STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555431	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Hills Post Acute	1580 Broadway El Cajon, CA 92021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure five out of 13 residents reviewed for dignity were provided care in a manner that promoted dignity and respect. (Resident 50, 218, 148, 5 and 51) This failure had the potential for the residents' self-esteem and self-worth to be devalued. Findings: 1. Resident 50 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty in swallowing) and dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's Admission Record. A record review of Resident 50's Activities of Daily Living (ADL-basic tasks of everyday life) care plan was conducted. The ADL care plan dated 6/24/20 indicated, .has a self-care deficit related to: .cognitive loss, dementia .Assist as needed with ADLs . 2. Resident 218 was admitted to the facility on [DATE] with diagnoses which included dysphagia and dementia according to the facility's Admission Record. During a record review of Resident 218's ADL care plan, the ADL care plan indicated, . at risk for ADL/mobility decline and requires assistance related to CVA [Cerebrovascular Accident- a condition affecting blood flow and blood vessels in the brain) .dementia . 3. Resident 148 was admitted to the facility on [DATE] with diagnoses which included dysphagia and dementia according to the facility's Admission Record. A record review of Resident 148's ADL care plan dated 1/13/25 was conducted. The ADL care plan indicated, .at risk for ADL/mobility decline and requires assistance .related to .dementia .encourage to participate in ADLs . On 3/11/25 at 11:46 A.M. a dining room observation on the third floor was conducted. Resident 50 was sitting with two other residents at a round table for lunch. Certified Nurse Assistant (CNA) 31 approached Resident 50 and began feeding Resident 50. CNA 31 was standing while feeding Resident 50. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a dining observation on 3/11/25 at 12:05 P.M. Resident 218 was observed seated in a wheelchair at the same table as Resident 50. After feeding Resident 50, CNA 31 approached Resident 218 and provided feeding assistance to Resident 218 while standing next to Resident 218. An interview on 3/11/25 at 12:07 P.M. was conducted with CNA 31. CNA 31 stated staff should be at eye level with the resident while feeding the resident. CNA 31 stated staff should have been seated for the resident to be able to communicate with staff. CNA 31 further stated there were no chairs available in the dining room for staff to use while feeding. During a dining observation on 3/11/25 at 12:07 P.M. Resident 148 was seated in a wheelchair at another round table in the dining room. CNA 34 approached Resident 148 and provided feeding assistance to Resident 148. CNA 34 was standing while feeding Resident 148. An interview on 3/12/25 at 8:40 A.M. was conducted with CNA 34. CNA 34 stated staff should have been seated during feeding assistance to be at eye contact with the resident. CNA 34 stated there were no chairs available at the dining room yesterday, 3/11/25. CNA 34 stated she should have been seated for Resident 148 to see her. An interview on 3/13/25 at 11:49 A.M. with the Director of Staff Development (DSD- a licensed nurse certified for staff training) was conducted. The DSD stated staff should have been seated during feeding assistance. The DSD further stated it was important for staff to have been seated for resident's dignity and respect. During an interview on 3/14/25 at 1:17 P.M. with the Director of Nursing (DON), the DON stated staff should not have been standing during feeding assistance for resident's dignity and safety. The DON stated staff should have been at eye level to communicate with the resident regardless of the resident's cognition. A review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated March 2022 was conducted. The P&P indicated, .Facility staff will serve resident trays and will help residents who require assistance with eating .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity .not standing over residents while assisting them with meals . 48263 4. A record review of Resident 5's Admission Record indicated Resident 5 was readmitted to the facility on [DATE] with diagnoses which included a history of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow movements). A record review of Resident 5's Minimum Data Set (MDS: nursing facility assessment tool) dated 2/28/25 indicated that Resident 5 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. Resident 5's MDS also indicated Resident 5 was dependent (helper does ALL the effort, resident does none of the effort to complete the activity). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 9:21 A.M., an observation and interview was conducted with Licensed Nurse (LN) 12, in Resident 5's room. Certified Nursing Assistant (CNA) 14 was observed feeding Resident 5 in bed while standing up. LN 12 stated that CNA 14 was standing over Resident 5 and should be feeding Resident 5 at eye level to connect with Resident 5. LN 12 stated visual inspection promotes respect and dignity at eye level. LN 12 stated feeding Resident 5 while standing can make Resident 5 feel intimidated. LN 12 stated CNA 14 should have sat next to Resident 5 to be at eye-level to ensure Resident 5 was fed properly. LN 12 further stated that sitting next to Resident 5 instead of standing would show a better visual of Resident 5 to monitor for swallowing issues. On 3/14/25 at 8:32 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated CNA 14 should have been seated next to Resident 5 and should not have stood at eye level to promote dignity and respect. The DSD stated standing over any resident while feeding them can make them feel rushed with their meals and can be an intimidating experience for the residents (all facility residents being fed). The DSD further stated, I would feel a little intimidated like oh no did I do something wrong. On 3/14/25 at 9:03 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated CNA 14 should have gotten a chair while feeding Resident 5 to be at eye level with Resident 5. The DON stated his expectations regardless of resident's cognitive status (confused or not) the nursing staff should have promoted dignity and respect for all facility residents while feeding at an eye-level to prevent intimidation while being fed. A review of the facility's policy and procedure titled ASSISTANCE with MEALS revised March 2023, indicated, .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals; . 5. A record review of Resident 51's Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses which included a history of End Stage Renal Disease (ESRD: irreversible kidney failure). A record review of Resident 51's Minimum Data Set (MDS: nursing facility assessment tool) dated 2/24/24 indicated that Resident 51 was rarely or unable to understand others or make self-understood and had severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to make decisions. Resident 51's MDS also indicated Resident 51 was dependent (helper does ALL the effort, resident does none of the effort to complete the activity). On 3/13/25 at 9:47 A.M., an observation and interview was conducted with LN 12, in Resident 51's room. CNA 14 was observed feeding another resident (Resident 51) who was in bed. CNA 14 stood and was not at eye-level with Resident 51. LN 12 stated CNA 14 should have sat on a chair at eye-level with Resident 51 to promote safety with eating, respect, dignity, and a non-intimidating feeding experience. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/14/25 at 8:32 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated CNA 14 should be seated next to Resident 51 and not standing at an eye level to promote dignity and respect. The DSD stated standing over any resident while feeding them can make them feel rushed with their meals and can be an intimidating experience for the residents (all facility residents being fed). The DSD further stated, I would feel a little intimidated like oh no did I do something wrong. On 3/14/25 at 9:03 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated CNA 14 should have gotten a chair while feeding Resident 51 to be at eye level with Resident 51. The DON stated his expectations where regardless of a any resident's cognitive status (confused or not) the nursing staff should be promoting dignity and respect for all facility residents while feeding at an eye-level to prevent intimidation while being fed. A review of the facility's policy and procedure titled ASSISTANCE with MEALS revised March 2023, indicated, .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals; .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to provide one of 37 sampled residents (Resident 55) with a suitable call button (button used to call for assistance). This failure prevented Resident 55 (R55) from being able to use his call button and had the potential for R55 to not have his needs met. Cross reference F919 Findings: Review of Admission Record indicated R55 was admitted on [DATE] with diagnoses which included Cognitive Communication Deficit(difficulties in communication stemming from impairments in cognitive [thinking ability] functions like attention, memory, or problem-solving, rather than a primary language or speech problem), Functional Quadriplegia (the complete inability to move due to severe disability or frailty, but without physical injury or damage to the brain or spinal cord), and Metabolic Encephalopathy (a condition where the brain does not function properly). Review of Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 12/31/24 indicated a Brief Interview For Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 13 which indicated intact cognition. Review of MDS Section M-Skin Conditions dated December 31, 2024, indicated R55 with one stage 3 pressure ulcer (bed sore) and one stage 4 pressure ulcer on admission. MDS Section M also indicated R55 required B. Pressure reducing device for bed .E. Pressure Injury Care . Review of MDS Section GG dated December 31, 2024 indicated R55 was either dependent or required Substantial/maximal assistance for all his Self-Care needs. Review of Care Plan Report dated 3/12/25 indicated .1. ADL[activity of daily living]/Mobility .at risk for ADL/Mobility decline and requires assistance .Encourage to use call light for assistance . On 03/11/25 at 10:13 A.M., a concurrent observation and interview was conducted with R55. R55's call button was observed to be one that needed to be gripped with his hand and pressed with his thumb. R55 stated I am unable to use and press the call button. To get staff I yell. Both of R55's hands were observed to be contracted (a shortening of muscles that prevents movement). On 3/12/25 at 9:45 A.M., an observation of R55's call button and interview with Licensed Nurse 51 (LN51) was conducted. LN51 stated that since R55's hands were contracted, he could not use the call button that was provided and he would need a call button that he could tap. LN51 stated the importance of having an appropriate call button was that R55 needed to be able to communicate his needs with the staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 9:55 A.M., a concurrent observation of R55's call button and R55's hands, and interview with Assistant Director of Nursing 4 (ADON4) was conducted. ADON4 stated that because R55's hands were contracted he could not press the provided call button, and he would need a call button he could tap. ADON4 stated the importance of using an appropriate call button was that the resident should be able to communicate his needs with the staff. On 3/14/25 at 10 A.M. an interview with the Director of Nursing (DON) was conducted. The DON stated that the expectation for R55's call button was that it should accommodate R55's ability and it should have been a tap call button. The DON stated that the importance of the correct type of call button was to enable R55 to make his needs known to staff. Review of the facility policy titled ACCOMMODATION OF NEEDS, dated 2001, indicated .2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis .4. In order to accommodate individual needs and preferences staff .are directed towards assisting the residents in maintaining independence, dignity, and well being to the extent possible and in accordance with the residents wishes .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary living environment for one of four reviewed hospice (end of life care) residents (Resident 297) when the shared bathroom was found dirty with feces on surfaces and had a strong odor. These deficient practices placed Resident 297, other residents, staff, and visitors at risk for exposure to harmful bacteria and potential health hazard. This deficient practice also created an unsanitary living condition for residents using the bathroom. Cross-Reference F689 Findings: A review of Resident 297's Admission Record indicated Resident 297 was admitted to the facility on [DATE] with diagnoses which included a history of Malignant Neoplasm of the Prostate (prostate [male organ below the bladder] cancer that is life-threatening once the cancer spreads to other parts of the body). On 3/11/25 at 2:49 P.M., an observation and interview was conducted with Resident 297 and family member's, in Resident 297's room. Resident 297's stated his room smelled like poop. Resident 297's family members stated that Resident 297's bathroom was dirty and saw that there were two shower blankets laid down on the floor in the bathroom with brown streaked poop-like stains scattered on the floor by the toilet and walls and the front door of the bathroom. Resident 297's family members stated Resident 297 had been on hospice at the facility and stated Resident 297's current room's bathroom was unsanitary. Resident 297's family members stated the room had a strong poop odor and would like Resident 297 to be in a more home-like comfortable environment. Resident 297's family members denied using Resident 297's bathroom because it was unsanitary when they visited. Observations were conducted during the following days in Resident 297's bathroom: Resident 297's bathroom was observed on 3/12/25 at 9:13 A.M. There were two white shower blankets found on the floor spread out from the toilet to the opening of the bathroom. There was a brown quarter to dime sized liquid spots at the corner edge of the wall across the toilet. Also observed was brown spotted scattered droplet sized drip like stains and quarter sized brown spots on the walls by the toilet. There was brown and yellow drip like stains on the toilet seat and edges. Resident 297's bathroom had a strong feces-like odor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 297's bathroom was observed on 3/12/25 at 3 P.M. There was skid-like dark brown large and small paper clip sized stains found on floor outside of bathroom door entry with two white shower blankets spread on the floor that had a brownish yellow streak like stain on the edge of the sheet. There were brown quarter to dime sized liquid spots at the corner edge of the wall across from the toilet. Also observed was a used dirty incontinence (uncontrollable bladder and bowel) pad with brown stains inside an unlined trash bin. There were brown scattered various sized large paper clip and coin sized brown thick spots found on the floor by the toilet. Also observed were brown and yellow drip like stains on the toilet seat and edges. The bathroom had a strong feces-like odor. Resident 297's bathroom was observed on 3/13/25 at 8:20 A.M. Resident 297's bathroom had a white draw sheet spread on the floor surrounding toilet. The toilet seat and edges had the same stain pattern as described on 3/12/25 (Brown and yellow drip like stains on the toilet seat and edges). Also observed were brown spotted scattered droplet sized drip like stains and quarter sized brown spots on the walls by the toilet. The white faucet with leather-like cover had dried dark brown various sized (baseball sized to thumb size) streaks scattered on cover. Resident 297's bathroom had a strong feces-like odor. An observation of Resident 297's bathroom with an interview from Certified Nursing Assistant (CNA) 11 was conducted on 3/13/25 at 8:22 A.M. CNA 11 stated the draw sheets were placed on the floor because Resident 297's roommate gets poop on the floor. CNA 11 stated it was convenient for staff to have the drawsheets on the floor to clean up after Resident 297's roommate used the bathroom. CNA 11 stated the brown stains scattered across the walls, floors, and faucet covers looked like poop and the room smelled like poop. CNA 11 stated the draw sheet could also be a fall hazard because it could cause someone to lose balance when going to the bathroom. On 3/13/25 at 8:28 A.M., an observation and interview was conducted with Licensed Nurse (LN) 12, in Resident 297's bathroom. LN 12 stated that the bathroom smelled like poop. LN 12 stated that the white faucet cover stains, and bathroom floors with stained brown spots looked like poop and that the walls scattered by the toilet looked like poop. LN 12 stated that white draw sheet on the floor would also be a fall hazard and cause someone to slip and trip. LN 12 stated that Resident 297's bathroom did not promote a home-like sanitary environment for Resident 297. On 3/14/25 at 9:32 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the nursing staff should not have placed drawsheets and/or shower blankets on the floor of Resident 297's bathroom for staff convenience when caring for Resident 297's roommates incontinence issues. The drawsheets and or shower blankets created a potential fall hazards. The DON stated Resident 297's bathroom did not promote a home-like sanitary, orderly, and hazard-free environment. The DON stated this was not a comfortable environment for Resident 297 who was on hospice. A review of the facility's policy and procedure titled HOMELIKE ENVIRONMENT dated February 2021, indicated, .The facility staff and management maximizes, to the extend possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview, and record review, the facility failed to submit the Minimum Data Set (MDS: a federally mandated resident assessment tool) timely to the federal database after the MDS was completed and signed by the LN for one of 36 residents (Resident 196) sampled. This failure resulted in the late submission of the MDS to the federal database. Findings: A review of Resident 196's Admission Record indicated Resident 196 was readmitted to the facility on [DATE] with diagnoses which included a history of Heart Failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A record review of Resident 196's quarterly MDS dated [DATE] indicated, the MDS completion date was completed and signed on 1/27/25. On 3/13/25 at 12:26 P.M., a record review was conducted on the MDS Final Validation Report. The MDS Final Validation Report dated 2/16/25 indicated the quarterly MDS (dated 1/13/25) was submitted late. The MDS Final Validation Report indicated, .the submission date is more than 14 days after Z0500 (A0050 equals 1) assessment . On 3/13/25 at 2:47 P.M., a record review was conducted with the MDS Coordinator (MDSC). The MDSC stated the MDS quarterly dated 1/13/25 was submitted (2/16/25) late because she completed and signed Z0500 (Signature of RN [Registered Nurse] Assessment Coordinator Verifying Assessment Completion) on 1/27/25. The MDSC stated she should have submitted the MDS within 14 days (2/10/25) after signing the Z0500. The MDSC stated it was important to submit a timely MDS assessments to let the federal database know the status of the facility residents. The MDS Coordinator continued to state, a late submission of the quarterly MDS delays the information needed by the federal database to know the status of the facility's quality measures related to resident care. The MDSC stated it was important to make sure all MDS completed were submitted timely to ensure care is not delayed and to be in compliance with the data being given to the federal database. On 3/14/25 at 9:47 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated his expectations was for the MDS to be completed timely and accurately according to the MDS Resident Assessment Instrument (RAI: MDS manual). A record review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page 5-2 and Page 5-3) 5.2 Timeliness Criteria: Transmitting Data .Assessment Transmission: .MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to accurately assess and transmit an MDS (Minimum Data Set, a resident assessment tool) assessment for five of 37 sampled residents (36, 166, 303, 278, 137). As a result, medical decisions based on the MDS had an increased risk of error. Findings: 1. Per the facility's Admission Record, Resident 36 was admitted to the facility on [DATE] with diagnoses which included, paranoid schizophrenia (a disconnection from reality), depression (a mental illness of persistent low mood), and bipolar disorder (a mental disorder of significant change in moods). On 3/13/25 at 11:29 A.M., a concurrent interview and record review was conducted with the Minimum Data Set Coordinator (MDSC). Per Resident 36's MDS 3.0 Nursing Home Comprehensive, dated 10/14/25, Section A1500, No was documented under the question of whether Resident 36 had a serious mental illness. The MDSC stated, Resident 36 had diagnoses of paranoid schizophrenia and bipolar disorder, which meant the MDS assessment on 10/14/25 was coded inaccurately. Per the facility's policy, titled Resident Assessments, revised March 2022, .All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information . 39220 2. According to the facility's Admission Record, Resident 166 was admitted to the facility on [DATE], with diagnoses which included cirrhosis of the liver, (a type of liver damage where healthy cells are replaced by scar tissue). Resident 166's clinical record was reviewed on 3/11/25. According to the facility's Smoking Observation/Assessment form, dated 12/13/24, Resident 166 was a tobacco user and required supervision while smoking. Resident 166's clinical record was reviewed on 3/11/25. According to Resident 166's care plan, titled Potential for Injury related to smoking, revised 2/12/25, listed interventions such as, cigarettes and lighter will be stored by the smoking monitor. Resident 166's clinical record was reviewed on 3/11/25. According to the Admission MDS (Minimum Data Set: a federally required assessment tool), dated 12/19/24, Section J, titled Health Condition, Resident 166 was coded as not a tobacco user. An observation of Resident 166 was conducted on 3/13/15 at 4:03 P.M., while smoking on the outside smoking patio. Resident 166 was sitting alone, smoking and not interacting with others. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and record review was conducted with the Minimum Data Set Coordinator (MDSC) on 3/13/25 at 9:38 A.M. The MDSC viewed the facility's Smoking Assessment, dated 12/13/24 and stated Resident 166 was identified as a smoker. The MDSC reviewed the Admission MDS, dated [DATE] and stated he was coded as a non-smoker, which was incorrect. The MDSC stated the use of tobacco by Resident 166 was not captured and it should have been. The MDSC stated the harm was CMS (Centers for Medicare and Medicaid Services- a federal agency that monitors healthcare programs and covers healthcare cost), was not informed of Resident 166's current health status and the use of tobacco. An interview was conducted with the Director of Nursing (DON) on 3/14/25 at 8:52 A.M. The DON stated he expected all MDS data to be accurate and correct. According to the facility's record, Resident Assessment Instrument (a comprehensive manual, standardized tool used in long-term care facilities to assess residents, guide care planning, and monitor quality of care, incorporating the Minimum Data Set (MDS) as its core component), dated 10/1/19, Section J, Health Condition, J-1300, titled Current tobacco use, .Steps for Assessment: 1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period. 2. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes . 3. According to the facility's Admission Record, Resident 178 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss) with agitation. Resident 178's clinical record was reviewed on 3/14/25. According to Resident 178's physician's orders, dated 10/3/24, .Lorazepam (a medication that produces a calming effect on the brain and nerves), 0.5 milligrams (mg). Give one tablet by mouth every 6 hours as needed for Anxiety . Resident 178's clinical record was reviewed on 3/14/25. According to Resident 178's care plan, Resident 178 used anti-anxiety medications (Lorazepam) related to feeling anxious and restlessness. Resident 178's care plan dated 10/3/24, listed interventions such as; Educate family/caregivers about risk, benefits and side effects, Give anti-anxiety medication, monitor/record occurrences of target behavior symptoms. Resident 178's record, the quarterly Minimum Data Set (MDS- a federally required assessment tool), dated 1/6/24 was reviewed. Section I Active Diagnoses: Psychiatric /Mood Disorder: the section for Anxiety, was not checked as an active diagnosis for Resident 178. An observation was conducted of Resident 178 on 3/13/25 at 8:44 A.M. Resident 178 was dressed and he had his hair neatly combed. Resident 178 was walking back and forth in the hallway and was non-verbal when spoken to. An interview and record review was conducted with the Minimum Data Set Coordinator (MDSC) on 3/14/25 at 8:43 A.M. The MDSC confirmed Resident 178 had received medication for anxiety. The MDSC reviewed the quarterly MDS, dated [DATE], and stated a diagnosis of anxiety should have been coded. The MDSC stated since Resident 178's diagnosis of anxiety was not coded correctly, CMS (Centers for Medicare and Medicaid Services- a federal agency that monitors healthcare programs and covers healthcare cost), was unaware of Resident 178's active diagnosis. An interview was conducted with the Director of Nursing (DON) on 3/14/25 at 8:52 A.M. The DON stated he expected all MDS data to be accurate and correct. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility's records titled Resident Assessment Instrument, dated 10/1/19, Section I, Active Diagnoses, Psychiatric/Mood Disorder, .1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days . 4. According to the facility's Admission Record, Resident 303 was admitted to the facility on [DATE], with diagnosis which included obstructive and reflux uropathy, (a blockage in the urinary tract). Resident 303's clinical record was reviewed on 3/12/25. According to the physician's Admission History and Physical, dated 2/7/24, Resident 303 was admitted with a urinary catheter (a tube used to drain urine from the bladder) in place for staff to monitor urinary output. Resident 303's clinical record was reviewed on 3/12/25. According to the Admission Minimum Data Set (MDS-a federally mandated assessment tool), dated 2/8/25, Section H, titled Bowel & Bladder, Section H-0100 Appliances, an indwelling urinary catheter was not checked. An interview and record review was conducted with the Director of Nursing (DON) on 3/12/25 at 10:39 A.M. The DON reviewed Resident 303's nurse's notes and stated Resident 303 did have a indwelling urinary catheter in place throughout his stay at the facility. The DON stated he expected every resident's MDS to be accurate, so it gave a clear picture of resident. An interview and record review was conducted with the Minimum Data Set Coordinator (MDSC) on 3/12/25 at 10:57 A.M. Resident 303's Admission MDS, dated [DATE] was reviewed. The MDSC stated when preparing an MDS, she reviewed the physician's order, medication record, care plans, History & Physical, and the nurses notes. The MDSC reviewed the nurse's notes and stated Resident 303 had a urinary catheter. The MDSC reviewed the Admission MDS and stated the urinary catheter was missed and it should have been captured. The MDSC stated since the urinary catheter was missed, CMS (Centers for Medicare and Medicaid Services- a federal agency that monitors healthcare programs and covers healthcare cost), was unaware of Resident 303's current status (with catheter) on admission. According to Resident Assessment Instrument, dated 10/1/19, Section H, titled Bowel and Bladder, H-0100, Appliances, .Steps for Assessment: 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary . 46235 5. Resident 137 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (CKD- progressive damage and loss of kidney function to filter waste and excess fluid from the blood) according to the facility's Admission Record. During an observation on 3/11/25 at 8:26 A.M. Resident 137 was sitting at the edge of her bed. Resident 137 stated she did not remember why and how long she had been at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 137's physician's orders was conducted. Resident 137's physician's orders indicated, .Monitor for s/s [signs and symptoms] of infection LUA [left upper arm] AV fistula [a connection between an artery and a vein used as an access site for dialysis [procedure done by a trained professional to remove wastes and excess fluids from the body] every shift .order date 11/21/23 .Monitor LUA fistula for thrills [vibrations felt through palpation] and bruits [a sound heard through a stethoscope] every shift .order date 4/12/24 . There was no physician's order for dialysis treatments. During a record review of the physician's progress notes for Resident 137 dated 3/10/25, the progress notes indicated, .Refusal of dialysis in the past . During a record review of the quarterly Minimum Data Sets (MDS- (a clinical assessment tool) section O0100 dated 11/13/24 and 2/11/25 indicated, .Dialysis .Yes . A review of Res 137's annual MDS section O0100 dated 8/15/24 indicated, .Dialysis .No . The MDS Coordinator (MDSC) was interviewed on 3/13/25 at 9:53 A.M., and a concurrent record review was conducted. The MDSC stated the annual MDS assessment dated [DATE] was coded, No dialysis. The MDSC stated the subsequent quarterly MDS assessments dated 11/13/24 and 2/11/25 were coded, No dialysis. The MDSC stated the quarterly MDS 11/13/24 and 2/11/25 for Resident 137 were inaccurately coded. The MDSC further stated it was important to accurately code the MDS assessments because they were submitted to the Centers for Medicare and Medicaid Services (CMS- a government health insurance) and the MDS provided the resident's status. During an interview with the Director of Nursing (DON) on 3/14/25 at 1:17 P.M., the DON stated the MDS assessment should be accurate because it was the summary of patient care, and it was sent to CMS. A record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 was conducted. Chapter 1.2, page seven of the User's Manual indicated, .the Resident Assessment Instrument (RAI) consisted of the MDS . The User's Manual chapter 1.2, page eight indicated, . The RAI process has multiple regulatory requirement .Federal regulations .require that (1) the assessment accurately reflects the resident's status . Furthermore chapter 5.5, page 668 of the User's Manual indicated, . the MDS must be accurate as of the ARD [Assessment Reference Date]. Minor changes in the resident's status should be noted in the resident's record .in accordance with standards of practice and documentation . During a record review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated March 2022, the P&P indicated, .All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information .

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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** 47956 Based on observation, interview and record review, the facility failed to create a comprehensive care plan to include special instructions for one of seven sampled residents (Resident 128). As a result Resident 128 was at risk for his dialysis to be interrupted or complications to occur by not having a staff person with him during dialysis. Findings: Per the facility's Admission Record, Resident 128 was admitted on [DATE] with a diagnosis of End Stage Renal Disease (ESRD-irreversible kidney failure). Based on observations on 3/11/25 at 2:17 P.M. and 3/13/25 at 2:43 P.M. at the 2 South Nurse's Station, Resident 128 was returned to the facility via medical transport. Resident 128 was not accompanied by a facility staff member on either occasion. During a concurrent interview and record review on 3/14/25 at 10:45 A.M. with Infection Preventionist (IP)1, Resident 128's electronic medical record was accessed and reviewed. The record indicated in the Special Instructions section that Staff must accompany to Dialysis. IP1 stated that means a staff member must go to dialysis with Resident 128. IP1 further stated, The staff member must stay there [at the dialysis center] with Resident 128. During the same concurrent interview and record review with IP 1, the care plan section of Resident 128's chart was reviewed. IP1 stated Resident 128 does not have a care plan for staff to escort him to dialysis. IP1 further stated, care plans are important because they drive resident care and keep the residents safe. During a concurrent interview and record review on 3/14/25 at 10:50 A.M. with the Director of Nursing (DON), Resident 128's electronic medical record was accessed and reviewed. The record indicated in the Special Instructions section that Staff must accompany to Dialysis. The DON stated Yes, I know its there, it's been there for a while. We just are not doing it. The interview and Resident 128's record review with the DON continued. The care plan section of Resident 128's chart was reviewed. The DON stated It (It-staff to accompany Resident 128 to dialysis) should be in the care plan too, if he had an outburst, it could cause a stop in treatment and medical complications. A record review of the facility policy titled End-Stage Renal Disease, Care of Resident revised September 2010, indicated .5. The Resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48263 Based on observation, interview, and record review, the facility failed to invite and notify residents and/or their responsible parties (RP) in advance about a Resident Council meeting and care conferences for three of five residents (Resident 150, 180, and 239) reviewed. These deficient practices placed all residents at risk for not having their preferences, health needs updated. This practice did not promote a person-centered care plan. The census was 302. Cross-Reference F867 Findings: On 3/12/25 at 10:12 A.M., an observation and interview with five resident council members were conducted, on the 4th floor dining room. Three residents (Residents 239, 180,150) stated they were not informed, invited, or asked to join a care conference with the interdisciplinary team (IDT-members of the facility involved with the resident's care) to provide their input on their preferences or to receive updates about their plan of care. Interview responses of residents on 3/12/25 at 10:12 A.M.: Resident 150 stated they don't ask me to come to care conference. Resident 180 stated she was in agreement with Resident 150. Resident 180 stated they have not attended an IDT meeting with all IDT members in one setting. Resident 239 stated IDT members would come talk to her one by one such as dietary and rehabilitation services, but never all at once to conduct a care conference meeting to discuss her preferences and care according to her care plan. On 3/13/25 at 11:56 A.M., an interview and record review was conducted with the Social Service Director (SSD). The SSD stated she planned care conferences according to the Minimum Data Set (MDS: federally mandated assessment tool) quarterly schedule typically about a week in advance. The SSD stated that every IDT member (dietary, nursing, rehabilitation services, social services, and activities) are responsible to fill out their portions of the IDT care conference report. The SSD stated care plans were not required to be signed by residents (all facility residents). Resident IDT care conference reports were reviewed with the SSD: On 3/13/25, Resident 150's record of care conference conducted on 1/21/25 was reviewed. The SSD stated Resident 150 was her own RP. The SSD stated Resident 150 did not join the care conference on 1/21/25. The SSD stated she was unable to find documentation that Resident 150 was notified or declined to join the care conference that was scheduled on 1/21/25. The SSD stated Resident 150 should have been notified of the care conference to provide an opportunity to participate and to share personal preferences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 Resident 180's record of care conference 2/19/25 was reviewed. The SSD stated Resident 150 was his own RP. The SSD stated Resident 180 did not join the care conference on 2/19/25. The SSD stated she was unable to find documentation if Resident 180 was notified or declined to join the care conference that had been scheduled on 2/19/25. The SSD stated Resident 180 should have been notified to allow participation with his plan of care and update any preferences. On 3/13/25 Resident 239's record of care conference was reviewed. The SSD stated Resident 239 was his own RP. The SSD stated Resident 239 did not join the care conference on 1/29/25. The SSD stated she was unable to find documentation if Resident 239 was notified or declined to join the care conference that was scheduled on 1/29/25. The SSD stated Resident 239 should have been notified of the care conference to promote resident participation and inclusion of resident preferences. On 3/13/25 at 12:13 P.M., an interview was conducted with the SSD. The SSD stated that all residents and/or their RP should have the opportunity to participate and join their care conference in order for them (residents) to be involved and help personalize their care plan by making updates to include preferences and concerns. On 3/14/25 at 9:50 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that it was important for all residents and/or RP's to be included to discuss their plan of care and encourage residents to participate with care conferences. The DON stated care conference were important because this was an opportunity for residents (all facility residents) and their families/RPs to communicate and care plans to be updated. Resident plans of care should be personalized according to their preferences and concerns. A review of the facility's policy and procedure titled CARE PLANS, COMPREHENSIVE PERSON-CENTERED revised March 2022, indicated, .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development of his or her plan of care, including the right to .h. see the care plan and sign it after significant changes are made. 5. The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on observation, interview and record review, the facility failed to provide routine nail care to one of one resident (Resident 190) reviewed for Activities of Daily Living (ADL, activities related to personal care) for dependent residents. As a result, Resident 190 was at risk for skin injury and infection. Findings: Resident 190 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (complete weakness of one side of the body and weakness on one part of the body following a stroke), dysphagia (difficulty of swallowing) following a stroke and epilepsy (seizures) per the facility Admission Record. A record review of Resident 190's physician history and physical examination (H&P) on 3/6/24 indicated Resident 190 did not have the capacity to understand and make decisions. On 3/12/25 at 2:43 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 21. CNA 21stated on Sunday's nail care was being provided to residents. On 3/13/25 at 9:08 A.M., a concurrent observation and interview was conducted with CNA 22. Resident 190 was observed with a contracted upper extremity. Resident 190 had long fingernails on the left hand with dark material under the nails. CNA 22 stated she had to check with the licensed nurses (LNs) to see if they (CNA's) could cut Resident 190's fingernails. On 3/13/25 at 11:22 A.M., an interview was conducted with LN 21, LN 22, and LN 23. LN 21 stated, CNAs provided care daily to residents and should have checked residents' finger and toenails and reported to LNs. LN 22 stated CNAs could cut residents fingernails when residents did not have diabetes (abnormal blood sugars) or fungus. LN 22 stated it was everyone's role to check resident fingernails. LN 23 stated CNAs should have observed finger and toenails during showers and documented in the shower sheets. On 3/13/25 at 11:53 A.M., a concurrent observation and interview was conducted with LN 21. Resident 190 was observed with long fingernails on his left hand with dark material under the nails. LN 21 was observed trying to remove the material under the fingernails. LN 21 stated Resident 190 had long fingernails on the left hand and there was dirt under the fingernails that should have been cleaned. LN 21 stated CNAs should have checked and performed nail care during showers and notified the licensed nurse. LN 21 stated Resident 190's fingernails should have been cleaned and trimmed for proper hygiene, to prevent infection and to promote dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 11:18 A.M., an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) was conducted. The DON stated it was everyone's responsibility to check residents' nails. The DON stated CNAs could have trimmed nails except toenails and those residents with diabetes. The DON stated CNAs should have reported to the licensed nurse to make sure nail care was being done. ADON 2 stated nail trimming should have been scheduled every Sunday. The DON stated Resident 190 's fingernails should have been trimmed for infection control. Per the facility policy titled Fingernails/Toenails, Care of, revision ate February 2018, .The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .General guidelines 1. Nail care includes daily cleaning and regular trimming .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to set low-air loss mattresses (LALM: a pressure relieving air mattress to alleviate pressure to boney areas of the body to help prevent skin breakdown and injury) according to manufacture weight recommendations and/or resident comfort for five of 36 sampled residents (Resident 240, 207, 51, 55, and 219) at risk for pressure ulcers. These deficient practices placed residents (Resident 240, 207, 51, 55, and 219) at risk for skin breakdown and injuries. Cross-Reference F867 Findings. 1. A review of Resident 240's Admission Record indicated Resident 240 was admitted to the facility on [DATE] with diagnoses which included a history of left side hemiplegia (total paralysis of the arm, leg, and trunk on the left side of the body). A record review of Resident 240's minimal data set (MDS-nursing facility assessment tool) dated 1/16/25 indicated Resident 240 had clear speech, was able to express her ideas and understood others. Resident 240 cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) score indicated, a 15/15 points. The MDS assessment further indicated, Resident 240 was at risk for pressure ulcers and skin injuries. On 3/11/25 at 9 A.M., an observation and interview as conducted with Resident 240, in Resident 240's room. Resident 240's LALM was set on the weight of 450 lbs (pounds) and Resident 240 was in an upright position in bed. Resident 240 stated she had back pains on her lower back and placed extra pillows and blankets for comfort. On 3/12/25 at 8:47 A.M., an observation and interview was conducted with Resident 240, in Resident 240's room. Resident 240's LALM was set on 450 lbs. Resident 240 was in an upright position watching television (TV) while adjusting her bottom back with pillows and extra blankets. Resident 240 stated her bed felt better when she repositioned pillows and blankets to relieve pressure to her lower back. On 3/13/25 at 9:08 A.M., an observation and interview was conducted with Resident 240, in Resident 240's room. Resident 240's LALM was set at 250 lbs. Resident 240 stated she was unaware what the LALM settings were and stated she still needed to adjust her lower back with pillows and extra blankets to be comfortable because her bed felt too hard. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 9:30 A.M., an observation, interview and record review was conducted with Licensed Nurse (LN) 12, in Resident 240's room. Resident 240's LALM was set at 250 lbs. LN 12 reviewed Resident 240's weight in the clinical record and stated Resident 240's weight on 2/27/25 was 164.7 lbs. LN 12 stated Resident 240's LALM should be set according to Resident 240's comfort level versus weight because she was verbal and cognitively intact. LN 12 stated she was unable to find records in Resident 240's clinical chart if LALM settings for comfort were tested and/or documented in the care plan to indicate the LALM settings were comfortable for Resident 240. LN 12 stated the LALM should be set according to Resident 240's weight if there was no indication of Resident 240's preference to prevent skin breakdown and injuries. On 3/14/25 at 9:21 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated for residents who are cognitive (Resident 240) and are able to determine their comfort level when it comes to LALM settings, the nursing staff should test the LALM settings and have Resident 240 involved to make sure they are comfortable with the settings. The DON stated this should be part of their personalized-centered care and updated in the care plan with their comfort settings adjusted to what they chose and preferred. The DON stated for Resident 240 to be comfortable with the LALM settings Resident 240 should not need to put extra pillows and/or blankets on her back to make use of the benefits of the pressure reducing device. A record review of the facility's policy and procedure titled PRESSURE ULCER INJURIES dated April 2020, indicated, .Review and select medical devices with consideration the ability to minimize tissue damage . 2. A review of Resident 207's Admission Record indicated Resident 207 was admitted to the facility on [DATE] with diagnoses which included a history of heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A record review of Resident 207's minimum data set (MDS - a federally mandated resident assessment tool) dated 12/31/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 12 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. The MDS assessment further indicated, Resident 207 was at risk for pressure ulcers and skin injuries. Observations were conducted during the following days on Resident 207 LALM settings: Observation on 3/11/25 at 8:58 A.M. Resident 207 was asleep in bed using oxygen via tubing in the nose. Resident 207's LALM was set on 320 lbs (pounds). Observation on 3/12/25 at 8:46 A.M. Resident 207 in bed using oxygen via tubing in the nose in upright position being assisted by nursing staff with feeding. Resident 207's LALM was set on 320 lbs. On 3/12/25 a clinical chart review was conducted on Resident 207's weight. Resident 207's weight on 3/6/25 indicated Resident 207 weighed 129.9 lbs. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 9:30 A.M., an observation and interview was conducted with Licensed Nurse (LN) 12, in Resident 207's room. LN 12 stated Resident 207's LALM was set on 150 lbs. LN 12 stated the LALM settings should be set according to weight to prevent pressure ulcers since Resident 207 had cognitive deficits and was at risk for pressure ulcers. On 3/14/25 at 8:06 A.M., Resident 207's record was reviewed. Resident 207's care plan, and progress notes were reviewed. There was no documentation of personalized comfort settings and/or evaluation in Resident 207's record. On 3/14/25 at 9:21 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated an evaluation for LALM comfort settings was not conducted and should be updated in the care plan for personalized care. The DON stated if Resident 207 was unable to state LALM comfort levels or had cognitive deficits the LALM should be set according to manufacture weight recommendations to prevent skin injuries and breakdown. A review of the facility's policy and procedure titled PRESSURE ULCER INJURIES dated April 2020, indicated, .Review and select medical devices with consideration the ability to minimize tissue damage . 3. A review of Resident 51's Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses which included a history of End Stage Renal Disease (ESRD: irreversible kidney failure). A record review of Resident 51's MDS (Minimum data set: nursing facility assessment tool) dated 2/24/24 indicated that Resident 51 was rarely or unable to understand others or make self-understood and had severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to make decisions. Observations were conducted during the following days on Resident 51 LALM settings: Observation on 3/11/25 at 9:10 A.M. Resident 51 resting in bed awake with bed at lowest position. LALM set on 85-90 lbs (pounds). Resident 51 in upright position by bedside table with food tray. Observation on 3/12/25 at 9:44 A.M. Resident 51 returned from dialysis and transferred by transport team back to bed. LALM set at 85-90 lbs. Observation on 3/13/25 at 8:48 A.M. Resident 51 awake and resting in bed. LALM set at 150 lbs. On 3/13/25 at 9:17 A.M., an observation, interview and record review was conducted with Licensed Nurse (LN) 12, in Resident 51's room. LN 12 stated Resident 51's LALM was set at approximately 120 lbs. LN 12 stated the setting should be less because Resident 51 did not weigh 120 lbs. LN 12 stated Resident 51 weighed 91.4 lbs. on 3/13/25. LN 12 stated Resident 51's LALM should be set according to her weight to be effective in preventing pressure ulcers and skin injuries. On 3/14/25 at 9:21 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 51's LALM should be set according to her weight to prevent pressure ulcers and skin injuries and would not be a able to determine LALM comfort levels due to Resident 51's severe cognitive deficit. (continued on next page)

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	555431	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Hills Post Acute	1580 Broadway El Cajon, CA 92021

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled PRESSURE ULCER INJURIES dated April 2020, indicated, .Review and select medical devices with consideration the ability to minimize tissue damage . 43518 4. A record review was conducted on 3/11/25. The Admission Record indicated Resident 55 (R55) was admitted on [DATE] with diagnoses which included Cognitive Communication Deficit (difficulties in communication stemming from impairments in cognitive functions like attention, memory, or problem-solving, rather than a primary language or speech problem), Functional Quadriplegia (the complete inability to move due to severe disability or frailty, but without physical injury or damage to the brain or spinal cord), and Metabolic Encephalopathy (a condition where the brain does not function properly). R55's record was reviewed on 3/11/25. R55's Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 12/31/24 indicated a Brief Interview For Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 13 which indicated intact cognition (process of thinking). R55's record was reviewed on 3/11/25. R55's MDS Section M-Skin Conditions dated December 31, 2024, indicated R55 with one stage 3 pressure ulcer (bed sore) and one stage 4 pressure ulcer on admission. MDS Section M also indicated R55 required B. Pressure reducing device for bed .E. Pressure Injury Care . On 3/11/25 at 10:13 A.M., an observation was conducted in R55's room during initial pooling. R55's LALM was set to the highest setting 400lbs, max. On 3/12/25 at 9:45 A.M., a concurrent interview with Licensed Nurse 51 (LN51) and observation of R55's LALM was conducted. R55's LALM was observed to be set to the highest setting 400lbs, max. LN51 stated that LALM should be set according to resident's weight. LN51 stated R55 did not weigh 400 lbs. LN51 stated the importance of setting the LALM to resident's weight was that R55 could sink into mattress and hit bedframe if set too low, and if set too high the LALM would not promote skin integrity. On 3/12/25 at 9:50 A.M., a concurrent interview with Licensed Nurse 52 (LN52) and observation of R55's LALM was conducted. LN52 was observed conducting a treatment on R55's sacral (bone in the lower back) wounds. R55's LALM was observed to be set to the highest setting 400lbs, max. LN52 stated that LALM should be set according to resident's weight. LN52 stated the importance of setting the LALM to resident's weight was that if set too high the LALM might not promote healing of wounds or maintain current skin integrity. On 3/12/25 at 9:55 A.M., a concurrent interview with Assistant Director of Nursing 4 (ADON4) and observation of R55's LALM was conducted. R55's LALM was set to the highest setting 400lbs, max. ADON4 stated that LALM should be set to R55's weight. ADON4 stated the importance of setting the LALM to R55's weight was to prevent skin breakdown and maintain skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/14/25 at 10 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that for LALM settings, the expectation if the resident had intact cognition, then set to resident's comfort, and if resident was not cognitively intact set to the resident's weight. The DON stated that the importance of setting LALM correctly was to maintain the resident's skin integrity. A record review on 3/14/25 was conducted. The facility policy titled SUPPORT SURFACE GUIDELINES, dated 2001 indicated, .1. Redistributing support surfaces are to promote comfort for all bed-or chairbound residents, prevent skin breakdown, and promote circulation, and provided pressure relief or reduction . A record review of LALM A-20 OPERATION MANUAL, MODEL MDT24A20, undated, indicated .1. Pressure Adjustment Knob .Higher pressures will support heavier patients. The pressure should be adjusted according to individual comfort preferences . 5. Resident 219's (R219) record was reviewed on 3/11/25. A record review of R219's Admission Record dated 3/10/23 indicated R219 was admitted for diagnoses which include: Hemiplegia (one-sided paralysis), Hemiparesis (weakness or the inability to move on one side of the body), and Cerebral Infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die). A record review of R219's Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 12/4/24 indicated Brief Interview For Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) was not able to be completed as resident is rarely/never understood indicating resident was not able to complete task. A record review of R219's MDS Section M-Skin Conditions dated 12/4/24 indicated that R219 was assessed at being at risk for developing pressure ulcers/injuries. On 3/11/25 at 9:23 A.M., an observation was conducted of Resident 219's LALM during initial pooling. R219's LALM was set to the highest setting 400lbs, max. On 3/12/25 at 9:45 A.M., a concurrent interview with Licensed Nurse 51(LN51) and observation of R219's LALM was conducted. R219's LALM was set to the highest setting 400lbs, max. LN51 stated that LALM should be set according to resident's weight. LN51 stated R55 did not weigh 400 lbs. LN51 stated the importance of setting the LALM to resident's weight was that R55 could sink into mattress and hit bedframe if set too low, and if set too high the LALM might not promote skin integrity. On 3/12/25 at 9:55 A.M., a concurrent interview with Assistant Director of Nursing 4 (ADON4) and observation of R219's LALM was conducted. R219 's LALM was set to the highest setting 400lbs, max. ADON4 stated that LALM should be set to R219's weight. ADON4 stated the importance of setting the LALM to R219's weight was to prevent skin breakdown and resident's maintain skin integrity. On 3/14/25 at 10 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that for LALM settings, the expectation if the resident had intact cognition, then set to resident's comfort, and if resident was not cognitively intact set to the resident's weight. The DON stated that the importance of setting LALM correctly was to maintain skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of facility policy titled SUPPORT SURFACE GUIDELINES, dated 2001 indicated, .1. Redistributing support surfaces are to promote comfort for all bed-or chairbound residents, prevent skin breakdown, and promote circulation, and provided pressure relief or reduction . A record review of LALM A-20 OPERATION MANUAL, MODEL MDT24A20, undated, indicated .1. Pressure Adjustment Knob .Higher pressures will support heavier patients. The pressure should be adjusted according to individual comfort preferences .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to maintain a safe hazard free environment for two of 34 residents (Resident 14, and Resident 15). As a result: 1. Resident 14 was placed at risk when the nursing staff placed shower blankets and/or drawsheets on Resident 14's bathroom floor for convenience, creating a slipping hazard which could have resulted in serious injury. Cross-Reference F584 2. Resident 15 was placed at risk for smoke-related injuries and burns when the facility failed to assess Resident 15's current smoking status and safety plan. Findings: A review of Resident 14's Admission Record indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses which included a history of unsteadiness of feet (balance issues with walking, and/or standing). A clinical chart review was conducted on Resident 14's fall care plans that indicated the following: - Fall risk care plan initiated 9/13/23 and revised 12/10/24, indicated, .at risk for falls related to . I am visually impaired and I want to protect my eyes from injuries. - sitting in peers wheelchair not meant for a person his size. - walks with his gown on and barefeet . -Unwitnessed fall care plan initiated 2/18/25, indicated, .has unwitnessed fall-found on the floor in the supine position . - Unwitnessed fall care plan initiated 2/20/25, indicated, .Falls: Resident had a self-reported fall unwitnessed on 2/17/25 at 22:45 [10:45 P.M.] . - Unwitnessed fall care plan initiated 2/25/25, indicated, .Resident had two unwitnessed falls within one hr [hour] apart and is at risk for injury from recurring falls . A clinical chart review was conducted on Resident 14's Fall Risk Observation/assessment dated [DATE] indicated Resident 14 had a fall history during the last 90 days with .3 or more falls . with a fall score risk of 16 considered as a high risk. Observations were conducted during the following days in Resident 14's bathroom: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/12/25 (9:13 A.M.): Two white shower blankets found on the floor spread on the floor from the toilet to the opening of the bathroom. [NAME] quarter to dime sized liquid spots at the corner edge of the wall across the toilet. [NAME] spotted scattered droplet sized drip like stains and quarter sized brown spots on the walls by the toilet. [NAME] and yellow drip like stains on the toilet seat and edges. The bathroom had a strong feces-like odor. - 3/12/25 (3 P.M.): Skid-like dark brown large and small paper clip sized stains found on floor outside of bathroom door entry with white drawsheet spread on the floor that had a brownish yellow streak like stain on the edge of the sheet. [NAME] quarter to dime sized liquid spots at the corner edge of the wall across the toilet. Used dirty incontinence pad with brown stains inside unlined trash bin. [NAME] scattered various sized large paper clip and coin sized brown thick spots found on the floor by the toilet. [NAME] and yellow drip like stains on the toilet set and edges. The bathroom had a strong feces-like odor. - 3/13/25 (8:20 A.M.): A white shower blanket spread on the floor surrounding toilet. Toilet seat and edges with same stain as described on 3/12/25 (Brown and yellow drip like stains on the toilet seat and edges). [NAME] spotted scattered droplet sized drip like stains and quarter sized brown spots on the walls by the toilet. [NAME] Faucet leather-like cover with dried dark brown various sized (closed fist sized to thumb sized) streaks scattered on cover. The bathroom had a strong feces-like odor. On 3/13/25 at 8:22 A.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 11, in Resident 14's bathroom. CNA 11 stated that the draw sheet were placed on the floor because Resident 14 gets poop on the floor. CNA 11 stated it was convenient for staff to have the drawsheets on the floor to clean up after Resident 14. CNA 11 stated the draw sheet could also be a fall hazard because it can slip and cause someone to loose balance when going to the bathroom. On 3/13/25 at 8:28 A.M., an observation and interview was conducted with Licensed Nurse (LN) 12, in Resident 14's bathroom. LN 12 stated that the bathroom smelled like poop. LN 12 stated that the white facet cover stains, and bathroom floors with stained brown spots looked like poop and that the walls scattered by the toilet looked like poop. LN 12 stated that white draw sheet on the floor would also be a fall hazard and cause someone to slip and trip. On 3/14/25 at 9:32 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the nursing staff should not be putting drawsheets and/or shower blankets on the floor for staff convenience to care for Resident 14's incontinence issues with the potential for fall hazards. A review of the facility's policy and procedure titled FALLS and FALL RISK, MANAGING revised March 2018, indicated .Environmental factors that contribute to the risk of falls include .obstacles in the footpath .e. improperly fitted or maintained wheelchairs; and f. foot wear that is unsafe or absent . 2. A review of Resident 15's Admission Record indicated Resident 15 was readmitted to the facility on [DATE] with diagnoses which included a history of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) with nicotine dependence (or tobacco addiction, means your body and brain become reliant on nicotine, making it hard to stop using tobacco products despite wanting to quit). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 15's minimum data set (MDS - a federally mandated resident assessment tool) dated 1/21/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 15 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 3/11/25 at 11:58 A.M., an interview was conducted with Resident 15, in Resident 15's room. Resident 15 stated he was a smoker. According to the facility's policy and procedure for Resident Assessments, revised March 2022. The Resident Assessment indicated .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements .Quarterly Assessment . On 3/13/25 at 2:54 P.M., an interview and record review was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated Resident 15's last smoking assessment was completed on 5/13/24. The MDSC stated that smoking assessments should be done on a quarterly basis because this information was needed to capture if Resident 15 smoked during the MDS look-back period and that it was necessary to re-evaluate if there were any changes to Resident 15's smoking safety (e.g. changes to finger dexterity of holding a cigarette) that needed to be updated in Resident 15's care plan for smoking and/or if he stopped smoking to make necessary recommendations and update interventions. The MDSC stated smoking assessments were important because of safety to prevent smoke-related injuries and burns from happening. On 3/14/25 at 9:40 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated a quarterly smoking assessment was needed for any residents who smoked to evaluate if residents were continuing to smoke and to update their care plans. The DON further stated Resident 15 should have a quarterly smoking assessment completed for safety and to prevent smoke-related injuries and burns. A review of the facility's policy and procedure SMOKING POLICY revised 8/28/18, did not indicate a frequency for a smoking assessment to be completed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review the facility failed to ensure the nutritional status was monitored for one of seven residents reviewed for nutrition, with progressive weight loss since admission (Resident 260). This failure had the potential to result in Resident 260 to experience further functional decline and loss of lean body mass (the body weight that includes muscles, bones, and organs and excludes fat). Findings: Resident 260 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty in swallowing) and pressure ulcers (bedsores) according to the facility's Admission Record. On 3/11/25 at 8:20 A.M., Resident 260 was observed in bed. Resident 260 had good eye contact and nodded only upon greeting. An interview on 3/12/25 at 8:50 A.M. with Certified Nurse Assistant (CNA) 35 was conducted. CNA 35 stated Resident 260 required feeding assistance with meals and one other CNA was responsible for assisting residents who required to be fed. CNA 35 stated Resident 260 already completed his breakfast. A review of Resident 260's meal percentage titled, POC Response History, dated 3/12/25 indicated, 26%-50% documented at 1:14 P.M. and 0-25% documented at 1:15 P.M. A review of Resident 260's weight records was conducted. The Weights and Vitals Summary indicated an admission weight of 128.7 lb. (pounds) on 10/2/24. The weight record indicated weekly weights for October 2024 through December 2024: 10/2/24 128.7 lb. 10/21/24 115.0 lb. 10/31/24 117.1 lb. 11/7/24 109.8 lb. 11/13/24 114.8 lb. 11/21/24 108.0 lb. 11/29/24 118.2 lb. 12/2/24 118.2 lb. 12/11/24 114.8 lb. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/18/24 116.4 lb. 12/26/24 105.8 lb. 1/23/25 96.2 lb. 2/20/25 100.0 lb. Resident 260 was not placed on weekly weights from 1/1/25-1/23/25 to monitor weight status after a significant weight loss of 17.8% (22.9 lb.) from 10/2/24 through 12/26/24. During an interview on 3/13/25 at 8:24 A.M. with Licensed Nurse (LN) 31, LN 31 stated one CNA was assigned to take all residents' weights and the CNA will notify a LN for any weight gain or weight loss. An interview and concurrent record review was conducted on 3/13/25 at 11:08 A.M. with the Registered Dietician (RD). The RD reviewed his progress notes (PN) and stated he documented the 17.8% weight loss on 1/3/25. The RD stated the following PN dated 2/3/25 was completed by the RD who was covering for him. The PN dated 2/3/25 indicated, .Lost 22# [pounds] in one month .Follow weights weekly for now due to significant weight loss . The RD reviewed Resident 260's weight record and stated there were no weekly weights recorded for the month of January and February 2025. The RD stated weekly weights were taken for four weeks for newly admitted residents and if there was a change in condition. The RD stated he determined when to discontinue a resident's weekly weights. The RD stated he was not sure why the weekly weights were not taken for Resident 260. The RD further stated it was important to do weekly weights for closer monitoring of the resident's weight. During an interview on 3/14/25 at 1:17 P.M. with the Director of Nursing (DON), the DON stated it was important to weigh residents weekly per the RD's recommendation to monitor the resident's weight loss. A review of the facility's policy and procedure (P&P) titled, Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, dated September 2012 was conducted. The P&P indicated, .The nursing staff will monitor and document weight and dietary intake of residents in a format which permits comparisons over time .The staff and physician will define the individual's current nutritional status (weight, food/ fluid intake and pertinent laboratory values) . The P&P did not provide guidance regarding RD assessment and recommendations.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews and record reviews, the facility failed to follow physician's orders for post dialysis care (Res 51) and did not follow special instructions during dialysis (Res 128) for two of nine reviewed residents (Resident 51 and 128) These deficient practices placed the residents (Resident 51 and 128) at risk for complications such as infection, clotting, discomfort and compromised safety. Findings: 1. A review of Resident 51's Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses which included a history of End Stage Renal Disease (ESRD: irreversible kidney failure) requiring dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). A record review of Resident 51's MDS (Minimum data set: nursing facility assessment tool) dated 2/24/24 indicated that Resident 51 was rarely or unable to understand others or make self-understood and had severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to make decisions. A clinical chart review was conducted on Resident 51's dialysis orders that included: MD order dated 12/6/24 indicated, .Dialysis Right AV Fistula, Remove Pressure Dressing 4-6 Hours Post Dialysis Treatment, If No Bleeding Noted. one [sic] time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] . A clinical chart review was conducted on Resident 51's dialysis care plan. The care plan did not include needs for Resident 51's post dialysis dressing care. On 3/12/25 at 9:42 A.M., an observation was conducted on Resident 51, in Resident 51's room. Two transportation service staff assisted in transferring Resident 51 back to her room and then safely moved her from the gurney to the bed after returning from a dialysis appointment. On 3/12/25 at 9:44 A.M., an observation and interview was conducted with Resident 51, in Resident 51's room. Resident 51 was confused and stated she went nowhere and showed right upper arm with a clean, white, and intact dressing. On 3/13/25 at 9:38 A.M., an observation, interview and record review was conducted with Licensed Nurse (LN) 12, in Resident 51's room. LN 12 assessed Resident 51's dialysis site on the right upper arm. LN 12 stated the dressing is clean and intact without no signs of bleeding observed on dressing. LN 12 stated the dressing should have been removed per MD orders within 4-6 hours. LN 12 stated a dialysis form titled Observation/Assessment was completed post-dialysis by a nursing staff and could be completed by a Licensed Vocation Nurse (LVN). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:46 A.M., an interview was conducted with Assistant Director of Nursing (ADON)3, at the three South Nursing station. ADON3 stated that only Registered Nurses (RNs) were allowed to do assessments for any residents on dialysis and not LVNs. On 3/13/25 at 9:47 A.M., an interview and record review was conducted with LN 12, at the three South Nursing station. LN 12 stated that she was unable to find documentation in Resident 51's electronic clinical record of a post dialysis assessment done by an RN. LN 12 stated it was important to do a post dialysis assessment and follow MD orders for Resident 51's post dialysis dressing to assess for dialysis complications for blood clots, infection and discomfort. On 3/14/25 at 9:12 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 51's dressing should be removed per MD orders and removed six hours post dialysis to prevent the dialysis from clotting. The DON stated his expectations for post dialysis care included being assessed by an RN and following MD orders to prevent infections, discomfort and post dialysis complications such as clotting. A review of the facility's policy and procedure titled END STAGE RENAL DISEASE, CARE of RESIDENT revised September 2010, indicated .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis .The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care . 47956 2. Per the facility's Admission Record, Resident 128 was admitted on [DATE] with a diagnosis of End Stage Renal Disease (irreversible kidney failure-ESRD). Based on observations on 3/11/25 at 2:17 P.M. and 3/13/25 at 2:43 P.M. at the 2 South Nurse's Station, Resident 128 was returned to the facility via medical transport. Resident 128 was not accompanied by a facility staff member on either occasion. During a concurrent interview and record review on 3/14/25 at 10:45 A.M. with Infection Preventionist (IP)1 Resident 128's electronic medical record was accessed and reviewed. The record indicated in the Special Instructions section that Staff must accompany to Dialysis. IP1 stated that means a staff member must go to dialysis with Resident 128. IP1 further stated, The staff member must stay there [at the dialysis center] with Resident 128. During the same concurrent interview and record review, the care plan section of Resident 128's chart was reviewed. IP1 stated Resident 128 does not have a care plan for staff to escort to dialysis. IP1 further stated, care plans are important because they drive resident care and keep the residents safe. During a concurrent interview and record review on 3/14/25 at 10:50 A.M. with the Director of Nursing (DON), Resident 128's electronic medical record was accessed and reviewed. Resident 128's electronic medical record was accessed and reviewed. The record indicated in the Special Instructions section that Staff must accompany to Dialysis. The DON stated Yes, I know it's there, it's been there for a while. We just are not doing it. (continued on next page)

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Country Hills Post Acute	1580 Broadway El Cajon, CA 92021

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same concurrent interview and record review, the care plan section of Resident 128's chart was reviewed. The DON stated It should be in the care plan too, if he had an outburst, it could cause a stop in treatment and medical complications. During a concurrent interview and record review on 3/14/25 at 10:50 A.M. with the Director of Nursing (DON), the State Operations Manual (SOM) Appendix PP revision date 8/8/24 was reviewed section 483. 25(l) indicated the facility is responsible for .Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments . The DON stated Yes, we are always responsible for the resident's care. A review of the facility policy titled End-Stage Renal Disease, Care of Resident revised September 2010, indicated .5. The Resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on observation, interview, and record review, the facility failed to properly store and label Resident 204's breathing treatment medications. As a result, the facility could not ensure medications were safely stored. Findings: On [DATE] at 10:28 A.M., an observation and interview were conducted with Resident 204. Resident 204 was in bed and connected to an oxygen concentrator machine. There was a CPAP (continuous positive airway pressure to keep airway while asleep) machine and nebulizer at bedside. Resident 204 pulled out unlabeled, undated and unpackage solution vials of Ipratropium- Albuterol medications from his bedside drawer. Resident 204 stated staff gave medications to him sometimes but he administered the solution via his nebulizer in the evenings. On [DATE] at 10:09 A.M., a concurrent observation and interview was conducted with RT 21. Resident 204 pulled out unlabeled, undated and unpackaged solution vials of Ipratropium-Albuterol medications from his bedside drawer. Resident 204 stated in the mornings and afternoons the RTs administered his nebulizer. Resident 204 stated in the evenings, he administered his nebulizer. RT 21 stated she has endorsed multiple times to the charge nurse that leaving medications at bedside was not allowed. RT 21 stated she would find nebulizer materials at bedside. RT 21 stated there was no physician order for self-administration. Resident 204's nebulizer should be supervised to make sure Resident 204 was receiving the correct dosage and frequency per the physician order. On [DATE] a record review of the Ipratropium Bromide-Albuterol Sulfate solution manufacturers guidelines indicated vials should be protected form light before use therefore keep unused vials in the foil pouch or carton. On [DATE] at 9:12 A.M., a concurrent interview and record review was conducted with RT 21. Resident 204's Ipratropium-Albuterol solution packaged indicated storage conditions vials should remain stored in protective foil pouch at all times. Once removed from the foil pouch, the vials should be used within one week. RT 21 stated Resident 204's vials of Ipratropium-Albuterol medications were not labeled with date and were outside the foil pouch. RT 21 stated we did not know how long the drug was stored at Resident 204's bedside. RT 21 stated Resident 204's vials of Ipratropium-Albuterol medications were stored at his bedside. RT 21 stated we would not be sure the effectiveness of the drug outside the foil pouch. RT 21 stated it should discarded. On [DATE] at 9:18 A.M. an interview was conducted with LN 21. LN 21 stated the facility did not allow to store medications at resident's bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:23 A.M., an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) 2 was conducted. The DON stated Resident 204's vials of Ipratropium-Albuterol medications should be labeled and dated to make sure medication was not expired. The DON stated storing Resident 204's unlabeled and undated vials of Ipratropium-Albuterol medications at bedside did not follow the manufacturer's guidelines for storage. The DON stated storing Resident 204's unlabeled and undated vials of Ipratropium-Albuterol medications at bedside should follow the manufacture guidelines for storage because the drug loses potency. Per the facility policy entitled Medication Labeling and Storage, date 2021, indicated .The facility stores all medications .in locked compartments .1. Medications .are stored in the packaging, containers or other dispensing systems in which they are received .3. The nursing staff is responsible for maintaining medication storage .in a safe .manner .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39220 Based on observation, interview, and record review, the facility failed to ensure kitchen staff maintained sanitary food practices when: 1. Drying racks and a drying cart were not clean; and 2. The hanging sprinkler system (Ansel) heads above the stove were covered in dust; and 3. A beard net was not being worn by a dishwasher; and 4. A dishwasher aide did not wash his hands after removing trash and reentering the kitchen. These failures had the potential for cross contamination and to cause food borne illness. Findings: 1. An observation and interview was conducted with Dietary Manager (DM) of the 3-compartment sink area on 3/12/25 at 8:17 A.M., Large pots and pans were upside down, air drying on 3-rack metal shelves next to the 3-compartment sink area. The 3-racks that the pots and pans were resting on appeared dirty and gritty. A finger sweep was performed on each rack, which left a clear, distinguished line on the rack. The DM stated, Yes, I see what you mean, they are dirty. The DM stated the kitchen was deep cleaned every Wednesday, but he could not provide a check list of items that were deep cleaned with staff initials as being completed. An observation and interview was conducted with the DM on 3/12/25 at 8:21 A.M., of a drying cart next to the 3-compartment sink area. The top of the cart contained wet pots with hole in the rack, so water drained to a lower shelf-catch system. The top shelve where the pots were, had debris which could be removed with the swipe of a finger. The DM stated, Yes, I see it and I will get it cleaned right away. According to the facility's policy titled, Sanitation, dated 2001, .2. All utensils, counters, shelves and equipment are kept clean .3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions . 2. An observation and interview was conducted with the DM of the water sprinkler heads above the stove on 3/12/25 at 8:32 A.M. The top of the sprinkler heads were covered in dust. The DM stated, Yes, they are dirty and the dust could fall onto the stove while cooking, which would cause cross contamination. According to the facility's policy titled, Sanitation, dated 2001, .8. When cleaning fixed equipment .a. wash and sanitize and non-removable parts cleaned with detergent and hot water . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. An observation and interview was conducted with the DM and the dishwasher (DSWH) on 3/12/25 at 8:49 A.M. The DSWH was observed removing clean dishwasher racks from the dishwashing machine and allowing them to airdry. The DSWH had a beard approximately 1 inch long and was not wearing a beard net. The beard net was hanging down, around the DSWH's neck. The DSWH stated he forgot it was around his neck and it should have been over his beard. The DSWH stated hair could fall onto the clean dishes. According to the facility's policy, titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 2001, .Hairnets: 15. Hair nets of caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens . 4. An observation and interview was conducted with the DM and the dishwasher aide (DWA) on 3/12/25 at 8:58 A.M., as the DWA removed trash from the kitchen. The DWA removed his gloves and wheeled the trashcan outside to the trash dumpsters. The DWA washed out the trashcan and returned to the kitchen. The DWA returned inside the kitchen to the dishwashing area and started to handle dishes without performing handwashing. The DWA stated he forgot to wash his hands when he returned to the kitchen, which could cause cross contamination. The DM stated he expected all staff to wash their hands when returning to the kitchen. An interview and record review was conducted with the DM on 03/12/25 at 9 A.M. of kitchen staff training, which included hair/beard nets and handwashing. The DSWH and the DWA completed training in August 2024. According to the facility's policy, titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 2001, .Hand Washing/Hand Hygiene: .c. Whenever entering or re-entering the kitchen; . An interview and record review was conducted with the Registered Dietician (RD) on 3/12/25 at 10:34 A.M. The RD stated he expected all shelves and surfaces to be clean and sterile, to prevent cross contamination. The RD stated dust on fire sprinklers above the stove could fall down and contaminate any food being prepared. The RD stated all staff needed to wear hair and beard covers to prevent hair from falling onto surfaces or into food. The RD stated anyone who entered or re-entered the kitchen, must wash their hands to prevent cross contamination. The RD stated he did a kitchen audit on 3/10/25, and provided a copy. The RD made handwritten notes on the bottom of the 2-page audit sheet. The handwritten notes pertained to undated/labeled food and the thawing of meat. The remaining list had line-by- line areas for inspection, which were blank. The RD stated he did not look at everything in the kitchen when he performed the audit and he should have. An interview was conducted with the Director of Nursing (DON) on 3/12/25 at 10:39 A.M. The DON stated he expected the kitchen to be cleaned daily and maintained in a clean, sanitary condition at all times. The DON stated he expected the kitchen to have a deep cleaning list, so staff knew what was expected to be cleaned. The DON stated all staff should wear hair and beard nets to prevent hair from falling into food. The DON stated he expected everyone to wash their hands whenever entering the kitchen to prevent cross contamination.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to date and later discard resident food, stored in three of six resident refrigerators, when reviewed for safe food handling practices. This failure had the potential for stored food to cause a food borne illness if consumed by the resident. Findings: An observation and interview was conducted with Licensed Nurse 41 (LN 41) of Station 4's north resident refrigerator on 3/11/25 at 1:54 P.M. Observed inside the resident refrigerator was a tray of store purchased sushi with a clear lid. The sushi tray contained a residents' name and room number, but no date of when it was placed in the refrigerator. LN 41 could not locate a best use by date on the sushi container. A large white plastic bag which contained a resident name and room number was opened. Inside the large plastic bag was a plastic store container of spinach/artichoke dip, which was half consumed. The spinach/artichoke dip container had no date of when it was opened, and LN 41 could not locate a best use by date on the container. The large plastic bag also contained partially consumed strudel (pastry), and an opened package of store-bought fudge cookies with eight cookies remaining. No open date could be located, and LN 41 could not locate a best use by date on either of the two packages. LN 41 stated all the items should have been dated when placed in the refrigerator or when opened, and they were not. LN 41 stated a resident could consume the food and potentially get ill. An observation and interview was conducted with LN 42 of Station 3's north resident refrigerator on 3/11/25 at 2:10 P.M. Inside the resident refrigerator was a cardboard to-go-container of food with a receipt taped to the outside, dated 3/5/25, labeled as kabor [NAME] Inside the food container was a meat and vegetable meal. The container was not labeled with a resident's name. On the side door of the refrigerator was a clear plastic container of raspberries, which appeared old and dehydrated. The outer clear plastic container had a handwritten residents' name, room number, and store labeled date of 3/4/25. LN 42 stated if the food was consumed, the residents' could get sick because the food had been stored too long. LN 42 stated food should be discarded after five days. An observation and interview was conducted with LN 43 of Station 3's south resident refrigerator on 3/11/25 at 2:18 P.M. Inside the resident refrigerator was a cardboard container of Mexican food. The cardboard container was labeled with a resident name and room number, but it did not contain a date of when it was placed in the refrigerator. LN 43 stated all food should be dated and labeled, so staff knew who it belonged to and when it should be discarded. LN 43 stated licensed nurses were responsible for checking the refrigerator and discarding any food items after two days of storage. An interview was conducted with the Dietary manager (DM) on 3/11/25 at 2:36 P.M. The DM stated he did not monitor the residents' refrigerators and nurses on units were responsible. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Registered Dietician (RD) on 3/11/25 at 2:38 P.M. The RD stated he did not inspect the resident refrigerators, and he did not know who was responsible for monitoring them. The RD stated all resident food needed to be labeled with the resident's name, room number, and date it was placed in the refrigerator. The RD stated all food should be discarded after 72 hours, if not residents were at risk for food borne illness. An interview was conducted with the Director of Nursing (DON) on 3/12/25 at 10:39 A.M. The DON stated the resident refrigerators need to be checked every shift by licensed nurses and food should be discarded after 72 hours. The DON stated he expected all resident food to be labeled properly with the resident's name, date, and room number. The DON stated by not discarding food after 72 hours, there was a potential for residents to become ill. According to the facility's policy, titled Food Brought by Family/Visitors, dated 2001, .5. Food brought by family/visitors that is left with the resident to consume later .b. Perishable food are stored in re-sealable containers with tight fitting lids .Containers are labeled with the resident's name, the item and the used by date. 6. The nursing staff will dispose perishable food on or before the use by date.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review the facility failed to properly explain the arbitration (a contract that says if there is a disagreement or legal issue between a resident and the facility, it will be settled by a private process instead of going to court) agreement to four of five reviewed residents (Residents 239, 229, 180, and 150) leaving them unaware that signing it meant waiving their rights to take legal actions. This deficient practice placed residents (Residents 239, 229, 180, and 150) at risk for signing an agreement without fully understanding their rights and options. Findings: On 3/12/25 at 10:12 A.M., an observation and interview with five resident council members were conducted, at the 4th floor dining room. Four out of five residents (Residents 239, 229, 180, and 150) during the resident council meeting stated they did not understand what the arbitration agreement was, were unaware they had 30 days to decline it, and were not given a copy. Residents interviewed responses were: Resident 180 reported that while being transported to the hospital, facility staff presented an arbitration agreement and insisted it be signed immediately, stating that refusal would result in denial of re-admission to the facility. The staff member presented the document abruptly during the transport, leaving Resident 180 feeling pressured to sign without proper explanation or opportunity to review the agreement. Resident 150 stated that they were unaware of what an arbitration agreement was and questioned whether signing it was mandatory. Resident 150 stated the facility staff failed to explain the agreement to her. Resident 150 stated they would have declined it if they had understood their options. Resident 229 stated that they were unaware of signing an arbitration agreement but likely did at the time due to being incoherent (confused, not fully aware, or unable to think clearly) from medications when he transferred to the facility. Resident 229 stated I don't think I got an explanation for it. Resident 239 stated that at the time, they probably would have signed the arbitration agreement, but they did not get an explanation about the arbitration agreement. Resident 239 stated they did not understand what it was and felt it would not have been a good idea to sign it and give up their rights. The residents (Residents 239, 229, 180, and 150) stated that they were not given a copy of the arbitration agreement and would have wanted one to review. The Facility staff failed to inform them (Residents 239, 229, 180, and 150) about their right to decline the agreement within 30 days, leaving them unaware of their options. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 11:27 A.M., an interview and record review with the Admission's Coordinator (AC) was conducted. The AC stated that part of the paperwork for admission includes the arbitration agreement. The AC stated that the arbitration agreement was only available in English and did not ensure that a translation service was used in all cases. Medical record reviews were conducted with the AC with the following: Resident 150 an arbitration agreement was signed on 3/18/18. The AC stated there was no documented evidence of a binding agreement being given to Resident 150. Resident 150's Minimum Data Set (MDS: federally mandated assessment tool) dated 1/21/25 on cognitive (mental process like thinking, remembering, learning and understanding) status showed a Brief Interview for Mental Status (BIMS: to assess a resident's cognitive function) score of 15 out of 15 that indicated no cognitive problems. Resident 180 an arbitration agreement was signed electronically on 10/8/21. The AC stated there was no documented evidence showing that a copy of the agreement was given to Resident 180 or discussed with Resident 180. Resident 180's MDS dated [DATE] indicated a BIMS score of 12 out of 15, that indicated Resident 180 had moderate difficulty with memory and thinking. Resident 239 an arbitration agreement was signed electronically on 10/31/23. The AC stated there was no documented evidence showing that a copy of the agreement was given to Resident 239 or discussed with Resident 239. Resident 239's MDS dated [DATE] indicated a BIMS score of 11 out of 15, that indicated Resident 239 had moderate difficulty with memory and thinking. Resident 229's arbitration agreement was given back to Resident 229 per AC. The AC stated there was no documented evidence showing that a copy of the agreement was given to Resident 229 or discussed with Resident 229. Resident 229's MDS dated [DATE] indicated a BIMS score of 12 out of 15, that indicated Resident 229 had moderate difficulty with memory and thinking. On 3/13/25 at 11:41 A.M., an interview was conducted with the AC. The AC stated that it was important to have documented evidence in the residents (Residents 239, 229, 180, and 150) medical record that the residents (Residents 239, 229, 180, and 150) acknowledged and understood the arbitration agreement because they needed to be aware that by signing it, they were waiving their right to a trial and agreeing to resolve disputes outside court. The AC stated the residents (Residents 239, 229, 180, and 150) should have received a copy of the arbitration agreement to confirm and review the document at any time and have the information available to them in order to cancel the agreement within 30 days. On 3/14/25 at 9:54 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that he believed it was important for the admissions team to fully explain the details of any contracts/agreements to the residents (all facility residents) and to provide copies of what they signed. The DON also stated that admissions should have documented in the resident's (Residents 239, 229, 180, and 150) medical record, that the arbitration agreement was explained to the resident and was given a copy to review and understand their rights. A review of the facility's policy and procedure titled BINDING ARBITRATION AGREEMENTS dated November 2023, indicated, .a. A signature alone is not sufficient acknowledgement of understanding. b. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47956 Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility), trends identified by surveyors during the recertification survey concerning delay of call lights, smokers, Registered Dietician (RD) recommendations, kitchen hygiene, RD kitchen audits, resident care conferences, and low air loss mattress settings. These failures had the potential for the facility to overlook trends in resident care that may have affected residents' dignity and/or health. Cross Reference: F847, F625, F550, F686, F657 Findings: On 3/14/25 at 1:59 P.M., A concurrent interview and review of the facility's QAPI/QAA program was conducted with the Administrator (ADM) and the Director of Nursing (DON). The DON stated the current QAPI programs were Falls, UTI, Hospital transfers, RNA residents, Infection reports, Pest control program, MDS assessment accuracy/Submission. During the recertification, deficient trends were identified in delay of call lights, smokers, Registered Dietician (RD) recommendations, kitchen hygiene, RD kitchen audits, resident care conferences, and low air loss mattress settings. The ADM stated they were not aware of the issues identified during the survey and the issues were not included in their current QAPI Program. The ADM stated it was important to add these concerns to promote the highest standard of care for their residents. According to the Centers for Medicare and Medicaid Services (CMS) QAPI AT A GLANCE 9/10/24 accessed at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Hills Post Acute	1580 Broadway El Cajon, CA 92021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to implement infection control standards of practice when: 1. A facility staff did not sanitize a blood pressure cuff in between use for different residents, 2. The facility did not update their Infection Prevention and Control Program (IPCP) policy and procedure (P&P) according to federal regulations. This failure had the potential to spread infection among the residents. In addition, staff had the potential to not know current standards of practice for preventing and controlling infections. Findings: 1. An initial tour of the facility was conducted on 3/11/25 at 9:25 A.M. Certified Nurse Assistant (CNA) 31 was observed in the hall holding a portable wrist blood pressure cuff. CNA 31 stated she was taking her residents' vital signs (temperature, pulse, respirations and blood pressure). CNA 31 was observed entering room [ROOM NUMBER] and was observed from the hallway taking a resident's blood pressure with the portable wrist blood pressure cuff. CNA 31 was then observed exiting room [ROOM NUMBER] and went directly to room [ROOM NUMBER] to take another resident's blood pressure. CNA 31 did not sanitize the portable blood pressure cuff. CNA 31 exited room [ROOM NUMBER] and stated she sanitized the blood pressure cuff after she was done taking everyone's blood pressure. CNA 31 stated she should have probably sanitized in between residents for infection control. During an interview on 3/11/25 at 9:38 A.M. with CNA 32, CNA 32 stated most staff had their own blood pressure cuff. CNA 32 stated blood pressure cuff and other equipment should be sanitized after each resident for infection control. An interview on 3/14/25 at 1:17 P.M. with the Director of Nursing (DON). The DON stated blood pressure cuffs should be sanitized before and after use to prevent the spread of infection. A review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022 was conducted. The P&P indicated, .Non-critical items include bedpans, blood pressure cuffs .require cleaning followed by either low-or intermediate level disinfection following manufacturer's instructions . The P&P did not provide guidelines regarding the frequency of sanitizing non-critical items such as a blood pressure cuff. During a review of the facility's current P&P titled, Infection Prevention and Control Program, dated December 2023, the P&P indicated, .Prevention of Infection .educating staff and ensuring that they adhere to proper techniques and procedures . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An interview and concurrent record review was conducted on 3/14/25 at 8:01 A.M. with Infection Preventionist (IP) 1 and IP 2. IP 1 reviewed the facility's policy and procedure (P&P) from her binder titled, Infection Prevention and Control Program. IP 1 stated the P&P was dated December 2023 which was not updated annually. IP 1 stated the facility's consultant was responsible for updating the P&P. An interview was conducted on 3/14/25 at 1:17 P.M. with the DON. The DON stated the Infection Prevention and Control P&P should be updated annually for accuracy of information and to reflect any updates with the regulation. During a review of the facility's current P&P titled, Infection Prevention and Control Program, dated December 2023, the P&P indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .The program is reviewed annually and updated as necessary .

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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** 43518 Based on observation, interview, and record review the facility failed to provide two residents of 37 sampled residents (Resident 55 and Resident 268) with functional call buttons. This failure prevented residents from using their call buttons and making their needs known and having their needs met. Cross reference F558 Findings 1. Review of Admission Record indicated Resident 55 (R55)was admitted on [DATE] with diagnoses which included Cognitive (process of thinking) Communication Deficit (difficulties in communication stemming from impairments in cognitive functions like attention, memory, or problem-solving, rather than a primary language or speech problem), Functional Quadriplegia (the complete inability to move due to severe disability or frailty, but without physical injury or damage to the brain or spinal cord), and Metabolic Encephalopathy (a condition where the brain does not function properly). Review of Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 12/31/24 indicated a Brief Interview For Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 13 which indicated intact cognition. Review of MDS Section M-Skin Conditions dated December 31, 2024, indicated R55 with one stage 3 pressure ulcer (bed sore) and one stage 4 pressure ulcer on admission. MDS Section M also indicated R55 required B. Pressure reducing device for bed .E. Pressure Injury Care . Review of MDS Section GG dated December 31, 2024 indicated R55 was either dependent or required Substantial/maximal assistance for all his Self-Care needs. Review of Care Plan Report dated 3/12/25 indicated 1. ADL (Activities of Daily Living)/Mobility .at risk for ADL/Mobility decline and requires assistance .Encourage to use call light for assistance . On 3/11/25 at 10:13 A.M., a concurrent observation and interview was conducted with R55. R55's call button was observed to be one that needed to be gripped with his hand and pressed with thumb. R55 stated I am unable to use the press the call button. To get staff I yell. Both of R55's hands were observed to be contracted (muscle shortening preventing normal movement). On 3/12/25 at 9:45 A.M., an observation of R55's call button and interview with Licensed Nurse 51 (LN51) was conducted. LN51 stated that since R55's hands were contracted, he could not use the call button that was provided and would need a call button that he could tap. LN51 stated the importance of having an appropriate call button was that R55 needed to be able to communicate his needs with the staff. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 9:55 A.M., a concurrent observation of R55's call button and R55's hands, and interview with the Assistant Director of Nursing 4 (ADON4) was conducted. ADON4 stated that because R55's hands were contracted he could not press the provided call button, and he would need a call button he could tap. ADON4 stated the importance of using an appropriate call button was that the resident should be able to communicate his needs with the staff. On 3/14/25 at 10 A.M. an interview with the Director of Nursing (DON) was conducted. The DON stated that the expectation for R55's call button was that it should accommodate R55's ability and it should have been a tap call button. The DON stated that the importance of the correct type of call button was to enable R55 to make his needs known to staff. Review of facility policy titled CALL SYSTEM, RESIDENTS, dated 2001, indicated that .1. Each resident is provided with a means to call staff directly for assistance from his/her bed .3. The resident call system remains functional at all times .4. If the resident has a disability that prevents him/her from making use of call system, an alternative means of communication that is usable for the resident is provided and documented in care plan . 2. Review of Admission Record indicated Resident 268's (R268) dated 9/13/24, indicated R268 was admitted for diagnoses which included: Paroxysmal Atrial Fibrillation (a type of irregular heartbeat that occurs intermittently and typically resolves spontaneously within a short period), Chronic Lymphocytic Leukemia (a type of blood cancer that affects white blood cells), Subarachnoid Hemorrhage (a bleeding in the space between the brain and the thin membranes that cover it). Review of Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 12/18/24 indicated Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment in long-term care facilities) score of 13 which indicated intact cognition(thinking process). Review of MDS Section GG-Functional Abilities date 12/18/24 indicated R268 was Dependent or needing Substantial/Maximal assistance with her Self Care activities. On 3/11/25 at 9:57 A.M., an observation of R268's call button was conducted. R268's call button was missing the red centerpiece of the button and was not functional. On 3/11/25 at 3:25 P.M., a concurrent interview with Facility Manager (FM), observation of R268's call button, and record review of 4th floor maintenance log was conducted. FM stated that there was no maintenance requests made for R268's call button. FM stated that the expectation is that if a call button is broken, staff should call maintenance and write the request in maintenance log. FM stated the broken call button should immediately be replaced with a functional one. FM stated the importance of making maintenance aware of repairs and logging them in the maintenance log is to account for all repairs. In addition, FM stated residents need to have functioning call buttons to communicate with staff. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 3:35 P.M., a concurrent interview with Certified Nursing Assistant 53 (CNA53) and observation of R268's call button was conducted. CNA53 stated that call buttons should functional and within reach of every resident. CNA53 stated the expectation for non-functional call buttons was that they should be reported to charge nurse, who would call maintenance and log the needed repair in maintenance logbook. CNA53 stated the importance of resident having a functional call bell was so that they can communicate their needs to staff. On 3/11/25 at 3:45 P.M., an interview with Licensed Nurse 54 (LN54) was conducted. LN54 stated that he reported the R268's broken call button to maintenance, but never wrote it needed repair in the maintenance log book. LN54 stated the expectation was that if there is broken call button, he should have called and documented broken equipment in the log book. LN54 stated that the expectation is that all resident's call buttons should be functional. LN54 stated the importance of following maintenance procedure was to make sure the resident had a functional call button to communicate their needs with staff. On 3/11/25 at 3:55 P.M., a concurrent interview with the Assistant Director of Nursing 4 (ADON4) and observation of R268's broken call button was conducted. ADON4 stated that expectation was that if call buttons were broken, staff needed to call maintenance and document in the maintenance log. ADON4 stated the expectation was that all residents should have a functional call button. ADON4 stated that the importance of having functioning call button was for resident safety and for communication of needs with staff. On 3/14/25 at 10 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation for call buttons was that they should be functional and should accommodate a resident's ability. The DON stated the importance of functional call buttons was to make sure the resident's needs were met. Review of facility policy titled CALL SYSTEM, RESIDENTS, dated 2001, indicated that .1. Each resident is provided with a means to call staff directly for assistance from his/her bed .3. The resident call system remains functional at all times .4. If the resident has a disability that prevents him/her from making use of call system, an alternative means of communication that is usable for the resident is provided and documented in care plan .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to keep one resident room (room [ROOM NUMBER]) free from cockroaches. This failure had the potential to affect the health of the three residents who reside in room [ROOM NUMBER]. Findings: A review of the Admission Record for Resident 258 (R258) dated 1/22/25 indicated R258 was admitted for diagnoses which included: Infection of sacrococcygeal region (the region at the base of the spine, encompassing the sacrum (bone of the lower back) and coccyx (tailbone)), Skin Graft failure (the transplanted skin tissue fails to survive and integrate with the recipient site), Aneurysm of ascending aorta(a bulge or widening of the ascending aorta, the part of the aorta that carries blood from the heart to the head and arms). A record review of Minimum Data Set (MDS-a standardized, federally mandated assessment tool used in nursing homes) Section C dated 2/11/25 indicated Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive[thinking process] impairment in long-term care facilities) score of 12 which indicated moderate cognitive impairment. A record review of MDS Section B, dated 2/11/25, indicated R258's vision as .Adequate-sees fine detail, such as regular print in newspaper/books . On 3/11/25 at 2:49 P.M., an observation was conducted. During an initial tour of the 3rd floor a cockroach was observed outside of room [ROOM NUMBER] on a glove dispenser. On 3/11/25 at 2: 53 P.M., a concurrent observation of room [ROOM NUMBER] and interview with R258 was conducted. R258 stated that there were cockroaches all over the room. R258 stated that morning the housekeeper saw cockroaches behind the dresser. R258 stated that both of her roommates had food stored in and around their dressers. R258 stated that there were dead cockroaches in the frame that held the daily menu and in the light behind her bed. Dead cockroaches were observed in both areas. On 3/11/25 at 3 P.M., a concurrent interview with Certified Nursing Assistant 55 (CNA55) and observation of cockroach outside of room [ROOM NUMBER] was conducted. CNA55 stated that if cockroaches or other pests are detected she would notify the charge nurse, and the charge nurse would notify maintenance who would make an entry into the log maintenance book. CNA55 stated the importance of keeping rooms pest free was for maintaining the health of the residents in the room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 3:15 P.M., a concurrent interview, observation, and record review with the Facility Manager (FM) was conducted. Cockroaches were observed in and around room [ROOM NUMBER]. A record review of the maintenance log was conducted with FM who stated there was no record of roaches in the maintenance log. The FM stated that the expectation for cockroaches or other pests is that when detected by staff or residents, staff should call maintenance and log request in the maintenance book. The FM stated that after he gets the report of pests, he calls the contracted pest control service and they do a focused extermination in the room where they were seen. The FM stated that the pest control company does routine checks of random rooms monthly. The FM stated that the importance of keeping residents' rooms pest free was for maintaining the health of the residents in the room. On 3/11/25 at 3:38 P.M., a concurrent interview with Licensed Nurse 56 (LN56) and observation of cockroaches in room [ROOM NUMBER] was conducted. LN56 stated the process if pests were discovered was to report to maintenance, log in the maintenance log book, and maintenance would call the pest control company. LN56 stated the expectation was that resident rooms should be pest free. LN56 stated that the importance of pest free resident rooms was for infection control. On 3/11/25 at 3:45 P.M., a concurrent interview with the Assistant Director of Nursing 3 (ADON3) and observation of cockroaches in room [ROOM NUMBER] was conducted. ADON3 stated that the expectation was resident rooms should be free of pests. ADON3 stated the importance of pest free rooms was for infection control. On 3/14/25 at 10 A.M. an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation is that the residents' rooms should be pest free. The DON stated the importance of pest free resident rooms was for infection control. On 3/14/25 at 10:30 A.M., an interview with the Administrator (ADM), was conducted. The ADM stated that the expectation was residents' rooms should be pest free. The ADM stated that the importance of pest free residents rooms was for resident's health and safety, and to maintain a homelike quality. A recored review of .PEST CONTROL, SERVICE SUMMARY REPORT, dated 2/28/25 indicated .#328 .This room had activity by the TV the first one as you come into the room .it would be wise to clear all those tables off and remove all books and all the stuff so that we could get behind it and have a better look . Review of facility policy titled PEST CONTROL, dated 2001, indicated Our facility shall maintain an effective pest control program .1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .