catheter, Manual Irrigation, revised on 8/2019 and interview with the Administrator (ADM) and the Director of Nursing (DON) on 10/04/2024, at 2:20 PM, the DON stated LVN 5 should have followed the facility's P&P for foley irrigation. The ADM stated LVN 5 did not follow the facility's P&P for foley irrigation. During a review of the facility's P&P titled, Catheter, Manual Irrigation, revised on 8/2019, the P&P further indicated, A closed indwelling urinary drainage system should be maintained whenever possible to prevent risks of contamination.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on observation, interview, and record review the facility failed to follow its oxygen therapy (a treatment that provides extra oxygen) policy for two (2) of three (3) sampled residents (Residents 8 and 37) by failing to: 1. Ensure Resident 8's humidifier bottle (plastic bottle of water that adds moisture to the flow of oxygen) was dated and not empty during oxygen therapy. This failure had the potential to result in adverse effects (an undesired harmful effect resulting from a medication or other intervention) of oxygen therapy for Resident 8 including nasal membrane (moist tissue that lines the nasal cavity and produces mucus) drying. 2. The facility failed to follow Resident 37's physician order to receive two (2) liters of oxygen per minute (LPM) via nasal cannula (oxygen tubing used to deliver supplemental oxygen that is placed directly on the nostrils) continuously and failed to store empty portable oxygen cylinder tanks separately from full portable oxygen cylinder tanks as indicated in the facility's policy and procedure (P&P). This deficient practice had the potential to result in oxygen toxicity (lung damage that happens from breathing in too much extra oxygen) to Resident 37 if receiving more oxygen than required. Storing empty and portable oxygen cylinders in the resident's room also had the potential for harm and injury to Resident 37, other residents, facility staff, and visitors. Findings: 1. During a review of Resident 8's Face Sheet, (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), asthma (a chronic lung disease that causes inflammation and tightening of the muscles around the airways, making it difficult to breathe), dependence on supplemental oxygen and shortness of breath (SOB- difficulty breathing). During a review of Resident 8's Minimum Data Set (MDS- a federally mandated assessment tool), dated 6/30/2024, the MDS indicated Resident 8 had moderately impaired cognitive skills for daily decision making and Resident 8 received oxygen therapy for respiratory treatment. The MDS also indicated Resident 8 required setup or clean-up assistance (staff help only prior to or following the activity completion) with eating and oral hygiene, partial/moderate assistance (staff does less than half the effort needed to complete the activity) with toileting and substantial/maximal assistance (staff does more than half the effort needed to complete the activity) with dressing and bathing. During a review of Resident 8's Physician Order, dated 10/1/2024 through 10/31/2024, the Physician's order indicated an order for continuous oxygen each shift, titrate (adjusting the amount of oxygen a patient receives to maintain a target oxygen saturation level) from 2 liters (L) to five (5) L per minute via nasal cannula (NC- a tube that provides oxygen through the nose) continuously for SOB keep oxygen saturation (the amount of oxygen carried by red blood cells) above 90 percent (%). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/1/2024 at 2:29 PM with Licensed Vocational Nurse 1 (LVN 1), at Resident 8's bedside, Resident 8 was observed receiving four (4) L of oxygen via NC with an empty, undated humidifier bottle attached to the oxygen concentrator (a medical device that produces a higher concentration of oxygen from the room air). LVN 1 stated Resident 8's humidifier was undated, empty and should not be. LVN 1 stated the facility policy is to date the humidifier bottle with the open date and should be changed when empty. LVN 1 also stated it is important to have water in the humidifier bottle during oxygen therapy because it is easy for Resident 8 to get a dry nose with the high oxygen [amount] the resident was receiving. LVN 1 added that the humidifier will prevent the drying of Resident 8's nose. During an interview on 10/4/2024 at 3:36 PM with Director of Nursing (DON), the DON stated Resident 8's humidifier bottle should not be empty because of the risk of Resident 8's nasal passages (the two sections of the nasal cavity that allow air to pass through the nose and into the body) drying. During a review of facility's policy and procedure P&P titled, Oxygen Therapy, revised 7/2022, indicated: a. Oxygen therapy is administered by a licensed nurse as ordered by the physician. b. Set oxygen flow rate as ordered and assess equipment for proper functioning. c. If oxygen liter flow is at 4 L per minute of higher, or the resident has problems with excessive drying of the nasal passages, a pre-filled or reusable humidifier may be used with distilled water. d. Label humidifier bottle with open date. e. When humidifier bottle is empty or essentially empty, detach and reattach a new prefilled bottle and label with open date. 46919 2. During a review of Resident 37's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), pleural effusion (a condition where fluid builds up in the thin cavity between the lungs and the chest wall), and hypotension (low blood pressure). During a review of Resident 37's History and Physical Examination (H&P), dated 8/22/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS-a federally mandated Resident assessment tool), dated 8/31/2024, the MDS indicated Resident 37 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 37 required supervision or touching assistance with eating and oral hygiene. Resident 37 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, upper and lower body dressing, sit to stand, and chair/bed-to-chair transfer. Resident 37 was on intermittent (not continuous) oxygen therapy. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's Physician's Order, with a report date range of 10/1/2024 to 10/31/2024, the Physician's Order indicated a start date of 8/24/2024, for continuous oxygen, each shift at 2 LPM via nasal cannula continuously for respiratory failure keep oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) greater than 90%. During a review of Resident 37's Care Plan titled, Alteration in Breathing Patterns related to history of respiratory failure, dated 8/24/2024, the care plan indicated an intervention for oxygen continuous at 2 LPM via nasal cannula. During an observation in Resident 37's room, on 10/1/2024, at 9AM, Resident 37 was sitting on his bed eating his breakfast. Resident 37 was receiving four (4) LPM of oxygen via nasal cannula. Resident 37 had three (3) portable oxygen cylinder tanks against the wall by the foot of the bed. Two out of the three portable oxygen cylinder tanks were empty. During a concurrent observation of Resident 37's bathroom and interview with Licensed Vocational Nurse 2 (LVN 2), on 10/1/2024, at 3:46 PM, LVN 2 checked Resident 37's oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to a resident in need of supplemental oxygen) in the bathroom and stated Resident 37 was receiving 4 LPM of oxygen. LVN 2 stated Resident 37 was only ordered for 2 LPM of oxygen. During the same concurrent observation of Resident 37's room and interview with LVN 2 on 10/1/2024, at 3:46 PM, LVN 2 stated Resident 37 had three portable oxygen cylinder tanks in his room. LVN 2 stated 2 out of the three (3) portable oxygen tanks were empty. LVN 2 stated empty portable oxygen tanks should be stored in the oxygen tank storage room. During an interview with the Director of Staff Development (DSD), on 10/1/2024, at 4:27 PM, the DSD stated empty portable oxygen cylinder tanks should be separated from full portable oxygen cylinder tanks. The DSD stated portable oxygen cylinder tanks are stored in the oxygen storage room for the safety of the residents and staff and to prevent fires. During an interview with LVN 6, on 10/2/2024, at 4:24 PM, LVN 6 stated Resident 37's oxygen cannot be increased to 4 LPM without getting an order or notifying the physician. LVN 6 stated Resident 37's physician order for oxygen was not followed on 10/1/2024. LVN 6 stated it was important to follow the physician's oxygen order because too much oxygen can drown (a term used when resident breaths in too much oxygen causing lung damage and even death) a resident. LVN 6 stated a resident can also go into respiratory distress and end up in the hospital from receiving too much oxygen. During the same interview with LVN 6, on 10/2/2024, at 4:24 PM, LVN 6 stated empty portable oxygen cylinder tanks should not be kept in the resident's room with full portable oxygen cylinder tanks. LVN 6 stated empty portable oxygen cylinder tanks were stored in the oxygen storage room. LVN 6 stated it was the responsibility of the licensed nurses and certified nursing assistants (CNA) to monitor and check the portable oxygen cylinder tanks in the residents' rooms. During a review of the facility's P&P, titled, Oxygen Therapy, revised on 7/2022, the P&P indicated, Oxygen therapy is administered by a licensed nurse as ordered by the physician or as an emergency measure until the order can be obtained. The P&P indicated to, Replace oxygen cylinders as needed based on flow rate and size. Securely store empty cylinders separately from full.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to to follow proper food handling practices in accordance with its policy and procedure by failing to:: 1. Properly label food items in the kitchen refrigerator. 2. Ensure there was no expired bread in the kitchen dry storage area. 3. Properly label food items in the resident refrigerator. These deficient practices have the potential to result in food borne illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) in a population of 35 residents who consume food by mouth. Findings: 1. During a concurrent observation and interview in the kitchen on [DATE] at 7:50 AM with [NAME] 1, there were multiple food items inside walk in refrigerator 1 without a label to indicate the date when the following food items were opened: a. One large clear container of cranberries b. One grocery bag (cook stated did not belong to the facility but could be from one of the staff) which contained coleslaw packed in a zip lock and in a small plastic container, one plastic bottle with tomato sauce and tortillas packed in a foil. During a concurrent observation and interview in the kitchen on [DATE] at 8:10 AM with [NAME] 1, there was one large pan of breaded meat without a label to indicate prepared date inside walk in refrigerator 2. Cook 1 stated he did not know who the grocery bag of food item was from and should have been placed in the employee lounge so not to contaminate other food items inside the kitchen refrigerator if they belonged to one of the employees. [NAME] 1 also stated he was not sure what kind of meat was the breaded meat item in the large pan and when it was prepared. [NAME] 1 further stated the breaded meat should have been labeled with the type of meat and date it was prepared. 2. During a concurrent observation and interview in the kitchen on [DATE] at 8:30 AM with [NAME] 1, there were three (3) bags of breadsticks and two (2) bags of Rye bread with an expiration date of [DATE] on the multiple tier bread rack. [NAME] 1 stated the expired items should be thrown away since they could develop molds and cause the residents to get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:20 AM, the Director of Dining Services (DDS) stated the expired bread should be removed since it potentially could cause health issues to the residents. The DDS also stated all food items in the refrigerator should be labeled to identify what they were. The DDS further stated the residents could potentially be given and could ingest the wrong food item if not labeled properly. During an interview on [DATE] at 11:55 AM, the Registered Dietician (RD) stated, expired items should be removed, discarded, and not served after expiration for food safety and palatability. The RD also stated, the food item should be labeled with the name of item if its not in the original container and should be labeled with the date it was opened and date it was prepared for food safety and for identifying the food. The RD further stated, serving undated food items to the residents that were potentially expired could cause food borne illness. 3. During a concurrent observation and interview on [DATE] at 11:24 AM with Licensed Vocational Nurse 5 (LVN 5), multiple food items without a label to indicate the opened date, residents name and room number, date food was prepared or first opened were found inside the resident's refrigerator by the hallway close to the nurse's station, which included the following: a. One small container of red sauce b. Three (3) pints sized and one gallon of ice cream LVN 5 stated it was not acceptable for food items brought in by families in the refrigerator not to have labels with the resident's name, room number, date the food was prepared, or first opened since bacteria could grow in food items which could possibly make residents sick if consumed. During an interview on [DATE] at 1:52 PM, Licensed Vocational Nurse 3 (LVN 3) stated the foods stored inside the resident's refrigerator should be labeled to identify which resident, room number, and date it was stored. LVN 3 also stated it is to ensure the food is still good for consumption. LVN 3 further stated residents could get food poisoning if the food being consumed was expired. During a review of the facility's Policy and Procedure (P&P) titled, Dining Services - Storage and Inventory, dated [DATE] indicated that all prepared foods and foods not in the original containers must be covered, labeled, and dated. During a review of the facility's P&P titled, Dining Services - Foods Brought into the Facility by Family Members or Guests, dated [DATE] indicated that foods shall be labeled by the person who brought the food. The policy also indicated that the label shall have: the residents name and room number, as well as the date the food was prepared or first opened. The policy further indicated that foods not properly labeled or have labels that are not easily readable will be immediately discarded.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 45099 Based on observation and interview the facility failed to ensure two (2) of three (3) dumpsters were covered with a lid and were not overflowing with trash in accordance with the facility policy. This failure had the potential to result in the attraction and spread of vermin (animals that are believed to be harmful, or that carry diseases, e.g., rodent's parasitic worms or insects) that could potentially enter the facility and spread diseases to the residents. Findings: During a concurrent observation of the facility's garbage area, and interview with the Director of Dining Services (DDS) on 10/1/2024 at 11:35 AM, there were 3 dumpsters located outside the facility's main kitchen area, which was about 15 to 20 feet away from the facility's kitchen exit. DDS verified 2 of the 3 dumpsters were observed without lids and both were overflowing with trash bags. DDS stated the dumpsters should have been covered with a lid and not overflowing with trash since this could attract all live animals. During observation of the facility's garbage area on 10/01/24 at 3:45 PM, about 5 empty boxes were observed in between 2 of the 3 dumpsters. The lid for one (1) of the 3 dumpsters was observed partially covering the dumpster due to boxes and trash overflowing from it. During an interview on 10/03/2024 at 9:57 AM, the Administrator stated that the lids on the dumpsters should be closed to keep pests away and to help keep the area sanitary. During a review of the facility's Policy and Procedure titled, Food and Nutrition Services, dated October 2024 indicated that the facility will properly dispose of garbage and refuse, maintaining containers in good condition (no leaks) with lids or otherwise covered. The policy also indicated that garbage storage areas will be maintained in a sanitary condition to prevent the harboring and feeding of pests.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, for one (1) of 12 sampled resident (Resident 5), the facility staff failed to: 1. Accurately and completely document the insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) dose administered on 10/2/2024, after administering insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). 2. Have documented evidence for the monitoring of signs and symptoms of hypoglycemia (a condition in which your blood sugar level is lower than the normal range) and hyperglycemia (a condition where too much sugar is circulating in the blood) as indicated in the resident's care plan and the pharmacist recommendations. These deficient practices placed Resident 5 at risk to not receive appropriate diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) management/care including unmonitored and untreated adverse reactions from insulin therapy, which could affect the resident's over all well being. Findings: 1. During a review of Resident 5's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- a long term lung disease causing difficulty breathing), acute respiratory failure (condition then there's not enough oxygen or too much carbon dioxide in the body), and feeding difficulties. During a review of Resident 5's History and Physical Examination (H&P), dated 6/8/2024, the H&P indicated Resident 5 had a history of AODM (adult-onset diabetes mellitus or type 2 diabetes). Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/14/2024, the MDS indicated Resident 5 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 5 required substantial/maximal assist (helper does more than half the effort) with toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and roll left and right. Resident 5 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) with shower/bathe self, sit to stand, and toilet transfer. Resident 5 was taking hypoglycemic (a condition where the level of sugar in the blood is too low) medication as indicated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility's form titled Patient Diagnoses Information, dated 10/3/2024, indicated Resident 5 with diagnoses that included type 2 diabetes mellitus (DM2 - a chronic metabolic disease that occurs when the body doesn't produce enough insulin or can't use it properly) with hyperglycemia, DM2 with hypoglycemia, long term [current] use of insulin and dementia (a condition characterized by progressive or persistent loss of intellectual functioning). During a review of Resident 5's Physician's Order, with a report date range of 10/1/2024 to 10/31/2024, the Physician's Order indicated a start date of 7/29/2024, for Fingerstix (a brand of lancets used to check the blood sugar) sliding scale (a treatment for diabetes that involves adjusting the amount of insulin a resident receives based on their blood sugar levels) three times a day before meals for Diabetes Mellitus 2 (diabetes), notify MD (physician) if BS (blood sugar) greater than or equal to (>/=) 301 or less than or equal to (</=) 80. Give Fiasp (insulin aspart, a prescription medication that helps control blood sugar levels in residents with diabetes) 100 U/ml (units per milliliter- a unit of measurement) Flextouch (a prefilled, disposable insulin pen) with sliding scale as follows: 0 to 80 = 0 units 81 to 120 = 4 units 121 to 200 = 8 units 201 to 300 = 15 units During a review of Resident 5's Sliding Scale Insulin Administration Record, the Sliding Scale Insulin Administration Record indicated on 10/2/2024, at 6:30 AM, Resident 5's glucose (blood sugar) level was 197. The record indicated Resident 5 was given 15 units of insulin on the right thigh. The box in the Sliding Scale Insulin Administration record to contain the initials of the licensed nurse who administered the insulin to Resident 5 on 10/2/2024, at 6:30 AM was blank. During a concurrent record review of Resident 5's Sliding Scale Insulin Administration Record, dated 10/2/2024, and interview with Licensed Vocational Nurse 1 (LVN 1) on 10/2/2024 at 2:40 PM, LVN 1 stated Resident 5's 6:30 AM insulin was administered by LVN 4 who was scheduled on 10/2/2024 from 11PM to 7AM shift. LVN 1 stated Resident 5's glucose (blood sugar) level was 197 on 10/2/2024, at 6:30 AM. LVN 1 stated Resident 5 should be administered 8 units of insulin for a blood sugar of 197 as indicated on the physician's order. LVN 1 stated the Sliding Scale Insulin Administration Record on 10/2/2024, at 6:30 AM, indicated Resident 5 was administered 15 units of insulin on the right thigh. LVN 1 stated LVN 4 did not and should have initialed the box on the Sliding Scale Insulin Administration Record after administering insulin to Resident 5 on 10/2/2024 at 6:30 AM. During a concurrent record review of Resident 5's Sliding Scale Insulin Administration Record, dated 10/2/2024, and interview with the Director of Nursing (DON) on 10/4/2024, at 4:46 PM, the DON stated LVN 4 made a transcription error and wrote the wrong amount of insulin on Resident 5's Sliding Scale Insulin Administration Record. The DON stated LVN 4 should have written 8 units instead of 15 units on the Sliding Scale Insulin Administration Record. The DON stated LVN 4 did not and should have written her initial on the Sliding Scale Insulin Administration Record after administering insulin to Resident 5. The DON stated LVN did not follow the policy for charting medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48152 2. During a review of Resident 5's Physician's Order, with a report date range of 10/1/2024 to 10/31/2024, the Physician's Order indicated a start date of 7/29/2024, for Fingerstix (a brand of lancets used to check the blood sugar) sliding scale (a treatment for diabetes that involves adjusting the amount of insulin a resident receives based on their blood sugar levels) three times a day before meals for Diabetes Mellitus 2 (diabetes), notify MD (physician) if BS (blood sugar) greater than or equal to (>/=) 301 or less than or equal to (</=) 80. Give Fiasp (insulin aspart, a prescription medication that helps control blood sugar levels in residents with diabetes) 100 U/ml (units per milliliter- a unit of measurement) Flextouch (a prefilled, disposable insulin pen) with sliding scale as follows: 0 to 80 = 0 units 81 to 120 = 4 units 121 to 200 = 8 units 201 to 300 = 15 units During a review of Resident 5's Sliding Scale Insulin Administration Record, the Sliding Scale Insulin Administration Record indicated on 10/2/2024, at 6:30 AM, Resident 5's glucose (blood sugar) level was 197. The record indicated Resident 5 was given 15 units of insulin on the right thigh. The box in the Sliding Scale Insulin Administration record to contain the initials of the licensed nurse who administered the insulin to Resident 5 on 10/2/2024, at 6:30 AM was blank. During a concurrent record review of Resident 5's Sliding Scale Insulin Administration Record, dated 10/2/2024, and interview with Licensed Vocational Nurse 1 (LVN 1) on 10/2/2024 at 2:40 PM, LVN 1 stated Resident 5's 6:30 AM insulin was administered by LVN 4 who was scheduled on 10/2/2024 from 11PM to 7AM shift. LVN 1 stated Resident 5's glucose (blood sugar) level was 197 on 10/2/2024, at 6:30 AM. LVN 1 stated Resident 5 should be administered 8 units of insulin for a blood sugar of 197 as indicated on the physician's order. LVN 1 stated the Sliding Scale Insulin Administration Record on 10/2/2024, at 6:30 AM, indicated Resident 5 was administered 15 units of insulin on the right thigh. LVN 1 stated LVN 4 did not and should have initialed the box on the Sliding Scale Insulin Administration Record after administering insulin to Resident 5 on 10/2/2024 at 6:30 AM. During a concurrent record review of Resident 5's Sliding Scale Insulin Administration Record, dated 10/2/2024, and interview with the Director of Nursing (DON) on 10/4/2024, at 4:46 PM, the DON stated LVN 4 made a transcription error and wrote the wrong amount of insulin on Resident 5's Sliding Scale Insulin Administration Record. The DON stated LVN 4 should have written 8 units instead of 15 units on the Sliding Scale Insulin Administration Record. The DON stated LVN 4 did not and should have written her initial on the Sliding Scale Insulin Administration Record after administering insulin to Resident 5. The DON stated LVN did not follow the policy for charting medications. During a review of the facility's policy and procedure (P&P) titled, Charting Guidelines, revised on 11/2019, the P&P indicated the following: a. Charting should be done as soon as possible after a given event. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Keep entries factual, specific, accurate and informative. c. Every nursing entry must be concluded by the name and credential of the writer. During a review of the facility's P&P, titled, Medication Administration General Guidelines, dated 1/2021, the P&P indicated, The Resident's MAR (Medication Administration Record)/TAR (Treatment Administration Record) is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific mediation dose administration and time. Initials on each MAR/TAR are verified with a full signature in the space provided on the nursing center's master employee log. 2. During a review of Resident 5's Diabetes Mellitus, at Risk of Complications care plan dated 9/18/2024, the care plan indicated the nursing interventions to monitor for signs and symptoms (S/S) of hyperglycemia: nausea, vomiting, headache, change in level of consciousness (LOC), confusion, frequency, skin hot/dry/flushed or excessive thirst and S/S of hypoglycemia: diaphoresis (excessive sweating due to a secondary condition), dizziness, headache, palpitations (a skipped, extra or irregular heartbeat), weakness, confusion, change in LOC, increased pulse, blurred vision, shallow respirations or lethargy (abnormal drowsiness). During a review of Resident 5's Medication Regimen Review (MRR- a thorough evaluation of a patient's medication regimen to identify and address any potential issues), dated 9/19/2024, the review indicated Resident 5 was on a high-risk medication with monitoring recommendations to monitor for s/s of hypoglycemia and the s/s of hyperglycemia. The review was signed by Resident 5's nursing staff (unable to identify) and physician. During a review of Resident 5's Physician Order, dated 10/1/2024 through 10/31/2024, the orders indicated an order Basaglar Kwikpen (a disposable insulin pen that contains a long-acting, man-made insulin) to take 20 units (U- a measurement used to give insulin) at bedtime subcutaneously (under, all the layers of the skin). During a concurrent interview and record review on 10/3/2024 at 10:52 AM with Licensed Vocational Nurse 5 (LVN 5), Resident 5's Physician Order, dated 10/1/2024 through 10/31/2024, and Treatment Administration Record (TAR) dated 10/1/2024 through 10/31/2024 were reviewed. LVN 5 stated there is no entry for monitoring for s/s of hypoglycemia and hyperglycemia indicated on the TAR and there is no current physician's order for the monitoring of Resident 5's S/S of hyperglycemia and/or hypoglycemia. LVN 5 stated the doctor must not have wanted it done because there was no order. During an interview on 10/3/2024 at 11:04 AM with Medical Doctor (MD), the MD stated she is aware of the pharmacist recommendations for the monitoring of s/s of hypoglycemia and hyperglycemia for Resident 5, but did not order for the monitoring of the hypoglycemia and hyperglycemia because monitoring is a nursing order and standard to monitor for symptoms and that is a standard that does not need a written doctor's order. MD stated it is important for [staff] to monitor Resident 5 for s/s of hypoglycemia because that can cause syncope (a brief loss of consciousness) and a coma (a state of deep unconsciousness where a person is unable to move or respond to their environment) and would indicate if the insulin order needs to be changed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/2024 at 11:49 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 5's Medication Administration Record (MAR) for the month of October 2024, was reviewed. The MAR failed to have any documented evidence for the monitoring of Resident 5 for s/s of hypoglycemia and hyperglycemia. LVN 1 stated there is no entry on MAR for monitoring of Reisdent 5's s/s of hypoglycemia and hyperglycemia. LVN 1 stated, he only documents in Resident 5's chart once the resident is experiencing a sign and/or symptom of hypoglycemia and/or hyperglycemia. During an interview on 10/4/2024 at 3:36 PM with the Director of Nursing (DON), the DON stated it is important to monitor Resident 5 for S/S of hypoglycemia and hyperglycemia so that staff can act promptly to stabilize the resident, notify the MD and to see if the insulin therapy needs to be modified accordingly. During an interview on 10/4/2024 at 4:23 PM with the DON, the DON stated there is no specific place for nurses to document the monitoring of Resident 5's S/S of The DON stated if something is not documented, she cannot ensure it was done. During a review of the facility's P&P titled, Adverse Drug Reactions, revised 2/2009, indicated residents who may be taking a medication known to have a possible adverse drug reaction, will be assessed [by facility] for evidence of any adverse reactions. During a review of facility's policy and procedure (P&P) titled Medication Regimen Review (MRR) and Reporting, dated 9/2018, the P&P indicated MRR as the thorough evaluation of the medication regimen of a resident, with the goals of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The policy indicated resident-specific MRR recommendations are documented and acted upon by the nursing care center and/or physician and recommendations that do not require physician intervention, the director of nursing or licensed designee will address the recommendations. During a review of the facility's P&P titled, Charting Guidelines, revised 11/2019, indicated the policy purpose is to provide facility guidelines for appropriate documentation in the health record and staff are to document normal findings as well as abnormal findings that shows the resident was assessed. The P&P indicated the following: a. Charting should be done as soon as possible after a given event. b. Keep entries factual, specific, accurate and informative. c. Every nursing entry must be concluded by the name and credential of the writer. During a review of the facility's P&P, titled, Medication Administration General Guidelines, dated 1/2021, the P&P indicated, The Resident's MAR (Medication Administration Record)/TAR (Treatment Administration Record) is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific mediation dose administration and time. Initials on each MAR/TAR are verified with a full signature in the space provided on the nursing center's master employee log.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Amended: Based on observation, interview and record review, the facility failed to implement appropriate infection control practices for 4 of 5 sampled residents (Residents 19, 24, 37 and 199) as indicated on the facility's policy and procedure (P&P) by failing to ensure: 1. Resident 199's visitor was educated and used indicated personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) inside novel respiratory isolation (an isolation that requires the use of a disposable gown, eye protection [goggles or face shield], fit-tested respirator [N-95 or higher] and gloves) room. 2. The nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was placed in a bag after use as indicated in the facility's policy and procedure (P&P) and ensure the oxygen tubing was not touching the floor for Resident 37. 3. Facility staff observed infection control measures for a Resident 24 who was on Enhanced Barrier Precautions (EBP or ESP- the use of gown and glove use for nursing home residents with wounds and indwelling devices during specific-high contact Resident care activities associated with multidrug-resistant organisms [MDRO] transmission) by failing to don (wear) personal protective equipment (PPE- a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) before checking for gastrostomy tube (Gtube- a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) placement prior to medication administration. 4. Resident 19's handheld nebulizer (delivers medicines in the form of aerosols to add moisture and help control respiratory symptoms) was stored in a clean bag when not in use. These deficient practices placed the residents, staff, and visitors at higher risk for transmitting and/or acquiring infection in the facility. Findings: 1. During a review of Resident 199's Face Sheet, the Face Sheet indicated Resident 199 was admitted to the facility on [DATE], with diagnoses that included Coronavirus disease 2019 (COVID-19 - a highly contagious infectious disease caused by severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]), pneumonia (PNA- an infection/inflammation in the lungs) and COPD. During a review of Resident 199's MDS dated [DATE], the MDS indicated Resident 199 had moderately impaired cognitive skills for daily decision making. The MDS also indicated Resident 199 was dependent (helper does all the effort) with toileting, bathing, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 199 substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with eating, oral and personal hygiene. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Gardens Health Care Unit	842 East Villa Street Pasadena, CA 91101

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 199's Physician's Order, the Physician's Order indicated contact (measures taken to prevent the spread of germs that are transmitted through touching) and droplet precautions (measures taken to prevent transmission when infection can be spread to others by speaking, sneezing, or coughing) for COVID [19].

During a review of Resident 199's Active Infection as Evidenced by Positive for COVID-19, care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), dated 9/27/2024, the care plan indicated contact and droplet precautions.

During an observation on 10/1/2024 at 9:18 AM in front of Resident 199's room, a STOP Novel Respiratory Precautions sign was posted indicating the wearing of a gown, N95 (a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air), face shield or goggles and gloves on room entry. A visitor was also observed opening Resident 199's door and entering the room with only a surgical mask on and no other PPE as indicated on the posted PPE sign.

During an observation on 10/1/2024 from 9:19 AM until 9:37 AM, the visitor of Resident 199 was inside Resident 199's room without a gown, N-95 and/or gloves.

During a concurrent observation in Resident 199's room and interview with Infection Preventionist Nurse (IPN) on 10/1/2024 at 9:26 AM, IPN stated the novel respiratory sign was observed and IPN stated to this isolation requires the use of the N-95 mask, gown, gloves and a face shield or goggles. IPN stated the visitor should have put on all required PPE [N-95, gown, gloves, and face shield/goggles] before entering Resident 199's room. IPN also stated Resident 199's visitor told her he did not wear the PPE because he did not know it was necessary for him. IPN stated is it important for visitors and staff to follow the novel respiratory isolation precautions to prevent the spread [of COVID-19] and for the safety of the residents and everyone.

During an interview on 10/4/2024 at 3:36 PM with the DON, the DON stated per facility protocol, facility does not force visitors to wear indicated PPE for COVID-19 isolation rooms, but staff are to educate visitors [on the use and importance of isolation precautions] and encourage PPE usage.

During a review the facility's policy and procedure (P&P) titled, Suspected or Confirmed COVID -19 Policy, revised 2/2024, indicated facility should provide instruction before visitors enter residents' rooms on hand hygiene, limiting surfaces touched and use of PPE according to current policy while in the resident's room.

46919

2. During a review of Resident 37's Face Sheet, the Face Sheet indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), pleural effusion (a condition where fluid builds up in the thin cavity between the lungs and the chest wall), and hypotension (low blood pressure).

During a review of Resident 37's H&P, dated 8/22/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.

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NAME OF PROVIDER OR SUPPLIER Villa Gardens Health Care Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 842 East Villa Street Pasadena, CA 91101	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was assessed having intact memory and cognitive skills for daily decision making. Resident 37 required supervision or touching assistance with eating and oral hygiene. Resident 37 required substantial/maximal assistance with toileting hygiene, upper and lower body dressing, sit to stand, and chair/bed-to-chair transfer. Resident 37 was on intermittent (not continuous) oxygen therapy. During a review of Resident 37's Physician's Order, with a report date range of 10/1/2024 to 10/31/2024, the Physician's Order indicated a start date of 8/24/2024, for continuous oxygen each shift at 2 LPM via nasal cannula continuously for respiratory failure keep oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) greater than 90%. During an observation in Resident 37's room, on 10/1/2024, at 9:00 AM, Resident 37 was sitting on his bed eating his breakfast. Resident 37 was receiving 4 liters of oxygen per minute (LPM) via nasal cannula. Resident 37's oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to a resident in need of supplemental oxygen) was in the bathroom. Resident 37's bathroom door was closed and the oxygen tubing touched the floor under the bathroom door. Resident 37 had a used nasal cannula hanging on top of the empty portable oxygen cylinder tanks against the wall by the foot of the bed. The nasal cannula was not stored in a bag. During a concurrent observation of Resident 37's room and interview with LVN 2 on 10/1/2024, at 3:46 PM, LVN 2 stated Resident 37's nasal cannula was on top of the portable oxygen cylinder. LVN 2 stated Resident 37's nasal cannula should be placed in a bag when not in use. During the same concurrent observation of Resident 37's bathroom and interview with LVN 2 on 10/1/2024, at 3:46 PM, LVN 2 stated Resident 37's oxygen tubing was touching the floor near the bathroom. During an interview with the Director of Staff Development (DSD), on 10/1/2024, at 4:27 PM, the DSD stated the oxygen tubings need to be changed when dirty, contaminated, or if it falls on the floor. During an interview with LVN 6, on 10/2/2024, at 4:24 PM, LVN 6 stated the facility's P&P indicated to change the oxygen tubing only as needed if it was dirty. LVN 6 stated an oxygen tubing was considered dirty if it was touching the floor. LVN 6 stated a dirty oxygen tubing can be a source of infection for a resident which can lead to respiratory problems. LVN 6 stated if a nasal cannula should be placed in a bag when it is not being used by a resident to prevent infection. During an interview with LVN 3, on 10/3/2024, at 11:10 AM, LVN 3 stated it was the licensed nurse's responsibility to change the oxygen tubing when it was dirty. 3. During a review of Resident 24's Face Sheet, the Face Sheet indicated Resident 24 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included dysphagia (difficulty or discomfort in swallowing), functional quadriplegia (paralysis that affects all four limbs plus the torso), and essential hypertension (high blood pressure). During a review of Resident 24's H&P, dated 8/22/2024, the H&P indicated Resident 24 had a Gtube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having severely impaired cognitive skills for daily decision making. Resident 24 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) with eating, oral hygiene, upper and lower body dressing, personal hygiene, and roll left to right (the ability to roll from lying on back to left and right side). During a review of Resident 24's Physician's Order, with a report date range of 10/2/2024 to 10/31/2024, the Physician's Order indicated an order, dated 8/30/2023, for gastrostomy tube replacement, each shift, check placement of GT prior to feeding or medication administration. During a review of Resident 24's care plan, titled, Enhanced Barrier Precautions, the care plan indicated Resident 24 was at risk for infection, high risk residents with feeding tube, colonized MDRO: extended-spectrum beta-lactamase (ESBL- an enzyme that makes some bacteria resistant to many antibiotics). Resident 24's care plan intervention indicated for the proper use of PPE (Glove and Gown) during high contact of care activities. During an observation of Resident 24's medication administration on 10/3/2024, at 1:55 PM, LVN 1 entered Resident 24's room, washed his hands and donned gloves. LVN 1 proceeded to unclamp Resident 24's Gtube and inserted a 60 milliliter (ml- unit of measurement) syringe to Resident 24's medication port. LVN 1 pulled the plunger back to check for residual and disconnected the 60 ml syringe from the medication port. LVN 1 stopped and stated he did not DON his gown before checking Resident 24's Gtube residual. LVN 1 removed his gloves, donned PPE from the PPE cart inside Resident 24's room, sanitized his hands with alcohol base hand rub, and donned gloves. LVN 1 reinserted the 60 ml syringe, flushed Resident 24's Gtube with 15 ml of water, administered Omeprazole (medication used to treat heartburn and stomach ulcers), flushed the Gtube once again with 15 ml of water, and disconnected the syringe. LVN 1 doffed (removed) his gown and gloves, washed his hands, and exited Resident 24's room. During an interview with LVN 1, on 10/3/2024, at 2:12 PM, LVN 1 stated Resident 24 was on enhanced barrier precautions because she had a Gtube. LVN 1 stated it was important to don PPE before providing direct contact care to Resident 24 to protect Resident 24 from contamination and infection. During an interview with the Infection Preventionist Nurse (IPN), on 10/3/2024, at 4:09 PM, the IPN stated residents with wounds, MDRO, Gtube, indwelling catheters are placed on enhanced barrier precautions. The IPN stated staff were required to don PPE before providing direct contact care to residents on enhanced barrier precautions to prevent them from getting an infection. During a review of the facility's P&P titled, Oxygen Therapy, revised on 7/2022, the P&P indicated, When nasal cannula or oxygen mask is not in use, place in a plastic bag or other infection prevention pouch to prevent contamination. The P&P also indicated to, Change oxygen tubing if it appears dirty or becomes contaminated. During a review of the facility's P&P titled, Infection Prevention & Control Program, revised 1/2024, the P&P indicated: Enhanced Standard Precautions (ESP) are indicated for high-risk SNF residents, those with infection or colonization with an MDRO when contact precautions do not otherwise apply and/or with wounds and/or indwelling medical devices (urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2022, revised 9/2022, the P&P indicated for ESP staff are to perform hand hygiene and don gloves, gown and mask/goggle/shield PPE within room before beginning activity 45099 4. During a review of Resident 19's Face Sheet, the Face Sheet indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and dependence on oxygen supplement. During a review of Resident 19's History and Physical (H&P), dated 8/3/2024, the H&P indicated Resident 19 does not have the capacity to understand and make decisions. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had an intact cognitive skill for daily decision making. The MDS also indicated Resident 19 was dependent (helper does all the effort) with toileting, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 19 partial assistance (helper does less than half the effort) with oral and personal hygiene and required supervision (helper provides verbal cues) with eating. During a review of Resident 19's Physician's Order, dated 9/20/2024, the Physician's Order indicated Resident 19 was on albuterol sulfate (treats and prevents breathing difficulties caused by lung diseases) 2.5 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) inhalation via handheld nebulization every six (6) hours for shortness of breath (SOB, difficulty breathing) due to COPD. During an observation on 10/1/2024 at 9:09 AM, Resident 19's handheld nebulizer was exposed on top of the bedside table and not stored in a clean bag. During an interview on 10/2/2024 at 4:47 PM, the LVN 6 stated the handheld nebulizer should be kept in a clean plastic bag to prevent from collecting dirt from the air and surfaces. During an interview on 10/4/2024 at 12:42 PM, the DON stated that the handheld nebulizer, masks, and nasal cannulas should be placed in a breathable bag to reduce the risk of contamination when not in use. The DON also stated when they (handheld nebulizer, masks, and nasal cannulas) get contaminated there's a risk for residents developing respiratory infection. During a review of the facility's P&P titled, Nebulized Medications, dated October 2011, the P&P indicated that nebulizers will be rinsed out after each use and stored in a clean plastic or mesh bag at the bedside.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within the resident's reach (arm's length) for one (1) of 1 sampled resident (Resident 24) as indicated on the facility's call system policy. This deficient practice had the potential for Residents 24 to not being able to call the facility staff for assistance especially during an emergency, which could lead to an injury or harm to Resident 24. Findings: During a review of Resident 24's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included functional quadriplegia (complete immobility due to severe disability from another medical condition without injury to the brain or spinal cord) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 24's Minimum Data Set (MDS- a federally mandated assessment tool), dated 8/20/2024, the MDS indicated Resident 24 had severe cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 24 was dependent (helper does all the effort) with eating, oral, personal and toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 10/2/2024 at 10:32 AM, Resident 24's call light was on the floor on the right side of the resident's bed. Certified Nursing Assistant 1 (CNA 1) stated Resident 24 would not be able to call for help if her call light is on the floor. During an observation and interview on 10/4/2024 at 10:06 AM, Resident 24's call pad (facility previously provided Resident 24 a call light) was on the floor on the right side of the resident's bed. Licensed Vocational Nurse 3 (LVN 3) entered Resident 24's room and heard the resident asking LVN 3 where her call light was. LVN 3 stated the call light is there for Resident 24 to call on staff for any needs she may have especially for emergencies so the staff could respond as soon as possible. LVN 3 also stated that is important to ensure the call lights are within residents' reach to prevent incidents such falls. During a review of the facility's Policy and Procedure (P&P) titled, Call System, dated February 2009, the P&P indicated to provide each resident with a call system to enable them to request assistance. The policy also indicated to make sure call cords are placed within the residents reach at all times.