STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555478	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Care Center	5445 Everglades St Ventura, CA 93003

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814 Based on observation, interview, and record review, the facility failed to ensure it promoted and maintained dignity and respect for three of four sampled residents (Residents 110, 240 , and 66) when: 1. Resident 110, confidential medical information was publicly displayed. This failure resulted in a violation of their right to dignity. 2. Resident 240, call light was not answered timely. This failure resulted in feeling embarrassed, frustrated, and angry. 3. Resident 66, call light was not answered timely. This failure resulted in feeling angry, frustrated, in pain, hungry, thirsty, and embarrassed. Findings: During a review of the facility's policy and procedure (P&P) titled, Dignity and Respect, dated 11/24, the P&P indicated, It is the policy of this facility that all residents be treated with kindness, dignity and respect. 1. During an observation on 2/24/25 at 11:57 a.m. in Resident 110's room, there was an orange Swallow Guide (SG) posted at the head of their bed. The SG identified Resident 110's name and specific treatment details including diet texture, head and body positioning, details on where to place solids in their mouth, consistency of liquids, not to lie flat for 30 minutes after eating/drinking, and aspiration precautions (preventing food/liquids from entering the lungs). During an interview on 2/25/25 at 4:45 p.m. with the Administrator (ADM), ADM stated the SG at the head of Resident 110's bed should be covered. 32661 2. During an interview on 2/24/25 at 11:25 a.m. in room [ROOM NUMBER]A with Resident 240, Resident 240 stated, Sometimes have to wait an hour, for staff to respond to call light requests. Resident 240 further stated this made her feel embarrassed, frustrated, and angry since she sometimes had to void in her bed and on herself. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of room [ROOM NUMBER]A's call light use log, Nurse Call Activity Report (NCAR), dated 2/21/25 to 2/27/25, the NCAR indicated: - On 2/21/25, at 7:30 a.m., the call duration (time resident's call light was answered) was 12:23 (12 minutes and 23 seconds). - On 2/21/25, at 8:37 a.m., the call duration was 48:59. - On 2/21/25, at 12:21 p.m., the call duration was 13:10. - On 2/21/25, at 8:34 p.m., the call duration was 31:17. - On 2/22/25, at 9:13 a.m., the call duration was 18:17. - On 12/243/25, at 1:12 a.m., the call duration was 19:25. - On 2/23/25, at 7:41 a.m., the call duration was 15:25. - On 2/23/25, at 1:35 p.m., the call duration was 20:50. - On 2/23/25, at 3:49 p.m., the call duration was 13:34. - On 2/23/25, at 8:29 p.m., the call duration was 20:19. - On 2/23/25, at 9:19 p.m., the call duration was 36:38. - On 2/24/25, at 9:34 a.m., the call duration was 15:39. - On 2/24/25, at 11:03 a.m., the call duration was 14:49. - On 2/24/25, at 2:06 p.m., the call duration was 12:27. - On 2/24/25, at 1:41 p.m., the call duration was 15:24. - On 2/25/25, at 5:19 p.m., the call duration was 13:01. - On 2/25/25, at 7:37 p.m., the call duration was 36:59. - On 2/26/25, at 6:03 a.m., the call duration was 14:10. - On 2/26/25, at 8:34 p.m., the call duration was 34:58. - On 2/26/25, at 9:33 p.m., the call duration was 27:36. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 2/24/25 at 11:37 a.m. in room [ROOM NUMBER]A with Resident 66, Resident 66 stated, Night shift [11 p.m. - 7 a.m.] has the worse call light response than mid shift [3 p.m.- 11 p.m.]. Resident 66 further stated, I have to wait an hour more or less for someone from the staff to respond to the call light. Resident 66 also stated this made Resident 66 feel angry, frustrated, in pain, hungry, thirsty, and embarrassed since Resident 66 had no choice but to do Business, in the bed. During a review of room [ROOM NUMBER]A's NCAR,) dated 2/15/25 to 2/26/25, the NCAR indicated: - On 2/16/25, at 6:24 a.m., the call duration was 20:04. - On 2/16/25, at 10:57 p.m., the call duration was 14:18. - On 2/17/25, at 3:22 a.m., the call duration was 15:38. - On 2/17/25, at 9:00 a.m., the call duration was 43:41. - On 2/17/25, at 10:26 a.m., the call duration was 31:15. - On 2/17/25, at 11:32 a.m., the call duration was 24:52. - On 2/17/25, at 7:40 a.m., the call duration was 14:31. - On 2/18/25, at 10:19 a.m., the call duration was 14:04. - On 2/19/25, at 7:43 a.m., the call duration was 14:50. - On 2/19/25, at 10:01 a.m., the call duration was 26:36. - On 2/19/25, at 4:12 p.m., the call duration was 25:17. - On 2/19/25, at 7:35 p.m., the call duration was 21:28. - On 2/20/25, at 5:04 a.m., the call duration was 14:08. - On 2/20/25, at 10:51 a.m., the call duration was 17:29. - On 2/20/25, at 6:25 p.m., the call duration was 24:10. - On 2/20/25, at 11:35 p.m., the call duration was 23:31. - On 2/21/25, at 4:04 a.m., the call duration was 16:04. - On 2/21/25, at 5:52 a.m., the call duration was 14:40. - On 2/21/25, at 10:59 a.m., the call duration was 19:16. - On 2/21/25, at 1:27 p.m., the call duration was 14:35. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 2/21/25, at 3:25 p.m., the call duration was 12:52. - On 2/21/25, at 7:59 p.m., the call duration was 13:38. - On 2/22/25, at 12:13 a.m., the call duration was 12:49. - On 2/22/25, at 10:48 a.m., the call duration was 18:13. - On 2/22/25, at 1:32 p.m., the call duration was 16:55. - On 2/22/25, at 7:30 p.m., the call duration was 13:58. - On 2/22/25, at 7:46 a.m., the call duration was 11:08. - On 2/23/25, at 10:35 a.m., the call duration was 15:03. - On 2/23/25, at 3:11 p.m., the call duration was 50:54. - On 2/23/25, at 4:25 p.m., the call duration was 18:19. - On 2/23/25, at 6:35 p.m., the call duration was 18:04. - On 2/23/25, at 7:20 p.m., the call duration was 25:56. - On 2/23/25, at 8:56 p.m., the call duration was 26:46. - On 2/25/25, at 3:14 p.m., the call duration was 20:59. - On 2/26/25, at 6:27 a.m., the call duration was 12:00. During a review of the facility's P&P titled, Call Light/Bell, dated 11/21, the P&P indicated in part, POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff . PROCEDURES: 1. Answer the light/bell within a reasonable time. During a concurrent interview and record review on 2/27/25 at 10:20 a.m. with the Director of Nursing (DON), Rooms 121A and 120A's NCARs were reviewed. DON stated a reasonable expectation for call light response time was 10 minutes. DON further stated call light response times of 40 to 50 minutes was unacceptable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814 Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 69), had the most current Physician Orders for Life-Sustaining Treatment (POLST) a form designed to improve resident care by creating a portable medical order form that records residents' treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency. This failure had the potential to result in Resident 69's end of life wishes not to be honored. Findings: During a review of the facility's policy and procedure (P&P) titled, Advanced Directives, POLST, dated , d+[DATE], the P&P indicated, Resident or surrogate decision maker will be offered and assisted by facility staff . to complete a POLST (Physician's Orders for Life Sustaining Treatment) document to formulate decisions regarding Life Sustaining Treatment. A copy of this document will be in the Medical Record of resident. During a review of Resident 69's POLST, dated [DATE], in Resident 69's paper medical record at the nursing station, the POLST indicated, Selective Treatment - goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate [insertion of a breathing tube down the throat into the lungs to provide oxygen to the body]. During a review of Resident 69's Physician Order (Order), dated [DATE] at 1:33 p.m., the Order indicated, CPR/Attempt Resuscitation. Trial period of full treatment. Trial period of nutrition, including feeding tubes. During a review of Resident 69's POLST, dated [DATE], in Resident 69's electronic Health Record (eHR), the POLST indicated, Trial Period of Full Treatment . primary goal of prolonging life by all medical effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation [using a machine to deliver air into and out of the lungs. During a concurrent interview and record review on [DATE] at 10:21 a.m. with a licensed nurse (LN2), Resident 69's paper POLST, dated [DATE], and electronic POLST, dated [DATE] were reviewed. LN2 stated the paper copy and electronic copy of the POLST do not match and they should. During a concurrent interview and record review on [DATE] at 10:30 a.m. with a Minimum Data Set licensed nurse (MDS1), Resident 69's electronic POLST, dated [DATE], POLST dated [DATE], and paper POLST, dated [DATE] were reviewed. MDS1 stated the three documents do not match and they should.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49405 Based on observation, interview and record review the facility failed to ensure: 1. Care plan interventions were implemented for three of 38 sampled resident's (Residents 61, 123 and 138). 2. Medication administration and interventions were completed as identified in the care plan for one of 38 sampled residents (Resident 682). 3. Consistent turning and repositioning of one of 38 sampled residents (Resident 5). 4. A snack was provided during Dialysis (treatment that removes waste and excess fluid from the body) days for one of 38 sampled residents (Resident 36). 5. Pillows were placed to offload pressure from heels for one of 38 sampled residents (Resident 121). This failure had the potential to result in the needs of residents not being met. Findings: 1. During a review of Resident 61's Admission Record (AR), dated 02/25/25, the AR indicated, Resident 61 was admitted [DATE] with diagnoses including but not limited to, anemia (not having enough healthy red blood cells), difficulty in walking, need for assistance with personal care, unspecified dementia (a general term for a group of brain disorders that cause a progressive decline in memory, thinking, reasoning, and problem-solving). During a review of Resident 61's Facility Order Summary Report, for active orders dated 02/25/25, the Order Summary indicated, an order dated 06/11/24 for foot cradle every shift for skin maintenance. During a review of Resident 61's Treatment Administration Record (TAR), dated 02/25/25, the TAR indicated, the following interventions were not implemented: - APP (alterrnate pressure) Mattress every shift for skin maintenance order date 05/02/24 and D/C (discontinued) 02/11/25 on 02/08/25 for 1500 (3:00 p.m.). - Foot cradle every shift for skin maintenance for 1500 on 02/08/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 123's AR, dated 02/25/25, the AR indicated, Resident 123 was admitted [DATE] with diagnoses including but not limited to, hemiplegia (a condition that involves partial or complete paralysis (inability to move) and weakness on one side of the body) unspecified affecting left nondominant side, epilepsy (seizure disorder) unspecified, sleep apnea (sleep disorder with repeated episodes shallow or no breathing during sleep), dysphasia (problem with speech resulting from brain disease or damage) following unspecified cardiovascular disease (group of conditions that affect blood flow to the brain), personal history of transient ischemic attack (TIA - or a stroke, a temporary interruption of blood flow to the brain) and cerebral infarction (blood flow to the brain is blocked) without residual deficits. During a review of Resident 123's Facility Order Summary Report, dated 02/25/25, the Order Summary indicated orders dated as follows: - 07/27/23 - H/S (bedtime) monitor QS (every shift) side effects of medication: . Zolpidem (medication used for insomnia to aid in sleep). - 07/27/23 - H/S non-pharma logical interventions . Zolpidem every shift. - 08/24/23 - Monitor for episodes of insomnia. - 07/12/23 - Pain, non-pharma logical interventions . every shift ordered 07/12/23. - 11/25/24 - Apply CPAP/BIPAP (Device that delivers continuous pressure used with sleep apnea) Trilogy Evo (type of device) settings . at bedtime for sleep apnea and remove per schedule. - 11/21/24 - Apply oxygen via nasal canula (tube placed in the nose used to give oxygen) at 2 LPM (liters per minute - amount of oxygen delivered) to maintain O2 (oxygen) saturation greater than 92% (unit of measure) at bedtime and remove per schedule. - 01/28/25 - Bilateral (both sides) grab bars up in bed to aid in bed mobility every shift. - 07/12/24 - BIPAP/CPAP/AVAP at HS (bedtime) and PRN (as needed) per settings. - 11/21/24 - Check O2 sat (saturation or amount) every shift. - 02/07/24 - Monitor episodes of combativeness during are . q (every) shift. - 02/07/24 - Monitor episodes of verbal aggression towards staff q shift. - 07/12/23 - Monitor for seizure activity every shift. - 07/12/23 - Monitor level of pain q shift. - 07/12/23 - Right internal shunt (a tube implanted in brain to drain excess fluid) to side of head extending to neck . every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 123's Medication Administration Report/Treatment Administration Record (MAR/TAR), dated 02/25/25 at 12:03 p.m., the MAR/TAR indicated, several interventions were not completed including: - Apply oxygen via nasal canula at 2 LPM to maintain O2 saturation greater than 92% at bedtime and remove per schedule for 02/18/25 and 02/19/25. - BIPAP/CPAP/AVAP at HS and PRN per settings . for 02/18/25 and 02/19/25. - Monitor for episodes of insomnia . on 02/18/25 and 02/19/25. - H/S monitor QS side effects of medication: . Zolpidem at 1500 (3:00 p.m.) for 02/18/25 and 02/19/25. - H/S non-pharma logical interventions . Zolpidem at 1500 for 02/18/25 and 02/19/25. - Pain, non-pharma logical interventions . every shift at 1500 for 02/18/25 and 02/19/25. - Bilateral (both sides) bars up in bed to aid in bed mobility every shift at 1500 for 02/18/25 and 02/19/25. - Check O2 sat every shift at 1500 for 02/18/25 and 02/19/25. - Monitor episodes of combativeness during . q shift at 1500 for 02/18/25 and 02/19/25. - Monitor episodes of verbal aggression towards staff q shift at 1500 for 02/18/25 and 02/19/25. - Monitor for seizure activity every shift at 1500 for 02/18/25 and 02/19/25. - Monitor level of pain q shift . at 1500 for 02/18/25 and 02/19/25. - Right internal shunt to side of head extending to neck . every shift at 1500 for 02/19/25. During a review of Resident 138's AR, dated 02/25/25, the AR indicated Resident 138 was admitted [DATE] with diagnosis including but not limited to, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, dysphagia following cerebral infarction, and need for assistance with personal care. During a review of Resident 138's MAR, dated 02/25/25, the MAR indicated, several interventions were not implemented including: - Up to chair for meals on 02/18/25, 02/19/25 and 02/22/25. - Pain, non-pharmacological (no medication) intervention . on 02/18/25, 02/19/25 and 02/22/25. - Bilateral grab bars up in bed to aid in bed mobility on 02/18/25, 02/19/25 and 02/22/25. - Head of bed elevated to 30 degrees on 02/18/25, 02/19/25 and 02/22/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- House supplement with meals for nutritional support . for the 1700 (5:00 p.m.) shift on 02/18/25 and 02/19/25. - Monitor for s/sx (signs and symptoms) of bleeding R/T (related to) anticoagulation/antiplatelet therapy (medications that reduce the risk of blood clots) for the 1500 shift on 02/18/25, 02/19/25 and 02/22/25. - Monitor level of pain q (every) shift . for 1500 shift on 02/18/25, 02/19/25 and 02/22/25. - One side of bed against the wall per family request every shift for 1500 on 02/18/25, 02/19/25 and 02/22/25. - Pad alarm in bed to remind resident not to get up unassisted every shift for 1500 shift on 02/18/25, 02/19/25 and 02/22/25. - Pad alarm in wheelchair to remind resident not to get up unassisted every shift for 1500 shift on 02/18/25, 02/19/25 and 02/22/25. - Weight Bearing as tolerated left leg every shift for 1500 shift on 02/18/25, 02/19/25 and 02/22/25. - Weight Bearing as tolerated right leg every shift for 1500 shift on 02/18/25, 02/19/25 and 02/22/25. During a review of Resident 138's Facility Order Summary Report, dated 02/25/25, the Order Summary indicated, orders were dated as follows: - 10/22/23 - Up to chair for meals every evening shift. - 10/22/23 - Pain Non-pharmacological intervention done. - 10/22/23 - Bilateral grab bars up in bed to aid in bed mobility. - 10/22/23 - Head of bed elevated to 30 degrees every shift. - 10/22/23 - Monitor for s/sx of bleeding r/t anticoagulation/antiplatelet therapy q shift. Notify MD if any of the following s/sx . - 10/22/23 - Monitor level of pain q shift using the following scale . - 02/05/25 - One side of bed against the wall . - 10/22/23 - Pad alarm in bed to remind resident not to get up unassisted. - 10/22/23 - Pad alarm in wheelchair to remind resident not to get up unassisted. - 10/22/23 - Weight bearing as tolerated left leg every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/22/23 - Weight bearing as tolerated right leg every shift. During review of facility's policy and procedure (P&P) titled, Care Planning, dated 11/2024, the P&P indicated in part, POLICY: . a comprehensive Person-Centered Care Plan for each resident based on the resident's needs to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being . 5. Based on the interdisciplinary review, the care plan will be implemented, with ongoing revisions as needed . During a concurrent interview and record review on 02/26/25 at 11:22 a.m. with Director Staff Development (DSD), Residents 61, 123, and 138's Order Summary Report and MAR/TARs, dated 02/25/25, were reviewed. The MAR/TARs indicated, missing multiple interventions on dates noted for residents. DSD stated for Residents 61, 123, and 138 the MAR/TAR for these residents had missing documentation [as noted on dates listed]. DSD stated nursing is to document interventions daily as ordered by physician and confirmed orders were written for the interventions not completed. 51706 2. During a review of Resident 682's Medical Record, indicated, Resident 682 is [AGE] years old, was transferred to the facility on [DATE] from an Acute Care Hospital after undergoing right hip fracture repair on 2/4/2025. Resident 682's most significant past medical history was Type 2 Diabetes, Chronic Kidney Disease and Hypertension. During Resident 682's admission he has been followed by physician for abnormal kidney function studies. During a concurrent observation and interview on 2/25/25 at 09:30 a.m. with Resident 682, a liter (1000 milliliters) of 0.45% Sodium Chloride intravenous (IV: Intravenous refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) was infusing by gravity and approximately 500 milliliters remained in solution bag. Resident 682 stated .[facility] tell me I'm dehydrated (not having the normal amount of water in your body that is needed). During a review of Resident 682's Care Plan, dated 2/17/25, the care plan indicated, a focus problem of elevated BUN (BUN: Blood Urea Nitrogen assesses kidney function and indicate hydration status. Elevated BUN can indicate dehydration). Interventions revised on 2/24/25 indicated, Sodium Chloride Intravenous Solution 0.45% (Sodium Chloride). Use 60 cc (cubic centimeter equivalent to 1 milliliter) intravenously, every shift for elevated BUN for 3 days ** ADD ANOTHER X 2 LITERS. During a concurrent interview and record review on 2/25/25 at 3:58 p.m. with Licensed Vocational Nurse (LVN 1), Resident 682's electronic health record for intake (the amount of food and drink a person consumes) and output, dated 2/25/25 was reviewed. The intake for a.m. was documented as 240/. LVN 1 stated, RN documents IV hydration and further stated could not see what fluid was being documented. During a review of Resident 682's Medical Order, dated 2/24/25 at 19:18 p.m. (7:18 p.m.) the Medical Order indicated, Sodium Chloride Intravenous Solution 0.45% - 60 cc for elevated BUN for 3 days **Add another x 2 Liters. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/26/25 at 10:47 a.m. with Registered Nurse (RN 1), Resident 682's Electronic Health Record, dated 2/25/25 was reviewed. RN 1 confirmed there was no documentation entry for IV infusing on 2/25/25. RN 1 confirmed there was no supplemental documentation or progress notes. During a concurrent interview and record review on 2/26/25 at 11:37 a.m. with RN 1, Resident 682's IV Medication Administration Record, dated 2/24/25 and 2/25/25 were reviewed. The IV medication administration record indicated, no staff documentation for night shift of 2/24/25, or day shift of 2/25/25. RN 1 stated the documentation areas for the IV administration should contain a check mark with the staff's initials and confirmed those documentation areas were empty. 39912 3. During an interview on 2/25/25 at 3:30 p.m.,with Resident 5, Resident 5 stated she had multiple sclerosis (chronic autoimmune disease that affects the central nervous system). When asked if she was repositioned/turned every two hours, Resident 5 stated that she was not regularly turned and repositioned. During a review of Resident 5's Health Record, dated 1/31/25 to 2/25/25, the Health Record indicated, turning and repositioning monitoring every shift. There are multiple eight days) during various shifts where no documentation was recorded for turning and repositioning. During a review of Resident 5's Care Plan (CP), the CP indicated, a CP titled, Physical mobility, at risk for further decline in ADL (activities of daily living) self care performance related to multiple sclerosis, UTI (urinary track infection) and COPD (chronic obstructive pulmonary disease), with an intervention for Bed Mobility - requires limited to extensive 1-2 assistance with turning and repositioning. During an interview on 2/26/25 at 12:09 p.m. with the Director of Nursing (DON), the DON acknowledged that multiple shifts were missing documentation for Resident 5's turning and repositioning. During a review of the facility's policy and procedure (P&P) titled, Turning and Repositioning System, dated 06/2024, the P&P indicated, 1. Turning and positioning schedule will be dependent on each resident's needs. Residents with current pressure injury or at a higher risk for developing pressure injuries will be repositioned on a more frequent basis. 2. All residents who are at risk for skin breakdown and who require repositioning will have an individualized Care Plan developed and carried out. 3. Turning will be monitored by supervising staff. 4. Turning and repositioning will be documented by cerfified nursing assistant in the electronic health records. 45741 4. During a review of Resident 36's Admission Record (AR), the AR indicated, Resident 36 was admitted on [DATE] with diagnoses including end-stage renal disease (kidneys have completely stopped working) and was placed on renal dialysis (treatment that removes waste and excess fluid from the blood). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 8:30 a.m. with Resident 36, Resident 36 stated that she gets hungry during her dialysis treatment, but no one has offered her sack lunch (a lunch that's prepared ahead of time and packed in a bag) or snacks to take with her to her. During a review of Resident 36's Physician Order (PO), dated 2/7/25, the PO indicated, Sack of lunch during dialysis days. During an interview on 2/26/25 at 2:00 p.m. with CNA 3, CNA 3 stated that sack lunch was not offered to Resident 36's because she leaves for dialysis after lunch. During a concurrent interview and record review on 2/26/25 at 3:00 p.m. with DON, DON stated that Resident 36 should have sack lunches when going to dialysis as ordered by the doctor and outlined in the care plan. 5. During a review of Resident 121's Admission Record (AR), the AR indicated, Resident 121 was admitted on [DATE] with diagnoses including toxic encephalopathy (brain becomes damaged due to the presence of toxins), and abnormalities of gait and mobility (irregular patterns in walking and movement). During a review of Resident 121's Physician Order (PO), dated 1/10/2025, the PO indicated, offload bilateral heels with pillows. During concurrent observations and interview on 2/25/25 at 11:30 a.m. with Infection Preventionist (IP) in Resident 121's room, Resident 121 was observed with no pillows under their heels. IP stated there should have been pillows. During an interview on 2/25/25 at 11:40 a.m. with Licensed Nurse (LN) 2, LN 2 stated pillows should have been placed under the Resident 121's heels to offload pressure. During a concurrent interview and record review on 2/25/25 at 3:00 p.m. with DON, Resident 121's care plans were reviewed. DON acknowledged there was no care plan documentation addressing the use of pillows to offloads heels. DON further stated that staff must follow the physician's order, and that care plan should have aligned with the order. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/2024, the P&P indicated, Based on the interdisciplinary review, the care plan will be implemented, with ongoing revision as needed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 106), was involved in review and revision of their care plan during the interdisciplinary (IDT) meeting of health professionals who plan and coordinate resident care meeting. This failure resulted in Resident 106 not being given the right to participate in deciding treatment options. Findings: During a review of the facility's policy and procedure (P&P) titled, Care Planning/Interdisciplinary Team Conference, dated ,d+[DATE], the P&P indicated, To the extent possible, the resident, the resident's family and/or responsible party should participate in the development of the care plan . Every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party. During an interview on [DATE] at 10:07 a.m. with Resident 106, Resident 106 stated not understanding why the facility does not invite her to the IDT meeting. During a concurrent interview and record review on [DATE] at 11:35 a.m. with a social services designee (SSD), Resident 106's IDT - Care Plan Review (IDTCPR), dated [DATE] ay 9:16 a.m. was reviewed. SSD stated SSD spoke with Resident 106 before the IDTCPR meeting. SSD also stated Resident 106 was not at the IDTCPR meeting. SSD further stated SSD did not review the IDTCPM changes with Resident 106. During a concurrent interview and record review on [DATE] at 11:50 a.m. with a minimum data set nurse assessment coordinator (MDS2), Resident 106's IDTCPR, dated [DATE] at 9:16 a.m. was reviewed. MDS2 stated, 'We never have the resident present at the meeting. MDS2 also stated the resident is never at the care plan meeting, adding, It's just been that way. MDS2 further stated after the IDTCPR meeting the revisions to the care plan are not reviewed with the resident. MDS2 finally stated the IDTCPR should have been reviewed with Resident 106 and it wasn't. During a concurrent interview and record review on [DATE] at 12:10 p.m. with the Director of Nursing (DON), Resident 106's IDTCPR, dated [DATE] at 9:16 a.m. was reviewed. DON stated Resident 106 was not at the meeting and not able to agree with or be informed of the IDT results. DON further stated all residents should be at the care plan meeting if they are able to.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with professional standards and practices for two of four sampled residents (Residents 93 and 13) when: 1. The facility did not maintain a complete, accurately documented, readily accessible, and systematically organized room transfer form for Resident 93's relocation. 2. The facility failed to monitor Resident 13's depression and mood as ordered by the physician. These failures had the potential to impact resident rights, care planning, and the provision of appropriate care due to inaccurate or incomplete documentation. Findings: 1. During a concurrent observation and interview on 2/24/25 at 10:47 a.m., with Resident 93, in room [ROOM NUMBER]A, Resident 93 stated, was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 2/13/25, without prior notification (verbal or written) from the facility and without signing any consent. Resident 93 stated she did not sign any document attesting to her giving her consent for a room change. During an interview on 2/26/25 at 9:57 a.m. with the Director of Nursing (DON), the DON confirmed the room transfer was done on 2/13/25. Resident 93 was transferred from room [ROOM NUMBER] to room [ROOM NUMBER]. A new admit resident (+COVID-19) needed to be on isolation and room [ROOM NUMBER] was the only available room for isolation. DON added Resident 93 was informed verbally by staff prior to transfer and it is documented in the nursing progress note dated 2/14/25. The DON admitted prior notice was not given to Resident 93 since the new admit resident's positive COVID-19 diagnosis was discovered when the facility did test upon resident's arrival in the facility. Facility did not receive any report from the hospital of the new admit resident being positive for COVID-19. During a concurrent record review and interview on 2/26/25 at 10:05 a.m. with the DON, the facility Policy and Procedure (P&P) titled, Notification of Room or Roommate, dated 11/2024,was reviewed and indicated in part, POLICY: It is the policy of this facility that the resident has the right to notification of room or roommate changes and to agree prior to the change taking place. PROCEDURES: 1. The Notification of Room or Roommate Change form is to be completed and used to document that the resident has been given written advanced notification of room or roommate change. Review of the provided Notification of Room or Roommate Change form was instead titled, STATUS CHANGE. The bottom of the form required a signature from the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON concurred there was a discrepancy where in the P&P indicated Notification of Room or Roommate Change form where as the facility was using a form titled STATUS CHANGE. The DON also concurred to the following: that no advance notification was given to Resident 93, that Resident 93 did not sign the form/consent since the facility practice was for the licensed staff to fill out the form without obtaining the resident(s) signature, that no STATUS CHANGE form was filled out by the staff for Resident 93's room transfer. 39912 2. During an interview on 2/24/25 at 2:56 p.m., Resident 13 stated is taking medication for his mood. During a review of Resident 13's Health Record, indicated Resident 13 had orders for: Depakote (drug used to treat mood disorder) oral tablet delayed release (Divalproex) 250 milligrams (mg) order date 2/11/25 - give 250 mg by mouth 2 times a day for mood disorder manifested by constant yelling. Sertraline (drug used to treat depression) oral tablet 37.5 mg, order date 2/12/25 - give 37.5 mg by mouth one time a day every Monday, Wednesday and Sunday for depression. Trazodone tablet (drug used to treat depression) 75 mg, order date 2/10/25 - give 75 mg by mouth at bedtime every Monday, Wednesday and Sunday for depression manifested by inability to sleep. Monitor episodes of depression manifested by inability to sleep, tally by hashmarks Trazodone every evening and night shift. Order date 11/11/21. Monitor episodes of mood disorder by constant yelling with apparent reason by hasmarks Divalproex every shift. Order date 5/1/21. Monitor episodes of depression manifested by verbalization of sadness, tally by hashmarks Sertraline every shift. Order date 5/1/21. During a review of Resident 13's Health Record, the Health Record indicated, no documentation for monitoring for episode of depression and mood disorder on PM shift on 2/13/25 and 2/14/25. During an interview on 2/26/25 at 12:08 p.m., with the DON, the DON acknowledged monitoring was not documented. During a review of the facility policy and procedure (P&P) titled, Documentation and Charting-General, dated 11/2024, the P&P indicated, A complete account of the resident's care, treatment, response to the care, signs symptoms, etc., as well as the progress of the resident's care in an accurate and chronological order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51706 Based on observation, interview, and record review, the facility failed to adhere to Infection Prevention and Control Program (IPCP) when: 1. Staff failed to follow Enhanced Barrier Precautions (EBP) when providing care for one sampled resident (Resident 682). 2. Staff failed to follow infection control protocols while assisting two unsampled residents (Residents 12 and Resident 94) with feedings. 3. Staff failed to label oxygen tubing, nebulizer mask, and nebulizer tubing for two sampled residents (Residents 232 and 93) and did not change contaminated gloves for one unsampled resident (Resident 240), which did not align with infection control protocols. 4. Staff failed to perform handwashing during wound care for one sampled resident (Resident 434). These failures had the potential to result in the spread of organisms from staff members to other vulnerable residents. Findings: 1. During an observation on 2/24/25 at 10:21 a.m. of care to Resident 682, staff Occupational Therapist (OT 1) and Physical Therapist (PT 1) were observed providing direct care to Resident 682, wearing gloves and masks. Signage from Center for Disease Controls (CDC) outside of Resident 682's room indicated, Resident 682 was on Enhanced Barrier Precautions (EBP: a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs). EBP are used in nursing homes and other long term care facilities). During an interview on 2/24/25 at 10:32 a.m. with Director of Nursing (DON), the DON stated it was the expectation If providing direct patient care for staff to wear gloves and gowns. During an interview 2/24/25 at 10:44 a.m. with OT 1 and PT 1, OT 1 and PT 1 stated they had not been wearing gowns when providing initial direct patient care to Resident 682. During a review of the facility's policy and procedure (P&P) titled, IPCP and Transmission-Based Precautions, dated 3/2024, the P&P indicated, Enhanced Barrier Precautions (EBP) used in conjunction with standard precautions and expand the use of PPE (Personal Protective Equipment: protects healthcare workers and patients form the spread of infection) through the use of gown and gloves during high-contact resident activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to resident . 2. During an observation on 2/24/25 at 11:57 a.m. in the Dining Hall, Certified Nurse Assistant (CNA1) was feeding two unsampled residents (Residents 94 and 12). CNA 1 was using right hand for both residents and while alternating, placed utensil on tray between feedings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 12:07 p.m. with the DON, the DON stated there should be one staff member to one resident when assisting with feeding. During a review of the facility's P&P titled, Feeding the Dependent Resident, dated 11/24, the P&P indicated, One staff member may feed two residents when needed while following these guidelines: Infection Control guidelines are to be followed as to prevent cross contamination. During a review of the facility's P&P titled, Hand Hygiene, dated 10/22, the P&P indicated, Use of an alcohol-based hand rub containing at least 62% alcohol or . soap (antimicrobial or non-antimicrobial) and water for the following situations . (b) Before and after direct contact with residents . (p) Before and after assisting a resident with meals . 32661 3. During an observation on 2/24/25 at 9:40 a.m. in room [ROOM NUMBER]A, Resident 232 had an undated nasal cannula, humidifier, and was missing a plastic storage bag to secure the nasal cannula when not in use. During an observation on 2/24/25 at 10:47 a.m. in room [ROOM NUMBER]A, Resident 93's nebulizer was in the bottom drawer. The nebulizer mask and the tubing were undated. There was no plastic storage bag to secure the nebulizer mask and tubing when not in use. During an observation on 2/25/25 at 9:09 a.m. in room [ROOM NUMBER]A, Resident 244, Med Nurse (MN 1) dropped the plastic wrap of a Lidocaine patch, picked it up from the floor, threw the plastic wrap in the trash, did not change gloves, and proceeded to administer the Lidocaine patch to Resident 244. During an interview on 2/25/25 at 3 p.m. with the Infection Preventionist Nurse (IPN -specialized nurse who focuses on preventing the spread of infectious disease within the healthcare facility), the IPN concurred with the findings. During an interview on 2/27/25 at 10:20 a.m. with the DON, when asked about the frequency of O2 tubing, nebulizer tubing, plastic storage bags and mask changes, DON said everything is done once a week and they should be labeled upon change. During a review of the facility Policy and Procedure (P&P) titled, Oxygen/Nebulization Therapy, dated 11/2024, the P&P indicated in part, Weekly tubing and storage bag changes, for both Oxygen and Nebulization tubing/masks with appropriate labeling. 45741 4. During an observation on 2/26/25 at 10:30 a.m. Resident 434's right medial wound care treatment with Treatment Nurse (TN 2) was observed. TN 2 with a new pair of gloves removed the soiled dressing and placed them in the garbage receptacle. TN 2 then removed the pair of dirty gloves, placed them in a garbage receptacle, and put on clean gloves without washing her hands. TN 2 proceeded to provide treatment to the wound, applied the skin protectant then grabbed the clean dressing and covered Residents 434's wound without removing her dirty gloves or performing hand hygiene after the treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:45 a.m. with TN 2, TN 2 acknowledged not washing her hands in between glove changes and not removing her soiled gloves after completing the treatment before touching the clean dressing and applying it to Resident 434. During a review of the facility's policy and procedure (P&P) titled, Wound Care and Treatment Guidelines, dated 11/2024, the P&P indicated, The use of gloves does not replace the need to wash or sanitize hands. Hand washing must be done before treatment is initiated, after soiled dressing are removed, and after completing the treatment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32661 Based on observation and interview, the facility failed to ensure to provide a functional and comfortable environment for residents when pull cords for overhead night lights were missing. This failure resulted in denying residents the use of a night light and had the potential to result in adverse consequences during nighttime hours, including increased fall risk. Findings: During an initial tour observation on 2/24/25 at 9:40 a.m. the following residents rooms/beds were missing a night light pull cord: Rooms 109A, 110A, 113A, 113B, 114A, 114B, 115A, 116A, 116B, 118A, 118B, 119B, 120A, 121A, 124A, and 125A. During an interview on 2/25/25 at 12:41 p.m. in the Administrators office, with the Director of Maintenance (DM) and the Assistant Maintenance (AM), both DM and AM confirmed pull cords for the night lights were missing in the identified residents rooms.