STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solheim Senior Community	2236 Merton Ave. Los Angeles, CA 90041

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49537 Based on observation, interview and record review, the facility failed to develop a comprehensive, resident-centered care plan (a document that outlines a resident's care goals and the activities that will be performed to achieve those goals) for resident's actual fall on 6/13/2024 and implement the care plan interventions for one of two sampled residents (Resident 44). 1. On 6/13/2024, Resident 44 was left unattended by facility staff during shower to dispose soiled clothes. 2. On 10/8/2024, Resident 44 was observed Resident 44 got up from his bed by himself, and walked to the restroom and was wearing non-skid sock (slip resistant socks designed to reduce the risk of slipping and falling on wet or slippery surfaces) on left foot and no non- skid sock on the right foot. 3. Resident 44's Actual Fall care plan initiated on 6/13/2024, did not indicate the resident needs assistance during bathing. These deficient practices resulted in Resident 44 from falling on 6/13/2024 and resident sustained left hand fifth digit laceration (skin tear) 0.5- centimeter (cm) x 0.5 cm and left hip redness and placed resident at risk for another fall after 6/13/2024. Findings: During a review of Resident 44's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 44 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), reduced mobility (a physical impairment that limits a person's ability to move around easily or freely), abnormalities of gait and mobility (abnormal walking pattern and ability to move), muscle weakness (loss of muscle strength), and lack of coordination (neurological sign that occurs when the brain's ability to coordinate movement is impaired). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 44's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 3/21/2024, the MDS indicated Resident 44 has severe cognitive (ability to think, learn, remember, use judgement, and make decisions) impairment, used a walker, required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower or bathing and required set up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for walking 10 feet, walking 50 feet with two turns, and walking 150 feet. During a review of Resident 44's Fall Risk Assessments dated 8/11/2020, 6/13/2024 and 9/9/2024, the Fall Risk Assessments indicated Resident 44 is at high risk for falls. During a review of Resident 44's Fall Care Plan, dated 9/16/2021, the Fall Care Plan indicated resident has potential for falls, and indicated interventions to provide assistance during transfer and mobility as needed, provide activities that minimize potential for falls while providing diversion and distraction, and assist to wear non-skid footwear (non- skid socks). The care plan did not indicate resident needs supervision during transfer, walking and assistance during bathing. During a review of Resident 44's Basic Care Needs and Preferences Care Plan, dated 9/16/2021, the Basic Care Needs and Preferences Care Plan indicated Resident 44 needs bathing assistance with one person assist. The care plan also indicated resident needs supervisions from 1 person during transfer and walking. During a review of Resident 44's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change in condition among the residents) notes, dated 6/13/2024, the SBAR indicated resident had a fall in the shower while trying to ambulate without assistance. During a review of Resident 44's Fall Care Plan started on 6/13/2024,the Fall Care Plan indicated resident had a fall during his shower on 6/13/2024. The care plan also indicated the goal was to have no falls or injuries and interventions included mobility and transfer assistance, have resident stand up slowly from a sitting position before attempting to ambulate or stand, instruct to stand, and gain balance before beginning ambulation, wear proper fitting shoes with nonskid soles (nonskid footwear) for ambulation, fall risk assessment, keeping walker within reach, and provide frequent reminders to use walker properly and to wear shoes. The care plan did not indicate interventions to supervise and provide assistance to the resident during shower. During an observation on 10/8/2024 at 9:12 AM in Resident 44's room, Resident 44's bed was on low position. Resident 44 got up from his bed by himself and walked to the restroom without using his walker. Resident 44 was wearing only one non-skid sock. During an interview on 10/9/2024 at 10:05 AM with Certified Nurse Assistant (CNA) 1 in Resident 44's bedroom, CNA 1 stated Resident 44 is a fall risk, and that the resident tends to get up and walk by himself. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review on 10/9/2024 at 2:50 PM with MDS Nurse (MDSN), Resident 44's Fall Risk Assessments dated 8/11/2020, 6/13/2024, and 9/9/2024, Basic Care Needs and Preferences care plan, SBAR notes (dated 6/13/2024), and Fall Care Plans 6/13/2024 were reviewed. MDSN stated Resident 44 was a high risk for fall, fell while in the shower on 6/13/2024 when resident attempted to self-transfer himself to his walker, lost his balance then fell and sustained a laceration on his left hand. MDSN stated, there was a CNA assisting resident during the shower, but CNA turned away to dispose soiled clothes when the fall happened. MDSN stated Resident 44 required supervision during transfer and walking and assistance during bathing so CNA should not leave the resident unattended on 6/13/2024 since it was in the Basic Care Needs and Preference care plan. In addition, MDSN stated, Resident 44's care plan started on 6/13/2024 should be more specific to the resident's needs and should have included the interventions to provide maximal assistance to the resident during bathing. During a follow up interview and review on 10/10/2024 at 2:22 PM with the MDSN, MDSN stated Resident 44's fall care plans, dated 9/16/2021 and 6/13/2024, were not specific to the needs of Resident 44 and were not comprehensive. During a review of the facility's Policies and Procedures (P&P) titled, Care Plan, dated 10/1/2019, indicated care plan goals and objectives are defined as the desired outcome for a specific resident problem, care plans will be modified accordingly, and goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition.

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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** 48903 Based on observation, interview and record review, the facility failed to address a significant unplanned weight loss of greater than five (5) % within 30 days from 9/6/2024 to 10/9/2024 for one (1) of 1 sampled Residents (Resident 62) in accordance with the facility policy. This deficient practice had the potential to cause Resident 62 to experience further weight loss and complications such as skin breakdown, malnutrition (faulty nutrition due to inadequate or unbalanced intake of nutrients), and weakness affecting the resident's over all well-being. Findings: During a review of Resident 62's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and severe obesity (when a person's weight is more than 80 to 100 pounds above their ideal body weight). During a review of Resident 62's History and Physical (H&P) dated 9/6/2024, the H&P indicated Resident 62 had the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS; a federally mandated resident assessment tool) dated 9/26/2024, indicated the resident was assessed to have intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for decision making. Resident 62 was dependent (helper does all effort) when showering, toileting, dressing and putting on footwear. The MDS also indicated Resident 62 was assessed to require partial assistance (helper does half the effort) for upper body dressing. MDS indicated Resident 62 required partial assistance (helper does less than half the effort) for eating, oral hygiene, and personal hygiene. During a concurrent interview and review of Resident 62's Weight Tracking System (WTS) on 10/9/2024 at 2:09 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the WTS indicated Resident 62 weighed 180 pounds (lbs) on 9/6/2024 and 170 lbs on 10/9/2024 resulting in 5.56% weight loss in 30 days. LVN 1 stated, this was considered a significant weight loss for Resident 62 and should have been reporter to MD or Registered Dietitian (RD) by the RN supervisor or so it can be addressed. LVN 1 stated the weight loss can be addressed by adding extra supplements to the resident's diet. LVN 1 stated if they do not notify the doctor about the resident's weight loss, the resident might decline in health and not get supplements to improve. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of Resident 62's WTS dated 9/5/2024 to 10/9/2024 and Interdisciplinary Notes (IDN) dated 9/5/2024 to 10/9/2024 and interview with the MDS Nurse (MDSN) on 10/9/2024 at 3:38 PM, the MDSN stated the WTS and IDN indicated Resident 62 had a 5.56% weight loss within 30 days on 10/1/2024. The MDSN stated there was no documented evidence that MD or RD was notified of Resident 62's unplanned weight loss. MDSN stated, Resident (Resident 62) lost more than 5% in a month from September 2024 (9/6/24) to now (10/9/2024). This is significant weight loss. MDSN stated the facility should have completed a change of condition (COC). MDSN stated the RD would need to monitor and document significant weight loss. There was no documented evidence of MD or RD notification of Resident 62's significant weight loss. MDSN stated Resident 62 was at risk for decline due to MD and RD not being notified to address the weight loss. MDSN stated the MD and RD can order supplements, labs, high calorie supplements, and change the diet if they were notified. MDSN stated, Since MD and RD were not notified, they cannot order these interventions for the resident (Resident 62) and the resident's condition may get worse. During a concurrent review of Resident 62's Nutrition Quarterly Assessment (NQA) and interview with the RD on 10/10/2024 at 2:52 PM, RD stated the NQA indicated that there was no documented evidence of RD addressing Resident 62's significant weight loss. RD stated, The last RD note was made on 9/6/2024. An MD would have to be notified for significant weight loss which was 5% weight loss. The resident can lose fat, have skin breakdown, malnutrition, and weakness if there are no interventions for significant weight loss. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention dated 11/2017, the P&P indicated: 1. The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 2. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. 3. Greater than 5% weight loss within a month is severe weight loss. 4.The multidisciplinary team will identify conditions and medications that may be causing weight loss. During a review of the facility's P&P titled, Change in Condition dated 11/1/2017, the P&P indicated: 1. Facility shall promptly notify the resident and their attending physician of changes in the resident's medical condition or status. 2. The nurse will notify the resident's attending physician when there is a significant change in the resident's physical condition. 3. A significant change of condition is a major decline that will not normally resolve itself without intervention by staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview and record review, the facility failed to administer the correct oxygen level for one (1) of 1 sampled resident (Resident 16) in accordance with physician's order. These deficient practices had the potential to cause Resident 16 to experience shortness of breath (SOB) and desaturation (low oxygen level). Findings: During a review of Resident 16's Face Sheet, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become shallow during sleep). During a review of Resident 16's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/11/2024, the MDS indicated the resident was assessed to have intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for daily decision making. Resident 16 was dependent (helper does all effort) when showering, toileting, dressing lower body and putting on footwear. The MDS also indicated Resident 16 was assessed to require partial assistance (helper does half the effort) for upper body dressing. MDS indicated Resident 16 required setup assistance (helper sets up) for eating, oral hygiene, and personal hygiene. MDS indicated Resident 16 had debility (weakness) and cardiorespiratory (related to the heart and lungs) conditions. MDS indicated Resident 16 required oxygen therapy. During a review of Resident 16's Physician's Orders, dated 7/11/2024, the Physician's Orders indicated to administer oxygen at two (2) to three (3) liters per minute (LPM) every shift. During a review of Resident 16's Care Plan dated 7/11/2023 the CP indicated, Resident 16 will be free from complications. It also indicated staff intervention to administer oxygen per order. During a concurrent observation and interview on 10/8/2024 at 9:51 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 16's oxygen setting was observed to be at 1 LPM. LVN 1 stated, The setting was at 1 LPM. Resident (Resident 16) was supposed to be administered with 2 LPM oxygen. The resident's oxygen level can go down and resident may have SOB if the oxygen setting was not correct. During a concurrent review of Resident 16's Physician Orders, dated 7/11/2024 and interview with LVN 2 on 10/9/2024 at 1:45 PM. LVN 2 stated Resident 16's Physician's Orders indicated to administer oxygen at 2 to 3 LPM every shift. LVN 2 stated, If the oxygen is not set at the correct level of at least 2 LPM, the resident may have SOB and the resident's oxygenation may drop. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, the P&P dated 1/2023, indicated: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The purpose of this procedure is to provide guidelines for safe oxygen administration. 2. Review the physician's orders for oxygen administration. 3. Start the flow oxygen at the rate of 2 to 3 liters per minute

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview and record review, the facility failed to provide pharmaceutical services for two of four sampled residents (Residents 16 and 53) by failing to: 1. Administer Resident 16's diltiazem (medication for high blood pressure and angina [chest pain]) as ordered by the physician. 2. Ensure no expired medication was kept in the medication cart and medication storage room. On [DATE], observed 1 expired bottle of diltiazem (Resident 16's medication), 2 bottles of buspirone (a medication that treats anxiety) and 3 bottle of Blood Sugar Check Machine Control solution (test strips used to check that the meter used to check blood sugar is working properly and is reflecting accurate results). 3. Administer Resident 53's Valproic Acid (medication given to treat Bipolar disorder which is a mental illness that causes extreme mood swings or shifts between mania and depression) as ordered by the physician. These deficient practices placed Resident 16 and Resident 53 at increased risk for being provided with less effective medication and pose a risk to the resident's health by missing a scheduled medication dose. Findings: 1. During a review of Resident 16's Face Sheet, the Face Sheet indicated Resident 16 was originally admitted at the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic diastolic congestive heart failure (a condition where the heart's left ventricle [chamber in heart that receives blood] stiffens and can't relax normally), paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs in brief episodes), hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure [when the force of blood pushing against artery {blood vessel that carries blood from the heart to tissues and organs in the body} walls is consistently too high]). During a review of Resident 16's History and Physical (H&P), dated [DATE], at 11:30 AM, the H&P indicated the plan was to continue administering diltiazem 120 milligram (mg, a unit of measurement) every day for hypertension and paroxysmal atrial fibrillation (A-fib, heartbeat irregularly and often faster than normal). During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 16 has the capacity to understand and make decisions. Resident 16 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, and lower body dressing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's Physicians Orders, dated [DATE], the Physician's Orders indicated diltiazem extended release (ER) 120 mg capsule give 1 tab by mouth daily for hypertension (HTN, high blood pressure [BP]), hold if systolic BP (the maximum pressure in the body's arteries when the heart contracts and pumps blood) less than 100 millimeters of mercury (mmHg). During a review of Resident 16's Care Plan, dated [DATE], the Care Plan indicated cardiovascular disease: has the potential from diagnosis of HTN, hyperlipidemia (HLD, elevated lipids [fat] in the body), A-fib. The care plan indicated provide medication and treatment per physician's orders: diltiazem 1 tablet daily. During a medication observation on [DATE] at 8:20 AM, License Vocational Nurse (LVN) 1 was observed checking Resident 16's medication list in the computer. Observed LVN1 preparing Resident 16's medication for administration by placing each medication in medication cups. Observed LVN 1 take out Resident 16's medication bottle, labeled diltiazem ER 120 mg ER with expiration date of [DATE] and placed one tablet inside medication cup. LVN 1 then proceeded to get ready to administer medication to Resident 16. During the same interview with LVN 1 on [DATE] at 8:28 AM, when surveyor instructed LVN 1 to double check the medication bottle for the diltiazem, LVN1 confirmed the medication bottle was in fact expired and had an expiration date of [DATE]. LVN1 stated, the nurses usually check medication carts every morning. I should have checked every medication to see if any were expired. If the resident would have taken expired medication, the resident could get ill, would not get the right dose or the desired effect of the medication. During an interview with MDS Nurse (MDSN) on [DATE] at 1:03 PM, MDSN stated, an expired medication should not be inside the medication cart because if given to the resident it can cause harm and will not have the correct medication effect. 2. During observation of the facilities medication room in Station 1 on [DATE] at 10:53 AM, a total of two unopened Buspirone 10 mg bottles with expiration date of [DATE] and 3 Blood Sugar Check Machine Control solution with expiration date of [DATE] were mixed in with private pay bin container medications. During an interview with LVN 3 on [DATE] at 10:55 AM, LVN 3 stated there were multiple expired medication bottles, buspirone and blood sugar check machine control solution mixed in with other medications inside the medication room in Station 1. LVN 3 stated, Expired medication should not be mixed in with other medication even if it is not opened. If this medication would be given to the resident it can cause harm to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 53's Face Sheet, the Face Sheet indicated Resident 53 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to dysphagia (difficulty swallowing food or liquids), oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), encounter for attention to gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach. Gastrostomy is used to provide a route for tube feeding if needed for four weeks or longer, and/or to vent the stomach for air or drainage) paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), ulcer (open sores) of esophagus (the part of the canal that connects the throat to the stomach) without bleeding. A review of Resident 53's H&P dated [DATE], the H&P indicated Resident 53 does not have the capacity to understand and make decisions. A review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathing, lower body dressing and personal hygiene. During an observation and interview with LVN 1 on [DATE] at 9:39 AM, LVN 1 signed in to the computer located on the medication cart, reviewed Resident 53's medications, unlocked medication cart and pulled out an empty bottle of Valproic Acid 250mg solution. LVN 1 stated the Valproic acid bottle was empty, and she would go check in the medication room to see if there were any extra. During a concurrent interview with LVN 1 on [DATE] at 9:46 AM, LVN 1 stated she did not find another Valproic acid bottle for Resident 53 in either of the nursing station medication rooms. LVN 1 stated, The doctor and pharmacy should have been notified immediately if the medication bottle was empty. I will not be able to give this medication to the resident right now. During an interview with LVN 3 on [DATE] at 10:53 AM, LVN 3 stated, The nurses have to check the resident's medication inside the carts for expired or empty containers. There should always be enough supply of the resident's medications inside the cart. When a nurse uses up the last of the medication, the nurse must peel the name tag off and throw the bottle away. But before that is done, the nurse must check the label. The tag has the information of when we can refill the medication so we can call the pharmacy and request more. This way the resident always has medication available. Technically the last person that used the medication should call the pharmacy to refill it. That is not always the case, but it is very important to do so because it can cause harm to the resident if they do not get their medication on time. During an interview with MDSN on [DATE] at 1:03 PM, MDSN stated, As soon as the nurse notices the resident's medication is empty, the nurse must call the doctor and the pharmacy right away to refill and notify the doctor. If it is not done the resident would not have medication, it can cause the resident harm even if they only miss one dosage, it might hurt the resident. The nurse should call even before the medication is completely gone; they should call the pharmacy for a refill immediately. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration General Guidelines, the P&P indicated no expired medication will be administered to a resident. The P&P also indicated medications are administered in accordance with the written orders of the prescriber. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P undated titled, Medication Ordering and Receiving from Pharmacy Provider, the P&P indicated floor stock medications kept in the original manufacturer's container must have the expiration date and lot numbers clearly labeled.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solheim Senior Community	2236 Merton Ave. Los Angeles, CA 90041

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 53) was free from unnecessary use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure Resident 53 has the specific target behavior and indication for the use and monitoring of quetiapine (Seroquel, to treat certain mental/mood disorders). This deficient practice had the potential to place Resident 53 at risk for significant adverse (harmful) consequences from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 53's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a type of mental health condition). During a review of Resident 53's History and Physical (H&P), dated 7/5/2024, the H&P indicated Resident 53 does not have the capacity to understand and make decisions due to schizophrenia. During a review of Resident 53's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/11/2024, the MDS indicated Resident 53's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS did not indicate presence of behavioral or mood symptoms. The MDS indicated Resident 53 required substantial/maximal assistance (helper does more than the effort) with eating and upper body dressing. The MDS also indicated Resident 53 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bath, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 53 received antipsychotic medication (any drug that affects brain activities associated with mental processes and behavior) on a routine basis. During a review of Resident 53's Care Plan (CP), dated 1/24/2024, the CP indicated Resident 53 has impaired behavior related to anxiety and schizoaffective disorder as evidenced by screaming loud when all needs are met, episodes of angry outbursts, and inability to sleep. The goal indicated that Resident 53 will demonstrate optimal ADL functioning and safety. The staff interventions were as follows: Behavior monitoring program to assist in determining cause and triggers. Intervene as necessary to ensure safety of resident and other. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Divert attention from stimulus. Avoid the following identified triggers. Administer quetiapine as ordered and monitor for effectiveness and adverse side effects. Document as appropriate. During a review of Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) notes, dated 6/11/2024, the Psychiatrist notes indicated Resident 53 has outburst episodes, becomes aggressive during shower, yells during sleep, and gets combative when someone changes her. During a review of Resident 53's Physician's Order, the Physician's Order indicated the following: Quetiapine 200 mg tablet for schizoaffective disorder manifested by inability to cope with external stimuli affecting ADLs, with order date of 7/3/2024. Monthly behavioral summary for diagnosis of schizophrenia, with order date of 6/9/2023 Monitor behavior of inability to cope with external stimuli causing affecting ADLs every shift. With order date of 6/9/2023. During a concurrent review of Resident 53's medical records and interview with Licensed Vocational Nurse 4 (LVN 4) on 10/11/2024 at 8:10 AM, LVN 4 verified Resident 53 has an active order of quetiapine for schizoaffective, ordered on 7/3/2024. LVN 4 stated that schizoaffective was not indicated as a diagnosis in Resident 53's face sheet. LVN 4 was unable to provide documented evidence of Resident 53's diagnosis of schizoaffective. LVN 4 stated that Resident 53 has episodes of mood swings. LVN 4 stated sometimes Resident 53 was calm and sometimes was uncooperative with care where in resident would refuse to be taken cared of by the staff. LVN 4 stated it was important to have a correct physician order with the specific target behavior before administering medication to ensure Resident 53 receives the correct medication for the correct reason. During a concurrent review of Resident 53's medical records and interview with MDS Nurse (MDSN) on 10/11/2024 at 8:40 AM, she verified Resident 53 has an order of quetiapine for schizoaffective manifested by inability to cope with external stimuli affecting ADLs, ordered on 7/3/2024. MDSN stated Inability to cope with external stimuli affecting ADLs is not a specific behavior, not a target a behavior. MDSN stated she did not know why Seroquel was ordered for schizoaffective because Resident 53 only has a diagnosis of schizophrenia. MDSN was unable to provide a documented evidence of Resident 53's diagnosis of schizoaffective. MDSN added that she had observed Resident 53 having behaviors of screaming and hallucination (when a resident hears voices, sees things, or smells things others cannot perceive) when Resident 53 had verbalized seeing and hearing something that does not exist. MDSN stated Seroquel order with a specific target behavior was necessary, so the staff know what the medication is for. The MDSN stated that psychotropic drugs need monitoring of specific target behavior so the facility would know if the behavioral management was effective or not. During an interview on 10/11/2024 at 8:47 AM, Social Service Designee (SSD) stated Resident 53's Seroquel order is for her behavior of refusing care, and episodes of yelling and screaming. SSD also stated, Inability to cope can be manifested by many ways. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 53's medical records and interview with Assistant Director of Nursing (ADON) on 10/11/2024 at 11:45 AM, ADON stated Resident 53 has a behavior of being verbally aggressive to staff, screaming out, striking staff, inability to relax, and verbalization of inability to breath. ADON verified that these behaviors were not indicated in Resident 53's quetiapine order, instead it was generalized as inability to cope. ADON stated the behavior indicated on the physician's order for the use of quetiapine was not specific. ADON stated the behavior should be specific so the nurses can monitor the behavior accurately. ADON also stated that Resident 53's medical records indicated a diagnosis of schizophrenia, and no documented evidence of a schizoaffective diagnosis. ADON stated that quetiapine order should have been clarified for the correct indication of use and specific behavior it was ordered for. During a review of the Facility's Policy and Procedure (P&P) titled, Monitoring of Psychotropic Medication, dated 10/1/2019, the P&P indicated when monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences. After initiating or increasing the dose of a psychotropic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, if not more often) to determine the potential for reducing or discontinuing the dose based on therapeutic goals and any adverse effects or functional impairment. It also indicated antipsychotic medications must be thoroughly documented in the medical record. Antipsychotic medications may be indicated if behavioral symptoms present a danger to the resident or others, and expressions or indications of distress that are significant distress to the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to ensure the medication error (any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, patient) rate during medication pass observation on [DATE] was not above (5) percent (%). The outcome was two (2) medication errors out of twenty-eight (28) opportunities for errors, which resulted in a Medication Administration Error Rate of 7.1%. Findings: 1. During a review of Resident 16's Face Sheet, , the Face Sheet indicated Resident 16 was originally admitted at the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic diastolic congestive heart failure (a condition where the heart's left ventricle [chamber in heart that receives blood] stiffens and can't relax normally), paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs in brief episodes), hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure [when the force of blood pushing against artery {blood vessel that carries blood from the heart to tissues and organs in the body} walls is consistently too high]). During a review of Resident 16's History and Physical (H&P), dated [DATE] at 11:30 AM, the H&P indicated the plan was to continue administering diltiazem 120 milligram (mg, a unit of measurement) every day for hypertension and paroxysmal atrial fibrillation (A-fib, heartbeat irregularly and often faster than normal). During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 16 has the capacity to understand and make decisions. Resident 16 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, and lower body dressing. During a review of Resident 16's Physicians Orders, dated [DATE], Physicians Orders indicated, diltiazem extended release (ER) 120 mg capsule give 1 tab by mouth daily for hypertension (HTN, high blood pressure [BP]), hold if systolic BP (the maximum pressure in the body's arteries when the heart contracts and pumps blood) less than 100 millimeters of mercury (mmHg). During a review of Resident 16's Care Plan, dated [DATE], the Care Plan indicated cardiovascular disease: has the potential from diagnosis of HTN, hyperlipidemia (HLD, elevated lipids [fat] in the body), A-fib. The care plan indicated provide medication and treatment per physician's orders: diltiazem 1 tablet daily. During a medication pass observation on [DATE] at 8:20 AM, License Vocational Nurse (LVN) 1 was observed checking Resident 16's medication list in the computer. Observed LVN1 preparing Resident 16's medication for administration by placing each medication in medication cups. Observed LVN 1 take out Resident 16's medication bottle, labeled diltiazem ER 120 mg ER with expiration date of [DATE] and placed one tablet inside medication cup. LVN 1 then proceeded to get ready to administer medication to Resident 16. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview with LVN 1 on [DATE] at 8:28 AM, when surveyor instructed LVN 1 to double check the medication bottle for the diltiazem, LVN1 confirmed the medication bottle was in fact expired and had an expiration date of [DATE]. LVN1 stated, the nurses usually check medication carts every morning. I should have checked every medication to see if any were expired. If the resident would have taken expired medication, the resident could get ill, would not get the right dose or the desired effect of the medication. During an interview with MDS Nurse (MDSN) on [DATE] at 1:03 PM, MDSN stated, an expired medication should not be inside the medication cart because if given to the resident it can cause harm and will not have the correct medication effect. 2. During a review of Resident 53's Face Sheet, the Face Sheet indicated Resident 53 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to dysphagia (difficulty swallowing food or liquids), oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), encounter for attention to gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach. Gastrostomy is used to provide a route for tube feeding if needed for four weeks or longer, and/or to vent the stomach for air or drainage) paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), ulcer (open sores) of esophagus (the part of the canal that connects the throat to the stomach) without bleeding. During a review of Resident 53's H&P, dated [DATE], the H&P indicated Resident 53 does not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathing, lower body dressing and personal hygiene. During an observation and interview with LVN 1 on [DATE] at 9:39 AM, LVN 1 signed in to the computer located on the medication cart, reviewed Resident 53's medications, unlocked medication cart and pulled out an empty bottle of Valproic Acid 250mg solution. LVN 1 stated the Valproic acid bottle was empty, and she would go check in the medication room to see if there were any extra. During a concurrent interview with LVN 1 on [DATE] at 9:46 AM, LVN 1 stated she did not find another Valproic acid bottle for Resident 53 in either of the nursing station medication rooms. LVN 1 stated, the doctor and pharmacy should have been notified immediately if the medication bottle was empty. I will not be able to give this medication to the resident right now. During an interview with LVN 3 on [DATE] at 10:53 AM, LVN 3 stated, the nurses have to check the resident's medication inside the carts for expired or empty containers. There should always be enough supply of the resident's medications inside the cart. When a nurse uses up the last of the medication, the nurse must peel the name tag off and throw the bottle away. But before that is done, the nurse must check the label. The tag has the information of when we can refill the medication so we can call the pharmacy and request more. This way the resident always has medication available. Technically the last person that used the medication should call the pharmacy to refill it. That is not always the case, but it is very important to do so because it can cause harm to the resident if they do not get their medication on time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MDSN on [DATE] at 1:03 PM, MDSN stated, as soon as the nurse notices the resident's medication is empty, the nurse must call the doctor and the pharmacy right away to refill and notify the doctor. If it is not done the resident would not have medication, it can cause the resident harm even if they only miss one dosage, it might hurt the resident. The nurse should call even before the medication is completely gone; they should call the pharmacy for a refill immediately. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration General Guidelines, the P&P indicated no expired medication will be administered to a resident. During a review of the facility's undated P&P titled, Medication Ordering and Receiving from Pharmacy Provider, the P&P indicated floor stock medications kept in the original manufacturer's container must have the expiration date and lot numbers clearly labeled.

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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** 45523 Based on observation, interview, and record review, the facility failed to ensure: 1. Resident 53's medication bottle for sucralfate (to prevent ulcers [open sores]) was labeled in accordance with doctor's orders and included the appropriate cautionary instructions regarding administration route. This deficient practice had the potential to harm Resident 53 due to potential dispensing and administration errors (incorrect route) and can possibly lead to adverse side effects, aspiration, and/ or death. 2. Resident 16's expired diltiazem (treats high blood pressure and prevents chest pain) was not stored in the facility's medication cart. This deficient practice had the potential for harm to Resident 16 due to the potential loss of strength of the drug, and for the residents to not receive the full effect of the medication. Findings: 1. During a review of Resident 53's Face Sheet, the Face Sheet indicated Resident 53 was originally admitted at the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to dysphagia (difficulty swallowing food or liquids), oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), encounter for attention to gastrostomy tube (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach. Gastrostomy is used to provide a route for tube feeding if needed for four weeks or longer, and/or to vent the stomach for air or drainage) paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), ulcer (open sores) of esophagus (the part of the canal that connects the throat to the stomach) without bleeding. During a review of Resident 53's History and Physical (H&P), dated [DATE], the H&P indicated Resident 53 does not have the capacity to understand and make decisions. During a review of Resident 53's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 53 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathing, lower body dressing and personal hygiene. During a review of Resident 53's Physician's Orders, dated [DATE], the Physician's Orders indicated Diet: pureed foods (all food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) thin liquid diet consistencies (refers to thickness of liquid, example jello, ice cream), three times a day. The order also indicated to administer sucralfate 100 milligram/ milliliter (mg/ ml) oral suspension to give 10 ml by G- tube. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication observation on [DATE] at 9:54 AM, Licensed Vocational Nurse 1 (LVN 1) prepared Residents 53's medication on side table. Observed LVN 1 approach closely to check placement and residual of Resident 53's G-Tube. LVN 1 then proceeded to flush g-tube (flush tube with warm water after each medication to keep it from becoming clogged) with water and administered Resident 53's Sucralfate 10 milliliter (ml, unit of measurement) suspension medication through gravity (administered above the patient at a specific height to create the desired flow pressure and flow rate). During concurrent interview with LVN 1 on [DATE] 10:00 AM, LVN 1 stated Resident 53 had a pureed diet and did eat and took medications by mouth. When surveyor instructed LVN 1 to double check the medication bottle for administration route, LVN 1 confirmed directions on sucralfate medication bottle indicated to take by mouth, however, LVN 1 pointed out that on Resident 53's Medication Administration Record (MAR) on the computer it indicated to administer via g- tube. LVN 1 stated Resident 53's sucralfate bottle had the wrong label of route of administration of medicine, and she was following what is in the MAR. LVN 1 stated the pharmacy provided the label instructions on the bottle. LVN 1 stated she should have checked the label in sucralfate bottle and clarified with either the doctor or the pharmacy before administrating the medication to Resident 53. During a concurrent interview with MDS Nurse (MDSN) on [DATE] at 1:05 PM, MDSN stated, a medication label must specify route (if by mouth or by g-tube) to give to resident. It is nursing basic to check name, route, time, and dose of the medication order. MDSN stated, if the directions are not followed it can cause harm to a patient in case it was given the wrong route. If the directions are to be given by mouth and the patient has a g-tube, we do not know if the patient can swallow, they might have dysphagia (difficulty swallowing food or liquids) or be at risk for aspiration. We do not know if it is safe, it can cause death to a patient, it is high risk. If g-tube patient has medication label indicating by mouth the medication should not be given via g-tube. We have to follow doctor's orders, also risk to resident for other injury, again, it can cause harm and possibly death. A g-tube patients medication label should not indicate by mouth and computer system indicate via g-tube. The nurse has to verify the order with the doctor before doing anything else, this can also cause harm because the right route needs to be clarified. 2. During a review of Resident 16's Face Sheet, the Face Sheet indicated Resident 16 was originally admitted at the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic diastolic congestive heart failure (a condition where the heart's left ventricle [chamber in heart that receives blood] stiffens and can't relax normally), paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs in brief episodes), hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure [when the force of blood pushing against artery {blood vessel that carries blood from the heart to tissues and organs in the body} walls is consistently too high]). During a review of Resident 16's H&P, dated [DATE] at 11:30 AM, the H&P indicated the plan was to continue administering diltiazem 120 milligram (mg, a unit of measurement) every day for hypertension and paroxysmal atrial fibrillation (A-fib heartbeat irregularly and often faster than normal). During a review of Resident 16's MDS. the MDS dated [DATE] indicated Resident 16 has the capacity to understand and make decisions. Resident 16 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, and lower body dressing. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 16's Physicians Orders, dated [DATE], the Physician's Orders indicated, diltiazem extended release (ER) 120 mg capsule give 1 tab by mouth daily for hypertension (HTN, high blood pressure [BP]), hold if systolic BP (the maximum pressure in the body's arteries when the heart contracts and pumps blood) less than 100 millimeters of mercury (mmHg). During a review of Resident 16's Care Plan dated [DATE], the Care Plan indicated cardiovascular disease: has the potential from diagnosis of HTN, hyperlipidemia (HLD, elevated lipids [fat] in the body), A-fib. The care plan indicated provide medication and treatment per physician's orders: diltiazem 1 tablet daily. During a medication observation on [DATE] at 8:20 AM, LVN 1 was observed checking Resident 16's medication list in the computer. Observed LVN1 preparing Resident 16's medication for administration by placing each medication in medication cups. Observed LVN 1 take out Resident 16's medication bottle, labeled diltiazem ER 120 mg ER with expiration date of [DATE] and placed one tablet inside medication cup. LVN 1 then proceeded to get ready to administer medication to Resident 16. During the same interview with LVN 1 on [DATE] at 8:28 AM, when surveyor instructed LVN 1 to double check the medication bottle for the diltiazem, LVN1 confirmed the medication bottle was in fact expired and had an expiration date of [DATE]. LVN1 stated, the nurses usually check medication carts every morning. I should have checked every medication to see if any were expired. If the resident would have taken expired medication, the resident could get ill, would not get the right dose or the desired effect of the medication. During an interview with MDSN on [DATE] at 1:03 PM, MDSN stated, an expired medication should not be inside the medication cart because if given to the resident it can cause harm and will not have the correct medication effect. During observation of the facility's medication room in Station 1 on [DATE] at 10:42 AM, a total of two unopened Buspirone (a medication that treats anxiety) 10mg (a unit of measure) bottles with expiration date of [DATE] and True Metric Level 3 Control solution (test strips used to check that the meter used to check blood sugar and performing correct results) with expiration date of [DATE] were mixed in with Private pay bin container medications. During an interview with LVN 3 on [DATE] at 10:55 AM, LVN3 confirmed there were multiple expired medication bottles mixed in with other medications inside the medication room. LVN3 stated, expired medication should not be mixed in with other medication even if it's not opened. If this medication would be given to the resident it can cause harm to the resident. During an interview with Minimum Data Set Nurse (MDS) on [DATE] at 1:03 PM, MDS stated, an expired medication should not be inside the medication cart because if given to the resident it can cause harm and will not have the correct medication effect. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration General Guidelines, the P&P indicated no expired medication will be administered to a resident. The P&P also indicated, prior to medication administration, the medication and dosage schedule on the resident's MAR is compared to the medication label. The P&P indicated, if the medication label and MAR are different and the container is not flagged indicating change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. The P&P also indicated, apply a direction change sticker to label if direction have changed form the current label. During a review of the facility'sundated P&P titled, Medication Ordering and Receiving from Pharmacy Provider, the P&P indicated floor stock medications kept in the original manufacturer's container must have the expiration date and lot numbers clearly labeled. The label should also include medication name, quantity, and expiration date.

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Solheim Senior Community	2236 Merton Ave. Los Angeles, CA 90041

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: 1. Label food items in the kitchen. 2. Discard expired food in the kitchen. 3. Discard dented soda can found in storage room. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization . Findings: During a concurrent observation and interview on [DATE] at 8:17 AM with kitchen staff (KS) 1, a tray of breaded fish was observed on a rack. The tray was not labeled with a preparation date or an expiration date. KS 1 stated the food item was breaded fish and it was not labeled. It should have been labeled with a preparation date and expiration date when it was prepared. During a concurrent observation and interview on [DATE] at 8:20 AM with KS 1, an open box of [NAME] Dean Sausages was observed without a label indicating the open date. KS 1 stated the box was not and should have been labeled with the date it was opened to ensure it was safe for the residents to eat. During a concurrent observation and interview on [DATE] at 8:24 AM with KS 1. A bread rack with about 35 bread packs with an expiration date of [DATE] was observed. KS 1 stated, All the breads were expired, I'll throw them out. They can make residents sick if they eat them. During a concurrent observation and interview on [DATE] at 8:45 AM with KS 1, a bag of walnuts and a bag of almonds were observed without a label indicating opened date. KS 1 stated the bag of walnuts and bag of almonds were not and should have been labeled with an open date. KS 1 stated, We do not know how old these food items were and might make the residents sick if they eat them. During a concurrent observation and interview on [DATE] at 9:27 AM with KS 1, five overripe, black in color bananas were observed in the refrigerator. KS 1 stated, Those bananas are black and not good anymore. I'll throw them out because they can get the residents sick if they eat them. During a concurrent observation and interview on [DATE] at 10:05 AM with KS 1, a dented soda can was observed among other beverages and not stored in a designated area for dented cans in the storage room. KS 1 stated, That soda can is dented and not good anymore. I'll throw it out. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, dated , d+[DATE], the P&P indicated: 1. All food items shall be stored in a manner as to prevent contamination and maintain the safety for human consumption. 2. Discard food past the use-by or expiration date. 3. Cover, label and date unused portions and open packages. 4. Maintain designated area for items that are damaged (such as dented cans) that are to be returned for credit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to follow its infection control policy for four (4) of 18 sampled residents (Resident 19, 60, 9 and 53) by failing to ensure: 1. 2. and 3. Staff were using a gown while providing wound care treatment to Residents 19, 60 and 9, who were on enhanced barrier precaution (EBP, an infection control practice that involves wearing gowns and gloves during high-contact activities with residents in nursing homes). 4. Staff was using a gown while administering medication via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems) tube to Resident 53 who was on enhanced barrier precaution. This deficient practice had the potential to result in Resident 19, 60, 9 and 53 developing an infection and spread of infection among staff and residents. Findings: 1. During a review of Resident 19's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 19 was originally admitted to the facility on [DATE]. Resident 19's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness. During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/28/2024, the MDS indicated Resident 19's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). It also indicated Resident 19 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 19's Physician's Order, dated 8/20/2024, the Physician's Order indicated a treatment order for coccyx (tailbone) and bilateral buttocks scattered moisture associated skin damage (MASD, caused from prolonged exposure to moisture). It indicated to cleanse with normal saline (used to clean wounds) and apply barrier cream (used to protect the skin from moisture, friction, and pressure to help prevent and treat bed sores) daily. During a wound care observation on 10/10/2024 at 8:29 AM in Resident 19's room, with Treatment Nurse 1 (TN 1) and Certified Nurse Assistant 4 (CNA 4), TN1 was observed not wearing a gown while providing wound care treatment to Resident 19. CNA 4 was also observed not wearing a gown while assisting TN1 with positioning Resident 19 during wound care treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with TN 1 on 10/10/2024 at 10:30 AM, TN1 stated that she did not wore a gown when she provided wound care treatment for Resident 19. TN1 stated that she should have also worn a gown and not only gloves during wound care treatment. TN 1 verified that there was no documented evidence that EBP should be implemented for Resident 19. TN 1 added that EBP should have been ordered and added in Resident 19's care plan. TN 1 stated that there was no EBP signage outside Resident 19's room to alert staff and visitors to wear appropriate PPE while rendering close contact care to Resident 19. TN1 stated that she's new in the facility and she did not know the facility's policy and procedure if EBP will be applied during wound care treatment. During an interview on 10/10/2024 at 2:40 PM, CNA 4 stated that she did not wear a gown when she assisted TN 1 during wound care treatment. CNA 4 stated Resident 19 need to be held and assisted while TN 1 was doing wound care treatment on Resident 19's back area. During a concurrent review of facility's policy and procedure titled, Isolation, dated 4/2024, and interview with Assistant Director of Nursing (ADON) on 10/11/2024 at 11:33 AM, ADON stated that facility follows and practices Centers for Disease Control and Prevention (CDC, national public health agency) guidelines when it comes to enhance barrier precautions. ADON stated the facility policy indicated to use EBP for residents with indwelling (inside your body) medical devices, wounds, or other high-risk factors. ADON also stated that policy indicated to apply EBP during high-contact resident care activities such as dressing, bathing, wound care and changing linens. ADON stated the personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) requirements for EBP is for staff to wear gloves and gowns during high contact care activities for residents on EBP. ADON stated TN 1 and CNA 4 should have worn a gown during wound care treatment to Resident 19 because both staff were in close contact with Resident 19. 2. During a review of Resident 60's Face Sheet, the Face Sheet indicated Resident 60 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 60's diagnoses included sepsis (a life-threatening blood infection), Benign prostatic hyperplasia (BPH, needing to urinate frequently), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 60's Physician's Progress Notes, dated 10/2/2024, the Physician's Progress Notes indicated Resident 60's active problems included cholecystostomy (a minor procedure that creates a surgical opening in your gallbladder, usually to place a catheter [tube] in it. The tube can drain excess bile and fluids when your gallbladder is swollen, blocked and/or infected) care, Foley catheter (a flexible tube that drains urine from the bladder into a collection bag outside the body), and sacral pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive skills for daily decision making was intact. MDS indicated Resident 60 required supervision (helper provide verbal cues or contact guard as resident completes activity) with eating and required partial/moderate assistance (helper does more than half the effort) with oral hygiene. MDS also indicated Resident 60 required substantial/maximal assistance (helper does more than the effort) with toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a wound care observation on 10/10/2024 at 9:37 AM in Resident 60's room, with TN 1 and CNA 5, TN1 was observed not wearing a gown while providing wound care treatment to Resident 60. CNA 4 was also observed not wearing a gown while assisting TN1 with positioning Resident 60 during wound care treatment. During an interview on 10/10/2024 at 9:45 AM, Infection Preventionist Nurse (IPN) stated the facility does adhere EBP, wherein PPE, such as wearing gown, gloves, and mask, is needed during physical contact care like wound care treatment. During a concurrent observation outside of Resident 60's room and interview on 10/10/2024 at 10:20 AM with CNA 5, CNA 5 stated there was no sign and PPE cart outside Resident 60's room to alert staff and visitors of the need to use gown [NAME] gloves before entering the room when conducting high contact activities to Resident 60. CNA 5 stated that she did not wore a gown when she assisted TN 1 with Resident 60's wound care treatment. CNA 5 stated that she did not know that a gown should be worn when assisting during wound care. During an interview with TN 1 on 10/10/2024 at 10:32 AM, TN1 stated that she did not wore a gown when she provided wound care treatment for Resident 60. TN1 stated that she should have also worn a gown and not only gloves during wound care treatment and foley catheter care. TN 1 verified that there was no documented evidence that EBP should be implemented for Resident 60. TN 1 stated that there was no EBP signage outside Resident 60's room to alert staff and visitors to wear appropriate PPE while rendering close contact care to Resident 60. TN1 stated wearing PPE was important to protect the resident. TN1 stated staff providing care to Resident 60 should wear the proper PPE for infection control because Resident 60 has a foley catheter and wound. 49537 3. During a review of Resident 9's Face Sheet, the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder with lewy bodies (a type of progressive dementia [progressive state of decline in mental abilities] that leads to a decline in thinking, reasoning, and independent function), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), protein-calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel leading to reduced blood flow and potential tissue damage). During a review of Resident 9's H&P, dated 12/21/2023, the H&P indicated resident does not have and has fluctuating capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], the MDS indicated resident has moderately impaired cognitive (ability to think, learn, remember, use judgement and making decisions) skills for daily decision making. Resident 9 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathing self, lower body dressing, and required substantial or maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's Physician's Orders for 10/9/2024, the Physician's Orders indicated treatment orders for left sacrum pressure injury (wound that occurs as a result of prolonged pressure on a specific area of the body), left great toe diabetic wound (an ulcer that does not heal properly and is a complication of diabetes), and moisture associated skin damage (MASD - a general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, or wound drainage) daily. During an observation in Resident 9's room on 10/10/2024 at 1:46 PM, TN 1 and CNA 1 did not wear personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments), specifically a gown, while providing wound care to Resident 9 and while CNA 1 was holding resident in position for wound care. Observed Identification badge (ID-card giving identifying data about a person [name and photograph]) and front part of scrubs (protective garment worn by medical personnel) of TN 1 and CNA 1 touching Resident 9's bed surface and resident's arms. During a concurrent review of the facility's Policies and Procedures (P&P), titled Wound Care and Infection Control and interview with TN1 on 10/10/2024 at 2:44 PM, TN 1 stated she did not wear a gown. TN 1 added it was important to wear a gown to protect the resident and herself from pathogens (microorganisms that can cause infections or diseases) and prevent the spread of said pathogens. TN 1 stated she did not follow the policy and procedure when performing wound care to Resident 9. TN 1 stated there was no signage by Resident 9's door with PPE supplies to be used. During an interview on 10/11/2024 at 11:25 AM, CNA 1 stated he forgot to wear a gown when he assisted TN 1 while providing wound care the day before to Resident 9 because there was no signage and supply of PPEs by Resident 9's door. CNA 1 stated should have worn a gown to prevent the spread of germs to others and himself when assisting TN1 with wound care to Resident 9 because this was considered a high contact resident care. During a review of the facility's undated P&P titled, Wound Care, the P&P indicated PPE will be necessary when performing this procedure, gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. During a review of the facility's P&P titled, Infection Control, Isolation - Categories of Transmission-Based Precautions, dated 4/2024, the P&P indicated Enhanced Barrier Precautions are also used to prevent the spread of multidrug-resistant organisms (MDROs-microorganisms, mainly bacteria, that are resistant to multiple classes of antibiotics [a medicine that inhibits the growth of or destroys microorganisms] and antifungals [drug that treats infections caused by fungi]) and other pathogens during high contact care activities, even if traditional isolation is not required. Enhanced Barrier Precautions should be applied during high contact resident care activities such as dressing, bathing, wound care, device care, and changing linens. 45523 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 53's Face Sheet, the Face Sheet indicated Resident 53 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to dysphagia (difficulty swallowing food or liquids), oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), encounter for attention to gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach. Gastrostomy is used to provide a route for tube feeding if needed for four weeks or longer, and/or to vent the stomach for air or drainage), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and ulcer (open sores) of esophagus (the part of the canal that connects the throat to the stomach) without bleeding. During a review of Resident 53's H&P, dated 7/5/2024, the H&P indicated Resident 53 does not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathing, lower body dressing and personal hygiene. During a medication observation on 10/9/2024 at 9:54 AM, Resident 53 was observed touching LVN 1's arm and clothing. LVN 1 prepared Residents 53's medication on side table, donned gloves, but did not wear a gown. Observed LVN 1 check placement and residual of Resident 53's G-tube (a surgically inserted tube that provides a way to deliver nutrition, fluids, and medications directly to the stomach). LVN 1 then proceeded to flush (flush tube with warm water after each medication to keep it from becoming clogged) Resident 53's G-tube and administered Resident 53's medication through gravity (administered above the resident at a specific height to create the desired flow pressure and flow rate) one by one. Observed LVN1's clothing coming into contact with Resident 53's bed linen and Resident 53 was observed to continue touching LVN 1's arm and hitting LVN1's leg. During an observation outside Resident 53's room on 10/9/2024 at 1:24 PM, there were no PPE containers (storage units that are used to store personal protective equipment) observed outside or near resident 53's room. During an interview with the Assistant Director of Nursing (ADON) on 10/9/2024 at 1:51 PM, the ADON stated there were no residents on Transmission Based Precautions (TBP) or Enhanced Based Precautions (EBP). During a review of the facility's undated P&P titled, Gastrostomy/ Jejunostomy Site (a soft, plastic tube placed through the skin of the abdomen [the belly] into the midsection of the small intestine [between the stomach and the large intestine, the colon]) Care, indicated, The purpose of the procedure are to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection. Equipment and Supplies Personal protective equipment (gowns, gloves, mask, etc., as needed)