STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555441	A. Building B. Wing	02/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital of Gardena D/P Snf	1145 W. Redondo Beach Gardena, CA 90247

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on observation, interview and record review, the facility failed to: 1. Ensure one of 27 sampled residents (Resident 4), was properly assessed for dry and crusty (rough or thickened texture) skin on his left palm. This deficient practice resulted in lack of or delay in care for Resident 4 and potential risk for skin breakdown. Findings: During an observation on 2/15/2024 at 8:25 a.m. in Resident's 4 room. Resident 4 was laying on the bed and unable to verbally communicate. Resident 4's left hand was closed with very dry skin white in color and rough. During a review of Resident 4's admission record, the admission record indicated Resident 4 was admitted on [DATE], with diagnoses that included cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain), tracheostomy (allows air to pass into the windpipe to help with breathing.), and coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked.) During a review of Resident 4's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 12/2/2024, the MDS indicated Resident 4 was rarely/never understood and rarely/never understand. The MDS indicated Resident 4 required dependent assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 4's TAR dated 2/2025, the TAR did not indicate Resident 4 had a left palm treatment order. During a concurrent observation and interview on 2/16/2025 at 9:52 a.m. with Treatment nurse (TN) 2 TN 2 was observed washing Resident's 4 right hand with water and soap. the skin to tear and keep moisten. It is important to check the skin daily. TN 2 proceeds to applied ammonium lactated lotion (indicated for the treatment of dry, scaly skin) to the right palm. TN 2 observed Resident's 4 left palm and stated the skin looks dry and is at risk for a skin breakdown. TN 2 stated (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin assessments are done weekly in every shower day. TN 2 stated yes the left palm is with very dry skin. TN 2 stated I will call the doctor to get an order to applied same lotion to the left palm. TN 2 stated, it is important to keep the skin moist to prevent skin breakdown and assess the skin every day. During an interview on 2/16/2025 at 4:35 p.m. with TN 2, TN 2 stated I called the doctor, and he told me to apply same lotion to the left palm. TN 2 stated in the left hand I was not putting any lotion because I did not call the doctor. During an interview on 2/16/2025 at 5:31 p.m. with the Director of Nursing (DON), the DON stated nurses need to assess and monitor wounds. The DON stated it is very important to assess Residents skin every day. The DON stated if any issues find with skin, nurses need to call the doctor and documented a changed of condition. The DON stated nurses need to follow the treatment doctor recommended. The DON stated, it is not acceptable that nurses do not assess Resident skin every day. During a review of the facility's policy and procedure (P&P) titled, Change in Resident Conditions, dated 4/2013, the P&P indicated, routine medical changes, all symptoms and unusual signs will be communicated to the physician promptly. This included a minor change in physical and mental behavior. During a review of the facility's P&P titled, Scope of Care, dated 1/2025, the P&P indicated, methods used to assess and meet patient needs: Re-assessment ongoing assessment in collaboration with IDT. Extent to which level of care of services meets patient's needs: skilled wound care treatment.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, and interview, the facility failed to: 1.Implement turning interventions in accordance with the facility's policies and procedures (P/P) for one of 27 sampled residents (Resident 5.) This deficient practice resulted in delayed turning for Resident 3 which resulted in a blister on left trochanter (hip joint) and two blisters on left thigh. Findings: During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5's was admitted to the facility on [DATE] with the diagnoses including cerebrovascular accident ([CVA] a medical emergency that occurs when blood flow to the brain is suddenly cut off) and hypertension (high blood pressure.) During a review of Resident 5's History and Physical (H&P), dated 5/18/2024, H&P indicated Resident 5's diagnoses included cerebrovascular accident ([CVA] a medical emergency that occurs when blood flow to the brain is suddenly cut off) and hypertension (high blood pressure.) During a review of Resident 5's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 10/12/24, the MDS indicated Resident 5's was able to understand and be understood by others. The MDS indicated Resident 5's required supervision with eating, shower/bath, dressing, and moderate assistance with oral hygiene, toileting hygiene, putting on/off footwear and personal hygiene. The MDS indicated Resident 5's was incontinent of bowel. The MDS indicated Resident 5's was at risk of developing pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) and one unhealed pressure injury. During a review of Resident 5's Care Plan dated 5/18/2024, indicated Resident 5's had a high risk for skin breakdown and interventions indicated to reposition Resident 5's every 2 hours to promote circulation. During a review of Resident 5's Progress Note Inquiry dated 2/16/2024, indicated new blister on left trochanter and left posterior thigh fluid fill blister. During a review of Resident 5's Braden Scale (a medical tool used to assess a patient's risk of developing pressure ulcers) dated 10/9/2024 indicated Resident 5's total scale was 10. The scale indicated anything greater than 12 represented high risk. During a concurrent observation with Licensed Vocational Nurse (LVN 1) on 2/15/2025 at 8:16 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation with LVN 1 on 2/15/2025 at 9:35 a.m. Resident 5's was turned towards the window (left side.) (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation with LVN 1 on 2/15/2025 at 11:00 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation and concurrent interview with Restorative Nurse Assistant (RNA 1) on 2/15/2025 at 12:42 a.m. Resident 5's was turned towards the window (left side.) RNA 1 stated Resident 5's should have been facing the door (turned to the right side), but she was not. During an interview on 2/16/2025 at 2:13 p.m. with LVN 1, LVN 1 stated from 8:16 a.m. to 11:00 a.m. there were no staff members entering the Resident 5's room to change her position. LVN 1 stated Resident 1 developed blisters could have been a result of her being laying on the same side for more than four hours. During a review of Policy and Procedures (P&P) titled Wound Care Policy and Procedure dated October 2022, indicated the objective of the facilities P&P was to develop a plan of care for prevention of pressure ulcers to patients determined to be at risk and provide guidelines for individualized treatment. The P&P further indicated interventions applied to all bedbound patients that require maximum assist every two hours turning and all other patients while in bed.

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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** 44294 Based on observation, interview and record review, the facility failed to ensure two of 27 sampled residents (Resident 5 and Resident 32) received care in accordance with the facility's policies and procedures (P&P) by failing to: 1. Implement turning interventions for Resident 5. 2. Provide wound care as ordered by the physician for Resident 32. These deficient practice had the potential for the resident to acquire new pressure ulcers and/or worsen current pressure ulcers. Findings: 1. During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5's was admitted to the facility on [DATE]. During a review of Resident 5's History and Physical (H&P), dated 5/18/2024, H&P indicated Resident 5's diagnoses included cerebrovascular accident ([CVA] a medical emergency that occurs when blood flow to the brain is suddenly cut off) and hypertension (high blood pressure.) During a review of Resident 5's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 10/12/24, the MDS indicated Resident 5's was able to understand and be understood by others. The MDS indicated Resident 5's required supervision with eating, shower/bath, dressing, and moderate assistance with oral hygiene, toileting hygiene, putting on/off footwear and personal hygiene. The MDS indicated Resident 5's was incontinent of bowel. The MDS indicated Resident 5's was at risk of developing pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) and one unhealed pressure injury. During a review of Resident 5's Care Plan dated 5/18/2024, indicated Resident 5's had a high risk for skin breakdown and interventions indicated to reposition Resident 5's every 2 hours to promote circulation. During a review of Resident 5's Progress Note Inquiry dated 2/16/2024, indicated new blister on left trochanter and left posterior thigh fluid fill blister. During a review of Resident 5's Braden Scale (a medical tool used to assess a patient's risk of developing pressure ulcers) dated 10/9/2024 indicated Resident 5's total scale was 10. The scale indicated anything greater than 12 represented high risk. During a concurrent observation with Licensed Vocational Nurse (LVN 1) on 2/15/2025 at 8:16 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation with LVN 1 on 2/15/2025 at 9:35 a.m. Resident 5's was turned towards the window (left side.) (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	During a concurrent observation with LVN 1 on 2/15/2025 at 11:00 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation and concurrent interview with Restorative Nurse Assistant (RNA 1) on 2/15/2025 at 12:42 a.m. Resident 5's was turned towards the window (left side.) RNA 1 stated Resident 5's should have been facing the door (turned to the right side), but she was not. During an interview on 2/16/2025 at 2:13 p.m. with LVN 1, LVN 1 stated from 8:16 a.m. to 11:00 a.m. there were no staff members entering the Resident 5's room to change her position. LVN 1 stated Resident 1 developed blisters could have been a result of her being laying on the same side for more than four hours. 45657 2. During an observation on 2/15/2025 at 10:20 a.m. in Resident's 32 room. Resident 32 was laying on the bed, awake, unable to communicate with dressings on both lower extremities. During a concurrent observation and interview on 2/15/2025 at 3:20 p.m. in Resident's 32 room, with Treatment Nurse (TN) 2. TN 2 when inside Resident's 32 room with wound care supplies. TN 2 wash hands and applied clean gloves and removed soiled dressing from Resident 32' s right lower lateral leg open pressure injury. TN 2 clean wound with normal saline [(NS) (saline is a mixture of sodium chloride and water] pat dry and TN 2 proceed to apply a dry foam with no Silvadene ointment (is a topical antimicrobial drug indicated as an adjunct for the prevention and treatment of wound) as order in the Treatment Administration Record (TAR). TN 2 stated yes the order is to apply Silvadene. TN 2 stated I forgot I will get the ointment right now and applied it. TN 2 reach for the Silvadene ointment, washed her hands and applied gloves and proceed to applied Silvadene to right lower lateral leg. TN 2 was observed applying a foam to the wound not an ABD (gauze pads are used to absorb discharges) pad as ordered in TAR. TN 2 stated I will get an ABD pad and applied to wound as ordered. TN 2 applied ABD pad and wrap the wound with Kerlix (a brand of gauze bandage rolls that are used to dress wounds). During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility on [DATE] with a diagnosis that included Atrial Fibrillation (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly), intracranial bleed (a bleeding that occurs within the skull, affecting the brain), and cardiomyopathy (group of diseases that affect the heart muscle, making it difficult for the heart to pump blood effectively) During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was rarely/never understood and rarely/never understand. The MDS indicated Resident 32 required dependent assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 32's TAR dated 2/2025, the TAR indicated Resident 32 had a right lateral lower leg pressure injury: cleanse with NS pat dry and apply Silvadene cover with ABD pad wrap with kerlix daily per 30 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/16/2025 at 10:11 a.m. with TN 2, TN 2 stated the wound treatment doctor comes to see the residents once a week and will place a wound care order for 30 days. TN 2 stated the doctors orders must be followed as prescribed. TN 2 stated nurses are not allowed to switched order for treatments. TN 2 stated if orders are not followed Resident 32 can be at risk for a decline in wound healing and wound can get worse. TN 2 stated before I started with my treatments, I need to check the doctors' orders and make sure I used the right dressing for Residents. TN 2 stated yesterday 2/15/2025, I did not check the orders. TN 2 stated I got confused with so many orders. During an interview on 2/16/2025 at 5:31 p.m. with the Director of nursing (DON), the DON stated TN 2 need to reviewed orders before they started with wound care and follow doctors orders. The DON stated the doctors' orders will indicate what type of material and medications are used for wound care. The DON stated the danger of not following doctors' orders is the wound getting worse. During a review of Policy and Procedures (P&P) titled Wound Care Policy and Procedure dated October 2022, indicated the objective of the facilities P&P was to develop a plan of care for prevention of pressure ulcers to patients determined to be at risk and provide guidelines for individualized treatment. The P&P further indicated interventions applied to all bedbound patients that require maximum assist every two hours turning and all other patients while in bed. During a review of the facility's P&P titled, Wound care, dated 1/2025, the P&P indicated, when patient with a wound use protocol for stage 1 and 2, call MD for consult orders for pressure injuries stage 3 and 4 and all types of wounds.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview, and record review, the facility failed to: 1. Ensure that the facility staffed sufficient Certified Nurse Assistant (CNAs) to administer and provide nursing services in a timely manner for one out of 27 sampled residents (Resident 5) The deficient practice resulted in delayed care for Resident 5. Findings: During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5's was admitted to the facility on [DATE]. During a review of Resident 5's History and Physical (H&P), dated 5/18/2024, H&P indicated Resident 5's diagnoses included cerebrovascular accident ([CVA] a medical emergency that occurs when blood flow to the brain is suddenly cut off) and hypertension (high blood pressure.) During a review of Resident 5's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 10/12/24, the MDS indicated Resident 5's was able to understand and be understood by others. The MDS indicated Resident 5's required supervision with eating, shower/bath, dressing, and moderate assistance with oral hygiene, toileting hygiene, putting on/off footwear and personal hygiene. The MDS indicated Resident 5's was incontinent of bowel. The MDS indicated Resident 5's was at risk of developing pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) and one unhealed pressure injury. During a review of Resident 5's Care Plan dated 5/18/2024, indicated Resident 5's had a high risk for skin breakdown and interventions indicated to reposition Resident 5's every 2 hours to promote circulation. During a review of Resident 5's Progress Note Inquiry dated 2/16/2024, indicated new blister on left trochanter and left posterior thigh fluid filled blister. During a review of Resident 5's Braden Scale (a medical tool used to assess a patient's risk of developing pressure ulcers) dated 10/9/2024 indicated Resident 5's total scale was 10. The scale indicated anything greater than 12 represented high risk. During a concurrent observation with Licensed Vocational Nurse (LVN 1) on 2/15/2025 at 8:16 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation with LVN 1 on 2/15/2025 at 9:35 a.m. Resident 5's was turned towards the window (left side.) During a concurrent observation with LVN 1 on 2/15/2025 at 11:00 a.m. Resident 5's was turned towards the window (left side.) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and concurrent interview with Restorative Nurse Assistant (RNA 1) on 2/15/2025 at 12:42 a.m. Resident 5's was turned towards the window (left side.) RNA 1 stated Resident 5's should have been facing the door (turned to the right side), but she was not. During an interview on 2/16/2025 at 2:13 p.m. with LVN 1, LVN 1 stated from 8:16 a.m. to 11:00 a.m. there were no staff members entering the Resident 5's room to change her position. LVN 1 stated not having enough CNAs was one of the problems the facility ha during the weekends and that the blisters Resident 1 developed could have been a result of her being laying on the same side for more than four hours. LVN 1 stated residents suffer from the lack of CNAs. During an interview on 02/16/25 01:56 p.m. with CNA 1, CNA 1 stated the facility was short staffed on weekends and the patients were not getting proper care. CNA 1 stated, sometimes we are not able to turn residents. CNA 1 stated the residents were at risk of skin breakdown due to the lack or missing of turning every two hours. During an interview on 2/16/2025 at 2:13 p.m. with Director of Nursing (DON), DON stated the facility did not have a contract for registry and she could not give a reason on why. DON stated they did not have a strong pool of CNA's the lack of CNAs in the facility could lead to delayed in care, turning and basic care of the residents. During a review of Policy and Procedures (P&P) titled Subacute Staffing Policy and Procedure dated January 2022, indicated Subacute will provide 24 hours nursing care for residents as required by the Department of Health Care Services. It also indicated Core staffing may be augmented as census and acuity changes.

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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** 45657 Based on observation, interview and record review, the facility failed to: 1. Ensure food items were labeled with received and used dates in the dry storage area and two refrigerators. 2. Ensure expired foods were not stored in the kitchen and accessible to be used in food preparation in accordance with food service safety. These failures had the potential to place the residents at risk for developing a foodborne illness. Findings: During a concurrent observation and interview on [DATE] at 11:43 a.m. at entrance of the kitchen observed shelves with plastic containers containing single serve lemon juice bags, 1 container with single serve ranch dressing bags, 1 container with single serve Italian dressing bags, 1 container with single serve grape jelly, 1 container single serve pack syrups, 1 container with single serve ketchup bags and 1 contain with single serve mayonnaise bags. Outside the plastic containers were not label with receiving or used by dated. The Kitchen Supervisor (KS) stated, I do not know the expiration date of these products. The KS stated the expiration date comes in the original box. The KS stated when I pour this product in the containers, I did not put the received or used by date. The KS stated. I understand it is important to know until when these products can be used by. The KS stated it is important ant to avoid give residents any expired food. The KS stated Residents can be at risk of getting sicker. During an observation on [DATE] at 12:30 p.m. in shelves next to cooking area were observed dry chiles containers with exp dated of [DATE], ground cardamom powder exp dated [DATE], poultry season powder exp dated [DATE], crushed spearmint exp dated [DATE], shitake mushrooms powder exp dated [DATE], cream of mushroom soup cans x 2 exp dated [DATE], crush red pepper exp dated [DATE], dark Chile powder exp dated [DATE], basil leaves exp dated [DATE], couscous box exp dated [DATE], and uncooked dry lasagna exp dated [DATE]. During a concurrent observation and interview on [DATE] at 12:40 p.m. in Refrigerator #1 were observed shelves with bags of bread with no receiving or used by dated. The Director of Nutritional Services (DNS) stated yes, I understand the bread should be dated as well. During an observation on [DATE] at 12:45 p.m. in Refrigerator #4 were observed shelves with frozen chicken patties with no receiving or used by dated. During an interview on [DATE] at 3:41 p.m. with the DNS the DNS stated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food items are delivered to the kitchen three times a week. The DNS stated we have a staff member who oversees receiving and storage the items. The DNS stated the food will be removed from the original boxes and storage on the shelves. The DNS stated every food item received needed to be label with receiving date before storage. The DNS stated yes the products needs to have the used by and expiration date. The DNS stated it is important to do it because we will know when the item will expire. The DNS stated the risk for residents receiving expired food items can be high or low depends on the food consumed. The DNS stated it can possibly cause foodborne symptoms in residents. During a review of the facility's policies and procedures (P&P) titled Freshness Dating and Labeling, dated , d+[DATE] the P&P indicated all foods will be dated for freshness and food safety. Delivery: Upon delivery of food items, if not already dated, it is the responsibility of the purchasing agent or individual checking the delivery foods to date the items with the current date.

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Memorial Hospital of Gardena D/P Snf	1145 W. Redondo Beach Gardena, CA 90247

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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 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** 45657 Based on observation, interview, and record review, the facility failed to observe infection control measures for four out of 27 sampled residents by failing to: 1. Sanitizing their hands between changing gloves, washing hands after cleaning the wound, and applying a clean dressing for Resident 32. 2. Sanitize hands and change gloves after cleaning the colostomy stoma (an opening in the abdomen that allows stool to pass through instead of the anus) and before putting on the new colostomy bag for Resident 38 and after cleaning the wound and before applying the treatment and dressing for Resident 38 and Resident 46. 3. Keep the urinary catheter bag off the floor for Resident 64. These failures had the potential to spread infections and illnesses amongst residents. Findings: 1. During an observation on 2/15/2025 at 3:20 p.m. in Resident's 32 room, with Treatment Nurse (TN) 2. TN 2 when inside Resident's 32 room with wound care supplies. TN 2 wash hands and applied clean gloves and removed soiled dressing from Resident 32' s sacral area. TN 2 removed gloves sanitized hands and applied clean gloves and proceeds to cleaned wound. TN 2 changed gloves and applied new gloves without sanitizing or washing hand and proceed applying new dressing and cover with foam. TN 2 removed gloves and without sanitizing or washing hands applied clean gloves and proceed to changed Resident's 32 left lower extremity scar tissue. TN 2 finished changing left lower leg dressing and changed gloves and proceed to Resident's 32 right lower extremity pressure injury. TN 2 removed dressing, sanitized hands and applied clean gloves. TN 2 clean wound and changed gloves without sanitizing hands and applied a clean dressing. During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility on [DATE] with a diagnosis that included Atrial Fibrillation (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly), intracranial bleed (a bleeding that occurs within the skull, affecting the brain), and cardiomyopathy (group of diseases that affect the heart muscle, making it difficult for the heart to pump blood effectively) During a review of Resident 32's Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 1/8/2025, the MDS indicated Resident 32 was rarely/never understood and rarely/never understand. The MDS indicated Resident 32 required dependent assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). (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 32's Treatment Administration Record (TAR) dated 2/2025, the TAR indicated Resident 32 had Sacral stage 4 pressure injury: Cleanse with normal saline [(NS) (saline is a mixture of sodium chloride and water], pat dry, apply Medihoney (help promote a moist wound environment that aids and supports autolytic debridement) cover with foam dressing every day for 30 days. During a review of Resident 32's TAR dated 2/2025, the TAR indicated Resident 32 had a left lateral lower scar tissue: cleanse with NS pat dry and apply ABD (gauze pads are used to absorb discharges) pad wrap with kerlix daily per 30 days. During a review of Resident 32's TAR dated 2/2025, the TAR indicated Resident 32 had a right lateral lower leg pressure injury: cleanse with NS pat dry and apply Silvadene (is a topical antimicrobial drug indicated as an adjunct for the prevention and treatment of wound) cover with ABD pad wrap with kerlix daily per 30 days. During an interview on 2/16/2025 at 4:06 p.m. with the TN 2, The TN 2 stated We need to sanitized hand between changing gloves. TN 2 stated, it is important to prevent bacteria entering to the wound. TN 2 stated it is important to wash hands when we are switched from one part of the body to another to prevent contamination of wound and develop of infection. TN 2 stated I did not sanitize my hands while changing gloves TN 2 stated the policy of the facility stated to wash or sanitized hands between gloves changes. During an interview on 2/16/2025 at 5:20 p.m. with the Director of Nursing (DON) The DON stated hand hygiene is very important during wound treatment. The DON stated If hands are visible soiled the nurses need to wash hands. The DON stated if there are several wounds, TN need to sanitized hands before applying clean gloves before switching sizes. The DON stated If the TN does not change gloves or sanitized hands the resident is at risk of potential develop of an infection in the wound. During a review of the facility's policy and procedure (P&P) titled, Hand hygiene, dated 5/2023, the P&P indicated, hand hygiene indications included before touching a resident or patient, before donning (putting on) gloves when providing direct patient/ resident care. 46505 2. During a review of Resident 38's Admission Record, dated 1/3/2025, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnosis of chronic respiratory failure with hypoxia (a condition when there is not enough oxygen in the tissues in the body). During a review of Resident 38's History and Physical (H&P), dated 4/24/2024, the H&P indicated Resident 38 had diagnoses of quadriplegia (a paralysis that affects all a person's limbs), multiple pressure sores present on admission (injury to skin caused by prolonged pressure to the skin), and tracheostomy (a procedure to help air and oxygen reach the lungs by creating a hole at the front of the neck). The H&P indicated Resident 38 was awake, alert, and interactive, but compromised in communication due to his tracheostomy. (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 38's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/24/2025, the MDS section B indicated Resident 38 was able to understand and be understood by others. MDS section C indicated Resident 38 was cognitively intact. MDS section GG indicated Resident 38 had impairments on both sides of the upper extremities (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, and foot). MDS section GG indicated Resident 38 was dependent on staff for assistance for activities of daily living such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. MDS section GG indicated Resident 38 was dependent on staff for rolling left and right and chair to bed transfer. During a review of Resident 38's physician orders, dated 2/4/2025, the physician orders indicated Resident 38's treatment orders were to cleanse the sacral (lower back), left ischium (left lower hip), right ischium (right lower hip) stage 4 with normal saline, pat dry, apply treatment, cover with gauze and foam dressing daily. The physician orders indicated Resident 38's treatment order for the colostomy was to cleanse with normal saline, pat dry, and change bag every other day or as needed. During a review of Resident 46's Admission Record, dated 1/14/2025, the Admission Record indicated Resident 46 was admitted to the facility on [DATE] with diagnosis of respiratory failure. During a review of Resident 46's H&P, dated 1/21/2025, the H&P indicated Resident 46 was on full life support with a poor prognosis. The H&P indicated Resident 46 had osteomyelitis (bone infection), pneumonia (lung infection), and multiple pressure sores. During a review of Resident 46's MDS, dated [DATE], MDS section B indicated Resident 46 never understood and was never understood by others. MDS section C indicated Resident 46 was severely cognitively impaired. MDS section GG indicated Resident 46 had impairments on both upper and lower extremities. MDS section GG indicated Resident 46 was dependent on staff for all activities of daily living such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. MDS section GG indicated Resident 46 was dependent on staff for rolling left and right, chair to bed transfer, and tub and shower transfer. During a review of Resident 46's physician orders, dated 2/5/2025, the physician orders indicated Resident 46's treatment orders for the sacrum, and left and right buttocks were to cleanse with normal saline, pat dry, apply treatment, pack with gauze, and cover with dry dressing daily. During an observation on 2/16/2025 at 8:28 a.m. in Resident 38's room, Treatment nurse (TN) 3 was observed performing a colostomy change. TN 3 performed hand hygiene and put on gloves, removed the colostomy bag, cleansed with normal saline and pat dry, put on the new colostomy bag, removed trash bag and threw the trash away, and took off gloves and performed hand hygiene. TN 3 then put on new gloves and cleaned around the bag and dated the bag before taking off gloves and performing hand 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 an observation on 2/16/2025 at 9:15 a.m. in Resident 38's room, TN 3 was observed performing wound care. Resident 38 had three wounds, one on the left hip, one on the right hip, and one on the sacrum. TN 3 performed hand hygiene and put on gloves, removed the dressings on the left hip, right hip, and sacrum with normal saline and covered with the wounds with gauze. TN 3 then changed gloves and performed hand hygiene, donned new gloves, cleansed the wound on the left hip with normal saline, applied treatment, and applied new dressing. TN 3 then removed gloves and performed hand hygiene before starting treatment on the sacrum. TN 3 then donned gloves, cleaned the wound with normal saline, applied treatment, and applied new dressing. TN 3 then removed gloves, performed hand hygiene, and donned new gloves. TN 3 then cleaned the wound on the right hip with normal saline, applied treatment, and applied new dressing. TN 3 then removed her gloves and performed hand hygiene. During an observation on 2/16/2025 at 10:27 a.m. in Resident 46's room, TN 3 was observed performing wound care. TN 3 performed hand hygiene, donned gloves, and removed the dressing on the sacrum and right and left buttock with normal saline. TN 3 then removed gloves, performed hand hygiene, and donned new gloves before cleaning the wound on the right buttock with normal saline and gauze, applied treatment, packed the wound, and applied the dressing. TN 3 then changed gloves and performed hand hygiene and put on new gloves. TN 3 then cleaned the wound on the sacrum with normal saline and pat dry with gauze, applied treatment, packed the wound, and applied the dressing. TN 3 then cleaned the wound on the left buttock with normal saline and pat dry with gauze, applied treatment, packed the wound, and applied the dressing. TN 3 then changed gloves and performed hand hygiene. TN 3 handled Resident 46's catheter bag and turned Resident 46. TN 3 then removed the dressing on Resident 46's back, cleansed the wound with normal saline and pat dry, put-on treatment and foam dressing. TN 3 then changed gloves and performed hand hygiene and put on new gloves. TN 3 removed the dressing on Resident 46's left hip, cleaned the wound with normal saline and pat dry, put treatment on the wound, packed the wound, and covered the wound with dressing. TN 3 then removed the gloves and performed hand hygiene. During an interview on 2/16/2025 at 1:27 p.m. with TN 3, TN 3 stated she would put on the gloves before the treatment, remove the dressing using normal saline to make it easier to come off and to clean it and cover the wound with gauze. TN 3 stated she would then change gloves and use hand sanitizer before putting on new gloves. TN 3 stated because she used normal saline to remove the dressing, the wound is already clean so she did not have to change gloves, but she would clean the wound again with normal saline and gauze and then put on the dressing. TN 3 stated for changing the colostomy bag, only one pair of gloves would be used, and they did not have to change gloves between cleaning the site and putting on the new bag. During an interview on 2/16/2025 at 2:15 p.m. with the Infection Preventionist (IP), the IP stated gloves and hand hygiene are supposed to be performed at the beginning of the wound care and between each wound. The IP stated new gloves and hand hygiene are required between each step of the wound care. The IP stated gloves and hand hygiene are required after removing the dressing, after cleaning the wound, and before putting on the new dressing. The IP stated for changing the colostomy bag, new gloves and hand hygiene are required after removing the bag, after cleaning the stoma (an opening), and before putting on the new bag. The IP stated if gloves are not changed, the nurse can contaminate clean supplies and can contaminate the wound. (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 on 2/16/2025 at 5:37 p.m. with the Director of Nursing (DON), the DON stated using normal saline to remove the dressing was not considered cleaning the wound and removing the dressing is considered dirty. The DON stated the nurse would have to remove gloves and perform hand hygiene and put on new gloves before cleaning the wound because after removing the dressing, the gloves were dirty and before putting on new dressings because after cleaning the wound, the gloves were dirty. The DON stated if gloves were not changed and hand hygiene was not performed between the steps of wound care, the wound can get infected. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, dated 5/2023, the P&P indicated hand hygiene was indicated before contact with a wound, before handling clean supplies, after contact with wounds, and after removing a dirty dressing and before applying a new dressing. During a review of Policy and Procedures (P&P) titled Prevention of Catheter Associated Urinary Tract Infections dated January 2024, indicated foley catheter should be maintained unobstructed urine flow, ensure there are no dependent loops in tubing and use bedsheet clip to keep tubing from falling off bed. The P&P also indicated to 44294 3. During a review of Resident 64's Admission Record, the Admission Record, indicated Resident 64's was admitted to the facility on [DATE]. During a review of Resident 64's History and Physical (H&P), dated 1/18/2025, H&P indicated Resident 64's diagnoses included history of pneumonia ([PNA] infection of one or both lungs caused by bacteria, viruses, or fungi) and hypertension (high blood pressure.) During a review of Resident 64's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 1/23/25, the MDS indicated Resident 64 was not able to understand and be understood by others. The MDS indicated Resident 64's was dependent with oral hygiene, toileting, shower/bath, dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 64 had an indwelling catheter (thin, flexible tube that drains urine from the bladder). The MDS indicated Resident 64 was always incontinent of bowel. During a review of Resident 64's Care Plan dated 1/17/2025, indicated Resident 64 had a foley catheter and the interventions were to keep catheter patent and in proper position. During a concurrent observation on 2/15/2025 at 4:29 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated the foley bag was on the floor and she did not know how long it had been on the floor. VLN 2 stated having the foley bag on the floor could have led to urinary tract infection for the Resident 64 and it should be placed below the bladder and off the floor. During a concurrent record review on 2/15/2025 at 4:29 p.m. with Licensed Vocational Nurse (LVN 3), LVN 3 stated that the care plan dated 1/17/2025 indicated to keep catheter patent and in proper position which meant no, kinks, below the bladder and not on the floor to prevent bladder infections. (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 Policy and Procedures (P&P) titled Prevention of Catheter Associated Urinary Tract Infections dated January 2024, indicated foley catheter should be maintained unobstructed urine flow, ensure there are no dependent loops in tubing and use bedsheet clip to keep tubing from falling off bed. The P&P also indicated to always keep the collecting bag below the level of the bladder and off the floor.

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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** 46505 Based on observations and interviews, the facility failed to: 1. Provide one of 27 sampled residents (Resident 38) a special call light system to use. This failure caused Resident 38 to feel frustrated and helpless. Findings During a review of Resident 38's Admission Record, dated 1/3/2025, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnosis of chronic respiratory failure with hypoxia (a condition when there is not enough oxygen in the tissues in the body). During a review of Resident 38's History and Physical (H&P), dated 4/24/2024, the H&P indicated Resident 38 had diagnoses of quadriplegia (a paralysis that affects all a person's limbs), multiple pressure sores present on admission (injury to skin caused by prolonged pressure to the skin), and tracheostomy (a procedure to help air and oxygen reach the lungs by creating a hole at the front of the neck). The H&P indicated Resident 38 was awake, alert, and interactive, but compromised in communication due to his tracheostomy. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS section B indicated Resident 38 was able to understand and be understood by others. MDS section C indicated Resident 38 was cognitively intact. MDS section GG indicated Resident 38 had impairments on both sides of the upper extremities (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, and foot). MDS section GG indicated Resident 38 was dependent on staff for assistance for activities of daily living such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. MDS section GG indicated Resident 38 was dependent on staff for rolling left and right and chair to bed transfer. During an observation on 2/15/2025 at 10:26 a.m. in Resident 38's room, a call bell was on the bedside table on the resident's left side. During a concurrent observation and interview on 2/15/2025 at 4:58 p.m. with Resident 38, Resident 38 stated he was not able to use the call bell at the bedside because he could not use his arms. Resident 38 gestured towards the call bell but was not able to reach the call bell. Resident 38 stated if his family was not with him, the nurses would not come and if his family was not with him, he would have to yell for help, and it was hard to yell for help and he felt frustrated. Resident 38 stated he had to yell for 45 minutes the previous night before he received help. During an interview on 2/16/2025 at 1:36 p.m. with Resident 38's family member, Resident 38's family member stated the nurses had issues with Resident 38 yelling for him but Resident 38 had no way to get in contact with the nurses. Resident 38's family member stated Resident 38 was not able to use the call bell and the nurses do not respond to Resident 38 yelling. Resident 38's family member stated the facility did not offer an alternative to the call bell. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/16/2025 at 2:24 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 38 was not able to use the call bell because Resident 38 was very stiff and could not extend his arm to reach the call bell. LVN 3 stated the call light system had been broken for three years and because Resident 38 could yell, LVN 3 stated he would stay nearby Resident 38's room so that he could hear Resident 38 yell. During an interview on 2/16/2025 at 5:17 p.m. with the Director of Nursing (DON, the DON stated the call lights are broken so they use call bells at the bedside. The DON stated if a resident could not use a call bell, they rely on the family members and the staff doing hourly rounding to see if the residents were in any distress or if the residents needed suctioning. During a subsequent interview on 2/16/2025 at 7:07 p.m. with the DON, the DON stated it was not appropriate for residents to have to yell for care. The DON stated the purpose of the call bell was to let someone know the resident was calling for help and for the attention of the nurse. The DON stated if the resident could not reach the call bell, then the family would have to use the call bell, but if there were no family available, then the nursing staff would have to do more hourly rounding. The DON stated Resident 38 yelling is him trying to get help. During a review of the facility's policy and procedure (P&P), titled Nurse Call System Failure Protocol, dated 7/2010, the P&P indicated if the length of down time was extensive, notify the administrative nursing supervisor to evaluate the situation for additional staff and engineering would assist nursing in providing temporary hand operated bell to each patient in the affected area and if repairs are beyond the scope of the hospital engineering department, the engineering director and or designee would contact the facility approved vender to provide immediate service and repairs to the nurse call system.