STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555567	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Coast Global Medical Center D/P Snf	2701 South Bristol Street Santa Ana, CA 92704

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 48882 Based on observation, interview, and facility P&P review, the facility failed to ensure the residents' PHI was kept confidential for 27 residents. All 27 residents' PHI was displayed on a computer screen and left unattended by the staff member. This failure had the potential to violate the residents' rights to PHI privacy. Findings: Review of the facility's P&P titled Confidentiality of Medical Records revised 8/2023 showed all the information contained within the medical record belongs to the resident and will be kept confidential. Access will be restricted to the authorized users. The records will be viewed by the facility staff member only on a need to know basis. On 1/21/25 at 0914 hours, an ongoing observation was conducted in Hallway 1. A computer was observed with the computer screen displaying the names, dates of birth, and ages of all residents currently residing in the facility. The computer was observed unattended without a staff member nearby and multiple staff members were observed walking pass the computer. On 1/21/25 at 0919 hours, an interview and concurrent observation was conducted with the IP. The IP verified the above findings. The IP stated when the computer was not in use or left unattended, the computer screen should be locked to prevent the exposure of the resident protected information. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated the staff were expected to ensure and protect the confidentiality of each of the resident's medical records. The Director of Sub-Acute Unit further stated the computer screens should be covered and signed out when the staff left the computer unattended. The Director of Sub-Acute Unit was informed and acknowledged the above findings.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48882 Based on observation, interview, and facility P&P review, the facility failed to maintain a clean, safe, and homelike environment for one of 13 final sampled residents (Resident 26). Multiple dry and brown colored residues were observed on Resident 26's enteral feeding pump device. This failure had the potential to negatively impact the resident's safety and quality of life. Findings: Review of the facility's P&P titled Environmental Services/Infection Control reviewed 8/2023 showed nosocomial infections may occur as the result of exposure to contaminated surfaces, equipment, and other inanimate objects. Soil and dust should be removed from the surfaces with clean equipment and facility approved germicide. The Central Supply and Nursing Service will care for the equipment. If the equipment is left in the room, to notify the nursing unit. On 1/22/25 at 0757 hours, an observation was conducted in Resident 26's room. Resident 26's enteral feeding pump device was observed with multiple dry, brownish colored residue. Resident 26's enteral feeding was observed off. On 1/22/25 at 1116 hours, an interview and concurrent observation was conducted with LVN 6. Resident 26's enteral feeding pump was observed infusing the Glucerna 1.2 (enteral feeding formula) at 90 ml/hr. LVN 6 verified the above findings and stated the licensed nurses were responsible for the cleaning of the enteral feeding pump when dirty. LVN 6 further stated she did not notice the stains on the enteral feeding pump device when she had turned the enteral feeding on. On 1/23/25 at 0847 hours, Resident 26's enteral feeding pump device was observed with multiple dry, brownish colored residue. On 1/23/25 at 0942 hours, an interview and concurrent observation was conducted with RN 3. RN 3 stated the daily upkeeping of the resident's enteral feeding pump device was done by the licensed nurse assigned to the resident. RN 3 stated the licensed nurses were responsible for checking the devices daily. RN 3 further stated the licensed nurses should check the enteral feeding pump device when turning on or off the enteral feeding, and if stains were observed, the licensed nurse should address the stains. RN 3 stated if the stains were not able to be cleaned off, the enteral feeding pump device should be placed in the dirty utility room and the licensed nurse should get a new enteral feeding pump. RN 3 verified the above finding and stated the multiple dry brownish colored residue were from the enteral feeding formula. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated the residents' rooms and environment should be presented as clean and comfortable. The Director of Sub-Acute Unit stated if the enteral feeding pump device was dirty, the licensed nurses were responsible for the cleaning. The Director of Sub-Acute Unit was informed and acknowledge the above findings.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview and medical record review, the facility failed to notify the resident and/or their representative of the transfer/discharge and the reasons for the transfer in writing for one of three final sampled residents (Resident 2) reviewed for hospitalization . This failure had the potential for the resident and/or their representative not knowing about the appeal process should the resident and their representative believe the transfer or discharge was inappropriate or involuntary. Findings: Medical record review for Resident 2 was initiated on 1/21/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2 's H&P examination dated 8/30/24, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Physician's Order dated 11/21/24, showed an order to transfer Resident 2 to the acute care unit and provide bed hold for seven days. Review of Resident 2's Event Note showed following: - On 11/21/24 1703 hours, showed the resident representative was informed and agreed for the transfer and bed hold for seven days. - On 11/21/24 at 1905 hours, showed on 11/21/24 at 1800 hours, Resident 2 was transferred to the acute care unit of the facility. Review of Resident 2's Resident Transfer and discharge date d 11/21/2024, did not show the signature of Resident 2's representative. The Resident Transfer and Discharge form showed, If you believe that the proposed transfer/discharge is inappropriate, you have the right to file an appeal in writing or by calling the following: - Contacting and discussing the transfer discharge with the Long-Term Care Ombudsman office. - California Department of Public Health Licensing and Certification District Office. - If developmentally disabled or mentally ill, then contact, Executive Director Protection and Advocacy, and Department of Developmental Services and Department of Mental Health. Further review of the Resident Transfer and Discharge form showed if appeal is intended then it is suggested that it be filed within ten calendar days of being notified of the proposed discharge. The decision regarding the appeal will normally be made within 30 days from the date of formal notification. However, the ability of the department to render a decision on the appeal with this time frame maybe jeopardize if the appeal is not submitted within the suggested 10-day time period. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 2's medical record did not show if Resident 2 and/or the resident's representative were provided the notification of the transfer and the reasons for the transfer in writing. On 1/23/24 at 1107 hours, an interview and concurrent medical record review for Resident 2 was conducted with the Social Service Staff. The Social Service Staff stated she was responsible to provide the notification of the transfer and discharge to the residents and/or their representative. The Social Service Staff she did not provide the notice of transfer and discharge in writing when the residents got transferred to the acute care unit of the facility. The Social Service Staff stated she called Resident 2's representative and verbally informed the resident's representative of the notification of the transfer. The Social Service Staff verified she did not provide the notice of transfer and discharge in writing for Resident 2 when the resident was transferred to the acute care unit of the facility on 11/21/24. On 1/23/25 at 1447 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to notify three of three residents (two final sampled residents, Residents 2 and 27 and one nonsampled, Resident 17) reviewed for hospitalization of their rights to a bed hold (holding or reserving a resident's bed while the resident in the acute care hospital) policy upon transfer to the acute care facility in writing. This failure had the potential for the residents and/or their representatives to be unaware of their rights to request a bed hold upon transfer. Findings: Review of the facility's P&P titled Bed Hold revised 7/2005 showed the residents will be informed upon admission of their right to have a bed hold in the event the resident must be transferred to an acute facility or during therapeutic leave. Under the Additional Policy Statements section, showed any resident to be transferred to an acute care facility or to go on a therapeutic leave will be offered a bed hold, which may be executed by the resident or representative. The P&P aslo showed to complete the Bed Hold Notification Form and give copy to the resident/family. 1. Medical record review for Resident 27 was initiated on 1/21/25. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 10/21/24, showed Resident 27 had anoxic encephalopathy (a condition that occurs when the brain is deprived of oxygen). Review of Resident 27's Resident Transfer or discharge date d 1/22/25, showed Resident 27 was transferred to the acute care hospital. Review of Resident 27's Bed Hold Notification form failed to show documented evidence Resident 27's representative was provided a copy of the form when the resident was transferred to the acute care hospital on 1/22/25. On 1/23/25 at 1359 hours, an interview and concurrent medical record review was conducted with the Social Service Staff. The Social Service Staff acknowledged the bed hold notification was not given or mailed to Resident 27's responsible party. The Social Service Staff stated she called Resident 27's family member but she did not mail the bed hold notification because Resident 27's family member did not request for it. 2. Medical record review for Resident 17 was initiated on 1/21/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 12/5/24, showed Resident 17 had anoxic encephalopathy (a condition that occurs when the brain is deprived of oxygen). Review of Resident 17's Resident Transfer or discharge date d 1/16/25, showed Resident 17 was transferred to the acute care hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 17's Bed Hold Notification form failed to show documented evidence Resident 17's representative was provided a copy of the form when the resident was transferred to the acute care hospital on 1/16/25. On 1/23/25 at 1440 hours, an interview and concurrent medical record review was conducted with the Social Service Staff. The Social Service Staff verified the bed hold notification was not given or mailed to Resident 17's responsible party. The Social Service Staff stated she did not mail the bed hold notification because Resident 17's family member did not request for it. The Social Service Staff stated she would give a copy of the bed hold notification when the resident's representative was in the facility and give a copy upon request if the resident's representative was not in the facility. On 1/23/25 at 1725 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings. 44175 2. Medical record review for Resident 2 was initiated on 1/21/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2 's H&P examination dated 8/30/24, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Physician's Order dated 11/21/24, showed an order to transfer Resident 2 to the acute care unit and to provide bed hold for seven days. Review of Resident 2's Event Note showed following: - On 11/21/24 1703 hours, showed Resident Representative 1 was informed and agreed of the transfer and bed hold for seven days. - On 11/21/24 at 1905 hours, showed on 11/21/24 at 1800 hours, Resident 2 was transferred to the acute care unit of the facility. Review of Resident 2's Bed Hold Notification dated 11/21/24, showed Resident 2 was transferred out of the unit on 11/21/24, and Resident Representative 1 was notified of the bed hold by telephone. Under the section In Person and Date Mailed of the Bed Hold Notification form did not show any entry. Further review of the Bed Hold Notification showed the facility will hold a bed for seven days without charge, after the seven days are completed, the bed may be filled by another resident or a new admission. If Resident 2 is covered by Medicare or privately funded, then his/her benefit do not routinely make payments for bed hold if desired the facility will maintain a bed hold at a private daily rate for the period of the bed hold. Further review of Resident 2's medical record did not show if Resident 2 and/or their representative were provided with the written information regarding the facility's bed-hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 1048 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 3. RN 3 was not able to show if Resident 2 and/or their representative was provided with the written information regarding the facility's bed-hold policy when Resident 2 was transferred to the acute care unit on 11/21/24. On 1/23/25 at 1447 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the PASRR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level 1 assessment was coded inaccurately for one of one final sampled resident reviewed for PASARR (Resident 26). This failure had the potential for having residents that were not appropriate in the facility and for Resident 26 not to receive the appropriate services. Findings: Review of the facility's P&P titled PAS/PASARR reviewed 8/2023 showed all the residents will be screened and identified for Level II and referred in a timely manner to the Department of Health Services and the Department of Mental Health (as appropriate). Medical record review for Resident 26 was initiated on 1/21/25. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's PASRR Level 1 Screening Form dated 10/14/24, showed Resident 26 had no diagnosed serious mental illness, or symptoms of psychosis (a condition that causes a person to lose touch with reality, making it hard to distinguish what's real and what's not), delusions, and/or mood disturbance. Further review of the form showed Resident 26 was coded for not having been prescribed psychotropic medications for serious mental illness. However, review of Resident 26's MDS dated [DATE], showed Resident 26 had severe cognitive impairment, psychotic disorder, and was taking an antipsychotic medication. Additionally, review of Resident 26's Patient Orders dated 1/22/25, showed the physician's order dated 1/14/25, to administer Zyprexa (antipsychotic medication) 10 mg via gastrostomy tube two times a day for psychosis manifested by thrashing in bed. Review of Resident 26's plan of care showed a care plan problem dated 10/15/24, addressing Resident 26's use of the antipsychotic medications Seroquel (antipsychotic medication) and Zyprexa medications. On 1/22/25 at 1203 hours, an interview and concurrent medical record review for Resident 26 was conducted with the DSD and Director of Sub- Acute Unit. The Director of Sub-Acute Unit stated the PASARR Level 1 screenings were completed by the discharging facility and sent to the facility prior to the resident's admission into the facility. The Director of Sub-Acute Unit stated the screening results were reviewed by the MDS nurse, DSD, or the Director of Sub-Acute Unit for accuracy. The Director of Sub-Acuute Unit verified the above findings and stated the PASARR Level 1 assessment for Resident 26 was inaccurate. On 1/23/25 at 1702 hours, an interview was conducted with the Director of Sub-Acuue Unit The Director of Sub-Acute Unit was informed and verified the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the low air loss mattress (pressure redistributing support surface) was set appropriately according to the resident's weight for one of three final sampled residents (Resident 24) reviewed for pressure ulcer (skin injury caused by prolonged pressure on an area of the body). This failure had the potential for Residents 24 not receiving the appropriate care and services to promote healing or prevent the development of the pressure ulcers. Findings: Review of the facility's P&P titled Mattresses revised 8/2023 showed the pressure reduction will be provided to the residents who are at risk for skin breakdown. Under the section Procedure, showed facility to be sure to mattress was inflated properly, and to check mattress routinely to ensure it is working properly. Review of the facility's document titled Power Pro Operating Maintenance and Troubleshooting undated, showed to select the resident comfort setting based on the average patient weight. Further review of the document showed for 36 inches mattress and for a resident weighing 115-145 pounds, light 2 (two) to be selected. On 1/21/25 at 1049 and 1448 hours, 1/22/25 at 1032 and 1433 hours, Resident 24 was observed lying on a low air loss mattress. The low air loss mattress was observed set to comfort light 8 (eight), which corresponded to a resident weight of 265-330 pounds. Medical Record Review for Resident 24 was initiated on 1/21/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Order Summary Report showed a physician's order dated 8/28/24, for a Blue-Chip Power Pro Elite Mattress for wound management. Review of Resident 24's MDS dated [DATE], showed Resident 24 was totally dependent on the staff member assistance for bed mobility. Further review of the MDS showed Resident 24 had memory problem and had severely impaired cognitive skills for daily decision making. Review of Resident 24's Pressure Ulcer Documentation and Treatment Record, showed on 1/20/25, Resident 24 had a UTD (unknown depth of injury) pressure ulcer on left buttocks area. Review of the Resident 24's Weight Chart showed Resident 24 weighed 53.3 kilos (117.5 pounds). On 1/22/25 at 1433 hours, an observation, interview, and concurrent medical record review for Resident 24 was conducted with LVN 4. LVN 4 verified Resident 24's low air loss mattress was set to light eight which corresponded to a resident with the weight of 265-330 pounds. LVN 4 verified Resident 24 weighed 117.5 pounds and had no capacity to understand and verbalize comfort level of the mattress. LVN 4 further stated Resident 24's light level for the low air loss mattress was supposed to be set to Resident 24's weight of 117.5 pounds (light 2), and not on light 8 (265-330 pounds). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/24 at 0841 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the RNA services as ordered by the physician for two of four final sampled residents reviewed for limited ROM (Residents 2 and 18). This failure had the potential for the residents' decline in ROM functions and deterioration in their ability to perform ADL care. Findings: Review of the facility's P&P titled Restorative Nursing Program dated 8/2023 showed all the residents will be assessed by the registered nurse on admission and ongoing for their restorative/rehabilitative needs and abilities. A plan of care will be developed to place the resident in programs specifically designed to promote functioning levels and enhance the quality of life. The RNA program to be provided seven days a week and will be provided based on physician order. On 1/21/25 at 1035 hours, Resident 2 was observed lying in the bed. Resident 2's legs were in a partially flexed position. There were no splint on both legs. Medical record review for Resident 2 was initiated on 1/21/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident 2's ROM functions were impaired for the bilateral upper and lower extremities. Review of Resident 2's Care Plan dated 8/30/22, showed the care plan problem addressing Resident 2's limitation in ROM functions. The goal was to minimize the functional limitation of the ROM and maintain the current ROM functions. The interventions included for the RNA to perform the ROM exercises as ordered. Review of Resident 2's Patient Orders showed an order dated 12/2/24, showed for the RNA to provide passive ROM to the bilateral lower extremities daily five days a week as able and for the bilateral knee splint three to five hours per day five days a week as able with every two hours of skin checks. Review of Resident 2's documentation for RNA services for Resident 2 from 1/1 to 1/21/25, showed the RNA services for the passive ROM exercises to the bilateral lower extremities and bilateral knee splint three to five hours were provided on 1/2, 1/4, 1/8, 1/9, 1/10, 1/14, 1/15, 1/16, 1/17, 1/19, and 1/21/25. Total of 11 days of RNA services were provided, and four days of RNA services were missed. However, there was no documented evidence to explain why the RNA services were not provided as ordered by the physician. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 0936 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 11. LVN 11 verified the above findings and stated most of the residents in the facility were on RNA services and required two RNAs to provide the RNA services to the residents; however, there were somedays with only one RNA assigned and it was difficult to provide the RNA services to all the residents requiring RNA services with only one RNA. On 1/23/25, at 1447 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings. 48882 2. On 1/21/25 at 1129 hours, Resident 18 was observed in bed, with limited movement to her left hand, and no movement in her right hand. Resident 18 was not observed having any splints applied. Medical record review for Resident 18 was initiated on 1/21/25. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 18's MDS dated [DATE], showed Resident 18 had severely impaired cognitive skills and had an impairment in functional limitation in ROM to the bilateral upper and lower extremities. Review of Resident 18's Patient Orders, showed the following physician's orders: - dated 10/28/24, to continue RNA P/A (passive/active) ROM for the BLE three days a week for 30 days as able; to apply the bilateral AFO two to four hours per day as able for five days per week for 30 days, with skin checks every two hours; and to apply the right knee splint three to five hours per day for five days per week as able, with skin checks every two hours, and - dated 1/9/25, to provide RNA passive ROM for the BUE, five times a week, and to apply the WHFO to Resident 18's right hand for six to eight hours five times a week as the resident tolerates, with skin checks every two hours. Review of Resident 18's plan of care showed the following care plan problems: - dated 9/18/20, addressing Resident 18's actual functional limitation in ROM and at risk for further functional limitation in ROM. The interventions showed for RNA to perform ROM exercises as ordered, to apply the bilateral AFO two to four hours per day as able for five days per week, with skin checks every two hours, and to apply the right knee split three to five hours per day for five days a week as able. - dated 11/15/24, addressing Resident 18's decreased ROM/strength. The interventions showed to apply the right WHFO five times a week for six to eight hours as tolerated, with skin checks every two hours. Review of Resident 18's documentation for RNA services for January 2025 showed on 1/19/25, the documentation showed the bilateral AFOs were missing, and the charge nurse was notified. Additionally, for the week of 1/12/25 to 1/18/25, the bilateral AFOs were documented as applied and removed for four days that week, when the physician's order was for five days a week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Coast Global Medical Center D/P Snf	2701 South Bristol Street Santa Ana, CA 92704

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 18's documentation for RNA services for January 2025 showed the following documentation: *For the application of the right knee splint three to five hours per day for five days per week: - On 1/1, 1/14/25, from 0830 to 1430 hours, a total of six hours, - On 1/2 and 1/3/25, blank - On 1/9, 1/10, 1/17, and 1/19/25, from 1000 to 1600 hours, a total of six hours, - On 1/15/25, from 0208 to 1430 hours, a total of 12 hours, and - On 1/16/25, from 0820 to 1420 hours, a total of six hours. There was no documented evidence the resident's physician was notified on 1/2 and 1/3/25, the right knee splint was not applied as ordered. In addition, the splint was applied more than five hours on the above dates. Additionally, for the week of 1/12/25 to 1/18/25, the right knee splint was documented as applied and removed for four days that week, when the physician's order was for five days a week. * For the application of the right WHFO, for six to eight hours five times a week as the resident tolerates: - On 1/2/25, from 1100 to 1600 hours, a total of five hours, - On 1/3/25, from 1050 to 1430 hours, a total of three hours and 40 minutes, - On 1/7/25, from 1120 to 1500 hours, a total of three hours and 40 minutes, - On 1/21/24, blank, - On 1/22/25, from 1550 to 1830 hours, a total of 2 hours and 40 minutes. There was no documented evidence the facility staff had coordinated with the physician Resident 18 can only tolerate less than six hours and the reason for not tolerating the WHFO as ordered. Additionally, for the week of 1/12/25 to 1/18/25, the right WHFO was documented as applied and removed for four days that week, when the physician's order was for five days a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1537 hours, an interview and concurrent observation was conducted with LVN 10. LVN 10 was observed providing ROM exercises and applying the right WHFO splint and right knee splint on Resident 18. LVN 10 stated she was assigned to provide RNA services to Resident 18. LVN 10 stated Resident 18 had contractures in her right side and the physician ordered for Resident 18 to have the right WHFO for six to eight hours for five days a week. LVN 10 stated she had just applied the WHFO splint and would come back before her shift ended at 1900 hours to remove the splint. LVN 10 agreed Resident 18 would not have the splint on for six to eight hours as ordered, and stated she was busy today with the other the residents and was unable to provide the RNA services to Resident 18 timely. On 1/23/25 at 0949 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 11. LVN 11 verified the above findings. LVN 11 stated the facility usually had two RNAs to provide the RNA services to the residents and some days there would be one RNA scheduled to provide the RNA services to all the residents who required RNA services. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated she expected the RNA services, including the application of the splints, to be administered as ordered by the physician. On 1/23/25 at 1702 hours, a follow up interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, and medical record review, the facility failed to ensure one of 13 final sampled residents (Resident 11) remained free from accident hazards. * The facility failed to ensure Resident 11 had a helmet protective device when out of bed per the physician's order. This failure had the potential risk for injury to Resident 11. Findings: On 1/21/25 at 1040 hours, Resident 11 was observed in his wheelchair in the activity room. No splints were applied on the resident and not wearing a helmet. Medical record review for Resident 11 was initiated on 1/21/25. Resident 11 was admitted on [DATE]. Review of Resident 11's MDS dated [DATE], showed Resident 11 had a diagnosis of siezurre diarder. Review of Resident 11's Physician's Order dated 10/28/24, showed an order for when Resident 11 out of bed, a two person assistance sideways in mechanical lift, applied a helmet. Review of Resident 11's plan of care showed a care plan problem dated 10/28/24, addressing the use of a helmet when Resident 11 was transferred out of the bed. The care plan interventions included a use of a helmet for safety. On 1/21/25 at 1157 hours, an observation and concurrent interview was conducted with CNA 2. Resident 11 was observed in the room. CNA 2 was asked if there were any safety precautions he should remember when transferring and getting the resident up in wheelchair. CNA 2 stated there should be always two staff using the mechanical lift and sling when transferring the Resident 11 from the bed to a wheelchair, and vice versa. When asked if there are any thing else for special safety precaution they should provide, CNA 2 stated he can not think of any. CNA 2 was asked to show the resident storage of the personal belongings, and was able to show the closet and bedside drawer. There was no helmet available for the resident to use when getting out of the bed was observed. CNA 2 verified there was no helmet for Resident 11's use when assisting in getting out of the bed. On 1/22/25 at 1038 hours, an interview was conducted with the Activity Coordinator. The Activity Coordinator stated she was familiar with Resident 11 and attended the activities three times a week when up in his wheelchair. The Activity Coordinator stated she observed the resident wears the splint and heel protectors, hold a little piece of tubing but did not observed wearing any protective device on his head. On 1/22/25 at 1356 hours, an interview was conducted with LVN 10. LVN 10 verified the physician's order for the helmet to apply to the resident during transfer and up in the wheelchair. LVN 10 acknowledged Resident 11 did not have any helmet to apply when the resident needs to transfer to the wheelchair. LVN 10 further stated, she did not observed any helmet when the resident was up in the wheelchair yesterday. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1131 hours, an interview and concurrent medical record review for Resident 11 was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated she expected the CNAs and all the staff member to observe safety at all times for all the residents in the unit. The Director of Sub-Acute Unit was informed and verified the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for two of two sampled residents (one nonsampled resident, Resident 12 and one final sampled resident, Resident 18) reviewed for GT care. * The facility failed to ensure the licensed staff elevated Resident 12's HOB at 30 degrees to 45 degrees prior to the administration of medications via GT. * The facility failed to ensure Resident 18 was administered the enteral feeding as per the physician's orders and failed to ensure Resident 18's water flush was labeled with Resident 18's name and the ordered rate. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Medication Administration via Feeding Tube revised 1/2011 showed the medications will be administered via the feeding tube by an RN or LVN, per the physician's order. Review of the textbook titled Foundations and Adult Health Nursing published 2023 showed the administering medication through nasogastric tubing to place patient in high Fowler's position. 1. Medical record review for Resident 12 was initiated on 1/22/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 1/22/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Physician Order Report dated 1/1/25 - 1/31/25, showed the physician's order dated 1/13/23, to elevate HOB 30-45 degrees at all times while feeding is administered or for one hour after feeding if bolus or intermittent. During a medication administration observation on 1/22/25 at 0758 hours with LVN 7, LVN 7 was observed elevating the HOB of Resident 12 before administering the medication. However, LVN 7 elevated the HOB at less than 30 degrees. LVN 7 administered the medications via GT after elevating the HOB of Resident 12. On 1/22/25 at 1002 hours, an observation and concurrent interview was conducted with LVN 7. LVN 7 acknowledged Resident 12's HOB was less than 30 degrees when she administered the medications. LVN 7 stated Resident 12 had GT and the HOB should be elevated to 30 degrees so the resident would not aspirate during medication administration. LVN 7 stated she just estimated if the bed was between 30 to 45 degrees because Resident 12's bed had no measuring device. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1725 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings. 48882 2. Review of the facility's P&P titled Enteral Feeding via G Tube or J Tube, Continuous (Pump) reviewed 8/2023 showed the enteral feeding would be administered by a continuous method via the pump as ordered by the physician. To review the order for the feeding- the formula; ml per hour; dose limit in ml; kcal and number of hours to infuse per the Physician's Order. Medical record review for Resident 18 was initiated on 1/21/25. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 18's Patient Orders dated 1/22/25, showed the following physician's orders: - dated 7/17/24, to flush the GT with water at 100 ml per hour and normal saline at 100 ml per hour, for a total of 200 ml per hour for 20 hours via the Kangaroo pump, to total 4000 ml/day, - dated 11/26/24, to administer Vital 1.5 (enteral feeding formula) at 55 ml per hour for 20 hours via the gastrostomy tube. To start the tube feeding at 1200 hours and continue until the total dose was completed. May use Pivot 1.5 (enteral feeding formula) at 55 ml per hour if Vital 1.5 not available. Review of Resident 18's plan of care showed the following care plan problems: - dated 9/18/20, addressing Resident 18's tube feeding for nutritional support. The intervention showed to administer the tube feedings as ordered. - dated 11/25/24, addressing Resident 18's gradual weight gain. The goal showed no further weight gain. The intervention showed to decrease the rate of the enteral tube feeding Vital 1.5 at 55 ml per hour for 20 hours. On 1/22/25 at 0820 hours, Resident 26 was observed lying in bed. An enteral feeding pump was observed with two kangaroo bags hanging from the enteral feeding pump pole. One bag was labeled Pivot 1.5 and the rate on the label showed 60 ml x 20 hours. The other bag was labeled H20/saline flush, however, the label failed to show the resident's name and the ordered flush rate. The enteral feeding pump device was observed on and infusing the enteral feeding at 60 ml per hour. On 1/22/25 at 1525 hours, an interview and concurrent observation was conducted at Resident 18's bedside with LVN 6. When asked about Resident 18's enteral feeding, LVN 6 stated, Resident 18 was receiving Pivot 1.5 at 60 ml per hour for 20 hours. The enteral feeding pump device was observed on and infusing Pivot 1.5 at 60 ml per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1546 hours, an interview and concurrent observation and medical record review for Resident 18 was conducted with LVN 6. LVN 6 reviewed Resident 18's medical record and verified the infused enteral feeding formula rate did not match the rate ordered by the physician; and verified the rate on the enteral feeding formula label was incorrect. LVN 6 stated the enteral feeding rate should be set and administered as per the physician's orders. LVN 6 further stated when starting the enteral feeding at 1200 hours, she should have checked the physician's order and verified the rate to be administered. Additionally, LVN 6 also verified Resident 18's water bag was not labeled with the resident's name and the ordered rate. When asked, LVN 6 stated the label should include the resident's name, the room number, the date and time the contents were hung, the content in the bag, and the ordered rate to administer. On 1/23/25 at 1448 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated prior to the administration of the enteral feeding, the licensed nurse was expected to review the physician's order and ensure the rate was correct. The Director of Sub-Acute Unit further stated the enteral feeding formulas and water flush bags should be labeled with the residents' name, the contents in the bag, the ordered rate, and the date and time the flush or feeding started. On 1/23/25 at 1702 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary respiratory care and services were provided for seven of 13 final sample residents (Residents 2, 6, 8, 18, 26, 27, and 28). * The facility failed to ensure Resident 18's Trach Bar (T-Bar) aerosol tubing set-up was labeled with the date. * The facility failed to ensure Resident 26's yanker was labeled with the opened date and changed per the facility's P&P; and failed to ensure the T-Bar aerosol set-up was labeled with the date. * The facility failed to ensure Resident 28's T-Bar aerosol tubing set-up was labeled with the date; failed to ensure the sterile water connected to the oxygen flowmeter was labeled with the opened date; and failed to ensure the yanker was changed per the facility's P&P. * The facility failed to ensure the suction canister (a container used in medical settings to collect and store bodily fluids, secretions, and other waste removed from a patient's body) and suction tubing was changed as per the facility's P&P for Residents 2 and 8. In addition, facility failed to ensure opened yankauer (a medical device used to remove fluids and debris from the body, such as mouth airway) tube was labeled for Residents 2 and 8. * The facility failed to ensure tracheostomy {an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs} site was clean to sight for Resident 8 * The facility failed to ensure Resident 6 was placed on the ventilator machine alarms were not set for high pressure alarms. In addition, the ventilator machine alarms were not check every shift per physician's order and the care plans for respiratory status was not included in the interventions for monitoring of the mechanical ventilator and settings. These failures had the potential to result in poor health outcomes to the resident and posed the risk of delayed intervention in the event of an emergency. * The facility failed to ensure Resident 27's set up bag was changed weekly. These failures had the potential for these residents to not receive the appropriate respiratory care and may negatively affect the residents' medical conditions. Findings: Review of the facility's P&P titled Oxygen Therapy reviewed 7/2024 showed to connect the humidifier to the outlet of the flowmeter and to label the humidifier with the date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Changing Disposable Equipment reviewed 7/2024 showed the purpose was to provide a schedule of when disposable equipment should be changed to minimize the risk of hospital acquired infections. The table would be followed as to the frequency and the responsible team member for changing the disposable equipment. Review of the table showed the following equipment and the frequency to be changed: - Aerosol tubing- inline Suction Catheter- weekly, - Aerosol water- weekly and as needed when empty, - Suction Canister Inner Liners and tubing- weekly or sooner if three-fourths (3/4) full, - Yanker- daily or as needed. Review of the facility's P&P titled Changing Disposable Equipment dated 7/2024 showed suction canister inner liners and tubing will be changed weekly or sooner if 3/4th full, yankauer needed to be changed daily or PRN (as needed). 1. On 1/21/25 at 0902 hours, Resident 18 was observed lying in bed with the Trach-Bar (T-Bar) connected to the aerosol set-up and receiving an oxygen therapy at 28 percent (%) FiO2 with the flowmeter set at five liters per minute. The aerosol set-up connected to the flowmeter was observed undated. Medical record review for Resident 18 was initiated on 1/21/25. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 18's Patient Orders dated 1/22/25, showed the following physician's order: - dated 5/17/23, to administer aerosol mist to the trach via T-piece or trach mask at 28% FiO2, - dated 5/17/23, to change the aerosol set-up weekly on Mondays. Review of Resident 18's MDS dated [DATE], showed Resident 18 had severely impaired cognitive skills and required an oxygen therapy, suctioning, and tracheostomy (breathing tube inserted through the neck into the airway to maintain an open airway) care. Review of Resident 18's plan of care showed a care plan problem dated 9/18/20, addressing Resident 18's altered respiratory status due to the tracheostomy, secondary to the diagnosis of chronic respiratory failure. The intervention showed to change the aerosol set-up every Monday. Review of Resident 18's Respiratory Care Orders Flowsheet for January 2025 failed to show documentation the aerosol set-up was changed weekly on Mondays. On 1/22/25 at 1111 hours, an interview was conducted with LVN 6. LVN 6 stated for the residents receiving the oxygen therapy via the T-Bar aerosol, the licensed nurses were responsible for the respiratory care and services, including the suctioning and changing of the aerosol set-up and tubing. LVN 6 stated the changing of the aerosol set-up was done every Mondays, Wednesdays, and Fridays. LVN 6 further stated, when changing the T- Bar aerosol setup, the licensed nurse should label the aerosol set up/tubing with the date it was changed, to ensure the staff knew when it was last changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 1127 hours, an interview and concurrent observation was conducted with LVN 6. Resident 18's aerosol set-up and tubing were observed undated. LVN 6 verified this finding. LVN 6 was asked when Resident 18's aerosol set-up was last changed and LVN 6 stated she did not know. 2. On 1/21/25 at 0847 hours, Resident 26 was observed sleeping in bed, Resident 26 was observed with the T-Bar connected to the aerosol set-up and receiving oxygen therapy at 28% FiO2 with the flowmeter set at five liters per minute. Medical record review for Resident 26 was initiated on 1/21/25. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's Patient Orders dated 1/22/25, showed a physician's order dated 10/16/24, to administer the oxygen therapy via cool aerosol at 28 % oxygen. Review of Resident 26's MDS dated [DATE], showed Resident 26 had severely impaired cognition, and Resident 26 required the oxygen therapy, suctioning, and tracheostomy care. Review of Resident 26's plan of care showed a care plan problem, dated 10/15/24 addressing Resident 26's altered respiratory status due to the tracheostomy, secondary to the diagnosis of respiratory failure. The intervention showed to change the aerosol set-up every Monday. Review of Resident 26's Respiratory Care Orders Flowsheet for January 2025 failed to show documentation the aerosol set-up was changed weekly on Mondays. On 1/22/25 at 1111 hours, an interview was conducted with LVN 6. LVN 6 stated for the residents receiving oxygen therapy via the T-Bar aerosol, the licensed nurses were responsible for the respiratory care and services, including the suctioning and changing of the aerosol set-up and tubing. LVN 6 stated the changing of the aerosol set-up was done every Mondays, Wednesdays, and Fridays. LVN 6 further stated, when changing the T- Bar aerosol setup, the licensed nurse should label the aerosol set up/tubing with the date it was changed, to ensure the staff knew when it was last changed. On 1/22/25 at 1116 hours, an interview and concurrent observation was conducted with LVN 6. Resident 26's aerosol set up was observed undated, and the yanker was observed opened and undated. LVN 6 verified the findings. LVN 6 was asked when Resident 26's aerosol set-up was last changed. LVN 6 stated she did not know. LVN 6 also stated she did not know when the yanker was opened. 3. On 1/21/25 at 0852 hours, Resident 28 was observed lying in bed. Resident 28 was observed with the T-Bar connected to the aerosol set up and receiving oxygen therapy at 28 % FiO2 with the flowmeter set at six liters per minute. The bottle of sterile water connecter to the oxygen flowmeter was observed undated. Medical record review for Resident 28 was initiated on 1/21/25. Resident 28 was admitted to the facility on [DATE] with a diagnosis of respiratory failure. Review of Resident 28's Patient Orders dated 1/22/25, showed the physician's order dated 12/2/24, to administer the oxygen therapy via the cool aerosol at 28 % oxygen and to maintain the oxygen saturation at 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's MDS dated [DATE], showed Resident 28 was in a persistent vegetative state or had no discernible consciousness, and required oxygen therapy, suctioning, and tracheostomy care. Review of Resident 28's plan of care showed a care plan problem dated 12/2/24, addressing Resident 28's altered respiratory status due to the tracheostomy, secondary to the diagnosis of respiratory failure. The intervention showed to change the aerosol set-up every Monday. Review of Resident 28's Respiratory Care Orders Flowsheet for January 2025 failed to show documentation the aerosol set-up was changed weekly on Mondays. On 1/22/25 at 0805 hours, Resident 28 was observed receiving oxygen therapy via the T-Bar at FiO2 28% with the oxygen flowmeter set at five liters per minute. The sterile water connected to the oxygen flowmeter was observed undated with one-third of the contents remaining in the bottle. The yanker was observed opened and dated 1/20/25. On 1/22/25 at 1111 hours, an interview and concurrent observation was conducted with LVN 6. LVN 6 stated for the residents receiving oxygen therapy via the T-Bar aerosol, the licensed nurses were responsible for the respiratory care and services, including the suctioning and changing of the aerosol set-up and tubing. LVN 6 verified the above findings. LVN 6 was asked when the aerosol set-up/tubing was last changed. LVN 6 stated the changing of the aerosol set-up was done every Mondays, Wednesdays and Fridays. LVN 6 stated the last change for the aerosol set up should have been on Monday. LVN 6 further stated, when changing the T- Bar aerosol setup the licensed nurse should label the aerosol set-up/tubing with the date it was changed to ensure the staff knew when it was last changed. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated for the residents receiving oxygen therapy via the T-Bar, the licensed nurses were responsible for the respiratory care, suctioning, and changing of the aerosol set-up. The Director of Sub-Acute Unit stated the sterile water used for the oxygen therapy should be dated when opened, and the yanker should be dated when opened and changed per the facility's P&P. The Director of Subacute Unit stated the aerosol set up should be changed every week and as needed, the tubing should be dated so staff were informed of when it was last changed, and the nurse should document the change of the aerosol set up in the flowsheet. On 1/23/25 at 1702 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings. 44175 4a. On 1/21/24 at 0845 hours, Resident 8 was observed in bed with a tracheostomy tube (breathing tube inserted through the neck into the airway to maintain an open airway) in place and connected to a mechanical ventilator (a machine that takes over the work of breathing when a person is not able to breathe enough on their own). A suction canister attached to the wall was observed connected to the resident's ventilator tubing with a suction tubing. The suction tubing and canister was observed labeled 1/12/24, and the suction canister was observed 1/3 full with greenish liquid. The yankauer tube was observed at the left side of Resident 8's bed, with brownish stain and inside an opened original package with no label. On 1/21/25 at 0855 hours, an observation and concurrent interview was conducted with RT 1. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RT 1 verified the above observation. RT 1 stated the facility staff member changed the suction tubing and canister every week and as needed. RT 1 verified the suction tubing and canister were not changed for the last nine days for Resident 8. RT 1 stated the yankauer tubing should be changed every shift and should have been labeled when it was opened. Medical record review for Resident 8 was conducted on 1/21/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Patient Orders showed following physician orders dated: - 12/20/23, for mechanical ventilation with the ventilation settings. -11/16/23, for tracheostomy care change trach dressing every shift and PRN when soiled. b. On 1/21/24 at 0845 hours, Resident 8 was observed in bed with a tracheostomy tube in place and connected to a mechanical ventilator. The tracheostomy tube was observed with dry brownish stain. On 1/21/25 at 0855 hours, an observation and concurrent interview was conducted with RT 1. RT 1 verified the above observation and stated the tracheostomy site for Resident 8 needed to be cleaned and the tracheostomy dressing needed to be changed. On 1/23/24 at 0841 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings. 5. On 1/21/25 at 0935 hours, Resident 2 was observed in bed with a tracheostomy tube in place and connected to a mechanical ventilator. A suction canister attached to the wall was observed connected to the resident's ventilator tubing with a suction tubing. The suction tubing and canister was observed labeled 1/12/24, and the suction canister was observed 3/4 full with greenish liquid. The yankauer tube was observed inside an opened original plastic package with no label, at the left side of Resident 2's bed. On 1/21/25 at 0945 hours, an observation and concurrent interview was conducted with RT 2. RT 2 verified the above observation. RT 2 verified the suction tubing and canister were not changed for the last nine days for Resident 2. RT 2 stated the yankauer tube should have been labeled when it was opened. Medical record review for Resident 2 was initiated on 1/21/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Patient Orders dated 11/27/24, showed an order for mechanical ventilation with the ventilation settings. 39670 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the facility's P&P titled Ventilator Alarm Setting Guidelines Troubleshooting and Corrective Action reviewed date 4/2020 showed the ventilator-dependent residents should have a safe environment by creating awareness of ventilator alarms and take corrective action when an alarm present itself. Alarms will be set appropriately for each resident needs. Team members will respond immediately to all ventilator alarms and the ventialtor alarm settings should be documented in the resident's medical record. On 1/21/25 at 0911 hours, and 1/22/25 at 0812 hours, Resident 6 was observed in bed with tracheostomy tube in place and connected to a mechanical ventilator. Resident 6's ventilator was observed set to tidal volume of 500 ml, breath rate of 10, High pressure Inspiration to 70. The mechanical ventilator machine had the red flashing light showing HIGH PRESSURE. There was no audible sound of the mechanical ventilator alarm was heard in the room or in the hallway. Medical record review for Resident 6 was initiated on 1/21/25. Resident 6 was admitted to the facility on [DATE] with a diagnosis of respiratory failure. Review of Resident 6's Physician's Order dated 5/31/23, to set Resident 6's ventilator to Assist control mode, rate of 10, tidal volume of 500 ml, and PEEP of 5. Another physician's order showed special instructions to check the high/low pressure ventilator alarms every shift. Review of Resident 6's Respiratory Flowsheets dated 1/15/25 to /1/22/25, showed Resident 6's ventilator machine settings and respiratory care were documented. However, there was no documented evidence the ventilator alarms were checked every shift per the physician's order. Review of Resident 6's plan of care showed a care plan problem dated 4/18/22, addressing the respiratory status of the resident. However, there was no interventions included for the mechanical ventilator monitoring of the alarms and settings per the physician's order. On 1/22/25 at 0855 hours, an observation and concurrent interview was conducted with the IP. The IP was asked at Resident 6's bedside about the vetilator machine flashing of red light High Pressure. The IP stated the ventilator machine flashing was from the old alarm that has not been cleared and when not cleared it will come. The IP stated the RT was responsible for the resident's respiratory care including the ventilator machines. The IP verified there was no alarm sounds heard from the ventialtor machine and in the hallway monitor. On 1/22/25 at 0859 hours, an observation and concurrent interview was conducted with RT 4. RT 4 was asked at the resident room bedside. The ventilator machine was observed flashingHigh Pressure. RT 4 was asked why was the ventilator machine flashing a high pressure, RT 4 stated when the resident cough and the ventilator machine detect high pressure, then it will flash the high pressure indication there was something going on with the resident. When asked why was there was no sounding alarm when the ventilator machine was showing a high pressure alarm, RT 4 stated the machine will go back to original setting when the resident had stop coughing. RT 4 was asked what was the purpose of the machine alarm, RT 4 stated to alert staff member to check on the resident's respiratory status. RT 4 was asked what other monitoring alarm will sound off when the ventilator machine detected an alarm, RT 4 stated there was a monitor on the hallway that will show an alarm and sounding off when the ventilator machine has alarm. When asked why there was no sounding alarm heard in the hallway when the ventilator machine had a high pressure alarm on, the RT was unable to explain. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 0915 hours, an observation and concurrent interview was conducted with RT 5. RT 5 was asked at the resident room and asked about the ventilator machine of the resident. RT 5 stated when the high or low pressure alarm would come off, the machine will sound off an alarm in the machine and in the hallway monitoring. RT 5 verified there was no sounding alarm for the monitor in the hallway and on the ventilator machine went off for a high pressure alarm. RT 5 was unable to explain why was the machine did not sounding off the alarm. Review of the Operator's Manual LTV 1200, 1150 Ventilator, Under Ventilator Alarms, showed when an alarm occurs, a flashing alarm message appears in the display window, an audible alarm sounds, and any associated control displays flash. Warning alert, showed for Audible Alarms: Failure to immediately identify and correct audible alarm situations may result in serious patient injury. On 1/22/25 at 1428 hours, an interview and concureent medical record review was conducted with RTs 4 and 5. RT 4 verified the physician's order for respiratory therapy. RT 4 was asked about the physician's order for checking of the high/low pressure ventilator alarms every shift. RT 4 was unable to provide a documentation the ventilator machine was checked for the alarm sound. RT 5 verified there was no documentation the ventilator machine sound alarm was checked every shift, and added they just enter the parameters on the machine and did not checked if the alarm sound of the machine was working or not. RT 5 was asked about the plan of care for the respiratory problem of the resident. RT 5 was able to show the care plan for respiratory failure, however, when asked if the interventions were included to check the alarm sounds of the ventilator machine, RT 5 verified there was no interventions included on checking the alarm sound of the vent machine. On 1/23/25 at 1133 hours, an interview and concurrent medical reord review for Resident 6 was conducted with the Director of Sub-Acute Unit. The Director of the Sub-Acute Unit stated she expected the residents machines were working properly including the sounding of the alarm to alert the staff member if the resident had any problem. The Director of the Sub-Acute Unit was informed and verified the above findings. 49644 * The facility failed to ensure Resident 27's set up bag was changed weekly. 7. During the initial facility tour on 1/21/25 at 0854 hours, Resident 27's was observed lying in bed with eyes closed. A set up bag with nebulizer inside was observed hanging on the oxygen flowmeter and dated 1/12/25. Medical record review for Resident 27 was initiated on 1/21/25. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's physician's order dated 1/24/25, showed a physician's order dated 10/19/24, to administer albuterol + ipratropium (treat symptoms of lung diseases) 2.5 mg-0.5 mg/3 ml inhalation, 3 ml nebulizer every six hours. On 1/21/25 at 0925 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 27's set-up bag for the nebulizer was dated 1/12/25, and should have been changed on 1/19/25. LVN 4 stated the respiratory therapist should have changed the nebulizer and the set-up bag every week. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 1144 hours, an interview was conducted with RT 3. RT 3 stated the night shift RT change the nebulizer on Sunday nights and as needed. RT 3 stated they changed the nebulizer and set up bag at the same time. On 1/23/25 at 1725 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs for two final sampled residents (Residents 23 and 2). * The facility failed to ensure the physician's orders for Residents 23 and 2 were accurate. The medication route was ordered to be oral instead of GT. This failure had the potential for the medications to be administered in errors. Findings: Review of the facility's P&P titled Medication Administration (General) revised 3/2023 showed to follow the six rights: patient, drug, dose, route, reason and check for contraindication, expiration date and stability of medications. Review of the facility's P&P titled Physician Orders revised 12/2008 showed guidelines have been established to aid the team members in obtaining, reviewing, and authenticating the physician's orders in an efficient and correct manner. The procedure section showed all the orders for the medications, procedures, and devices shall be clearly documented, in writing, or by CPOE, in the resident's medical record and shall include: the name and drug strength, and specific instructions for the administration (route, dose, and frequency). 1a. On 1/22/25 at 0758 hours, a medication administration observation for Resident 23 was conducted with LVN 6. LVN 6 was observed administering all the medications via GT to Resident 23. Medical record review for Resident 23 was initiated on 1/22/25. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Patient Orders dated 1/24/25, showed the following physician orders: - dated 10/31/23, to administer ferrous sulfate 330 mg (supplement) oral daily. - dated 7/4/24, to administer lactobacillus acidophilus (a medication to aid digestive system) (known as Bacid) one capsule oral daily. - dated 8/24/23, to administer Phenobarbital (antiseizure) 129.6 mg oral two times per day. Special instructions: Dose = 145.8 mg = (4 x 32.4 mg) + 16.2 mg. - dated 8/24/23, to administer Phenobarbital (antiseizure)16.2 mg oral two times per day. Special Instructions: Dose = 145.8 mg = (2 x 64.8) + 16.2 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1536 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified she gave the medications via GT but Resident 23's physician order was to administer the medications via oral route. LVN 6 stated she would report the error on the physician's order to the charge nurse. LVN 6 stated the charge nurse should have verified the route of the medication order to Resident 23's physician. On 1/22/25 at 1542 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 verified the above findings. RN 4 stated there were limitations on ordering the route of the medications in the resident's electronic health record. RN 4 stated the physician, RN, or pharmacist can type the route of the medication order in the comment section if there was no option for ordering the GT route. On 1/23/25 at 1341 hours, an interview and concurrent medical record review was conducted with the Pharmacist. The Pharmacist verified the oral medication orders for Resident 2. The Pharmacist stated the new electronic health record sometimes did not have an option for the GT route. The Pharmacist further stated some residents can take PO or GT. The pharmacist stated she should have asked the licensed nurse if the resident can take the medication oral or GT. b. On 1/22/25 at 1149 hours, a medication administration observation for Resident 2 was conducted with LVN 8. LVN 8 was observed administering all the medications via GT to Resident 2. Medical record review for Resident 2 was initiated on 1/22/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 23's Patient Orders dated 1/24/25, showed a physician's order dated 5/16/23, to administer Simethicone (antacid) 80 mg oral every six hours. Special instructions: for gas relief On 1/22/25 at 1523 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified the LVN 8 acknowledged she gave the medications via GT but Resident 2's physician order was to administer the medications via oral route. LVN 8 stated the route on the physician's order should be GT instead of oral. LVN 8 stated the RN should have called Resident 2's physician and wrote the order. On 1/22/25 at 1542 hours, an interview and concurrent medical record review was conducted with RN 4 . RN 4 verified the above findings. RN 4 stated there were limitations on ordering the route of the medications in the electronic health record. RN 4 stated the physician, RN, or pharmacist can type the route of the medication order in the comment section if there was no option for ordering the GT route. On 1/23/25 at 1341 hours, an interview and concurrent medical record review was conducted with the Pharmacist. The Pharmacist verified the oral medication order for Resident 2. The Pharmacist stated the new electronic health record sometimes did not have an option for GT route. The Pharmacist further stated some residents can take PO or GT. The pharmacist stated she should have asked the licensed nurse if the resident can take the medication oral or GT. On 1/23/25 at 1725 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P& P review, the facility failed to ensure one of five final sampled residents (Resident 2) reviewed for unnecessary medications was free from the unnecessary psychotropic medications. * The facility failed to ensure the PRN order for the psychotropic medication was limited to 14 days for Residents 2. This failure had the potential to result in unnecessary use of, ineffective and/ or lack of monitoring or interventions for the use of the psychotropic medication that could negatively affect Resident 2 highest practicable mental, physical, and psychosocial well- being. Findings: Medical record review for Resident 2 was initiated on 1/21/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Patient Orders showed an order dated 5/16/23, for lorazepam (antianxiety medication) 1 mg intramuscular (into a muscle) every four hours as needed for seizure (a temporary disruption in brain activity that can cause a person to experience abnormal movements, behaviors, or loss of consciousness). Further review of Resident 2's medical record did not show if the physician or prescribing practitioner documented the rational for the extension of the lorazepam medication and specified the duration for the above PRN psychotropic medication. On 1/23/25 at 1035 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 5. LVN 5 verified the above findings and stated she was not able to find the physician documentation which provided rational for continue usage of PRN psychotropic medication for Resident 2. LVN 5 stated Resident 2 had last received PRN lorazepam on 10/4/24. On 1/23/25 at 1359 hours, an interview and concurrent medical record review for Resident 2 was conducted with the Director of Pharmacy. The Director of Pharmacy stated the PRN psychotropic medication should be limited to 14 days and acknowledged if the psychotropic medication extended beyond 14 days, the physician should document rational for continue usage of PRN psychotropic medication in the resident's medical record and specified the duration of the therapy. The Director of Pharmacy was not able to show the physician documented the rational for continue use of the lorazepam beyond 14 days for Resident 2. On 1/23/25 at 1447 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48332 Based on observation, interview, and facility P&P review, the facility failed to ensure one of four medication carts (Medication Cart B) was properly locked and secured when unattended. This failure had the potential for unauthorized persons having access to the medications kept inside the medication cart. Findings: Review of the facility's P&P titled Medication Storage and Access revised 9/2023 showed all the drugs and biologicals must be kept in a secured area and locked when appropriate. A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. An area in which staff is actively providing care to patients or preparing to receive patients, i.e., setting up for procedures before the arrival of a resident would generally be considered a secure area. When a resident care area is not staffed, both controlled and non-controlled substance are expected to be locked. Due to their mobility, mobile nursing medication carts containing drugs or biologicals must be locked in a secure area when not in use. Employees shall make certain the security and monitoring of carts, locked or unlocked, containing drugs and biologicals in all patient care areas, to ensure their safe storage to ensure resident safety. During a concurrent observation on 1/22/25 from 1130 hours to 1141 hours, Medication Cart B was observed unlocked while not being attended by a facility staff member. At 1130 hours, during the observation Medication Cart B was observed at the end of the hallway near the activity room, all the drawers, except the drawer with lock, could be pulled open. There was no staff member in front of the medication cart. At 1135 hours, the IP passed by and provided the glucometer (machine to measure amount of sugar in the blood) manual that was requested earlier. When asked, the IP stated Medication Cart B belonged to LVN 1. The cart had three rows of about 10-12 small drawers on the left side and three larger drawers in a column on the right side with a key punch number code on the top right and a lever on the right side panel of the cart. The small drawers were labeled 120-2 to 125-2 and contained one tablet of Valsartan (antihypertensive medication) 80 mg in a drawer marked for Resident 1 and insulin pen in drawer marked for Resident 25. Another drawer contained multiple alcohol pads and lancets (needle devices for blood sugar checks). Six containers of the eye drops were present for Residents 25, 15, 6, and 11. The second to the bottom right column of the larger drawers contained multiple medication containers for Resident 22 which included Metoclopramide (antiemetic), Midodrine (use to treat low blood pressure), Acidophilus (probiotic), Magnesium (supplement), Baclofen (for muscle spasm), Zinc (supplement), Famotidine (acid reducer), vitamin C (supplement), Tylenol (analgesic), Simethicone (used to treat the symptoms of gas), docusate sodium (stool softener), multivitamin (supplement), Miralax (laxative), and Refresh eye drops (use for dry, irritated eyes) medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1141 hours, LVN 1 came out of Resident 22's room and confirmed it was her medication cart, and it should have been locked. LVN 1 closed the drawers, pushed numbers on the key pad and pushed lever down on the right side of the medication cart and walked down the hall. After a few seconds, LVN 1 was called to return to cart because the right column of drawers was pulled open. LVN 1 said the cart drawers should not have been able to be pulled open since she locked the cart. LVN 1 confirmed that the drawers were opened. On 1/22/25 at 1146 hours, an interview with concurrent observation was conducted with the Director of Sub-Acute Unit in front of Medication Cart B. The Director of Sub-Acute Unit engaged cart locks and confirmed the right column drawers did not lock and could be opened after locks were engaged. The Director of Sub-Acute Unit stated she will call the Engineering. The Engineering confirmed the cart drawers could be opened after the locks were engaged. The Engineering removed all the drawers on the right column and removed about 30-40 oral swab sticks from the back of the cart and other debris, reset the drawers in the cart and confirmed the cart was now fully locked after the locks were engaged. The Director of Sub-Acute Unit stated the medication cart should not be unlocked while not attended.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44175 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the cook followed the recipe when preparing the puree Swiss steak. This failure had the potential of not meeting the residents' nutritional needs which could lead to nutritional related health complications. Findings: Review of the facility's untitled document for the diet orders for the residents dated 1/21/25, showed one of 27 residents was receiving pureed food prepared from the kitchen. Review of the facility menu dated 1/22/25, showed the lunch menu included Swiss steak. Review of the facility's P&P titled Pureed Diet dated 6/2023 showed to follow the written pureed diet recipe instructions. Under the section How to Make Pureed Diet showed the following instructions: - Measure the amount of food needed to be pureed based on number of patients on the pureed diet and serving size. (for example, if you need six serving of the pureed food and the menu ask for 6 oz per serving, you need to multiply 6 x (times) 6 which equals to 36 oz. - In the food processor add liquid to the food that needs to be pureed (for instance; up to one cup of broth per one-pound cooked meat). - Blend the food until it has the consistency resembling apple sauce and contains no chunk and to add additional broth if needed while blending food. - To shape the puree food add two to three tablespoon of thickner per one pound solid food. On 1/22/24 at 1028 hours, an observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 was observed preparing the puree Swiss steak. [NAME] 1 stated he was preparing the puree Swiss steak for one resident in the facility. [NAME] 1 was observed measuring the Swiss steak in a weighing machine, and showed 4 oz of Swiss steak. [NAME] 1 was then observed putting the Swiss steak and beef broth in the blender and blended the Swiss steak. [NAME] 1 was not observed measuring the beef broth. Then, [NAME] 1 was observed adding one teaspoon of the thickener for consistency. On 1/22/24 at 1037 hours, an interview was conducted with [NAME] 1. [NAME] 1 informed and verified the above observation. [NAME] 1 stated he should have measured the beef broth before he blended the Swiss steak for the puree. On 1/22/24 at 1042 hours, an interview was conducted with the RD. The RD was informed of the findings. The RD stated [NAME] 1 should follow the instruction while preparing the puree diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44175 Based on observation, interview, and facility document review, the facility failed to ensure the food safety and sanitation guidelines were followed when: * The facility failed to ensure a tray and a red blender were not stored wet. * The facility failed to ensure a rack for pots and pans were in a sanitary condition. * The facility failed to ensure four cutting boards were not heavily marred. These failures had the potential to result in foodborne illnesses for the residents receiving kitchen services in the facility. Findings: Review of the facility's untitled document for diet orders for the residents dated 1/21/25, showed one of 27 residents was receiving food prepared from the kitchen. 1. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 1/21/25 at 0754 hours, an observation and concurrent interview was conducted with the Clinical Dietician. The following were observed: - One steel tray was observed stacked wet on top of multiple steel trays. The Clinical Dietician verified the observation and stated the staff member should have air dried the steel tray before storing in the clean dish storage area. - A red blender was observed stored wet in the food preparation area. The Clinical Dietician verified the observation and stated the red blender should have air dried before storing in the kitchen. 2. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils. Equipment food - contact surfaces and utensils shall be clean to sight and touch. On 1/21/25 at 0754 hours, an observation and concurrent interview was conducted with the Clinical Dietician. A rack with five shelves was observed with white water residue and dry dust in four bottom shelves, the rack was observed with clean pots and pans were ready to use. The Clinical Dietician verified the observation and stated the rack for the clean pots and pans should have been cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 1/21/25 at 0754 hours, an observation and concurrent interview was conducted with the Clinical Dietician. Two brown, one red, and one yellow cutting boards were observed to be heavily marred with whitish discoloration. The Clinical Dietician verified the observation and stated the above cutting boards needed to be replaced.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. Include a plan to maximize recruitment and retention of direct care staff; and 4. Include a contingency plan for staffing needs. This failure placed the residents at risk for unmet care needs if their assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and includes the active involvement of direct care staff in developing the Facility Assessment. Also includes the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the FA; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 1/23/25 at 1602 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the DON/Interim CNO and the Director of Sub-Acute Unit. The DON/Interim CNO and the Director of Sub-Acute Unit verified the Facility Assessment was dated 1/2/25, and was based on the 10/4/16 CMS regulations. The DON/Interim CNO and the Director of the Sub-Acute Unit verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The DON/Interim CNO and the Director of Sub-Acute Unit further verified there were no resources necessary to care for the residents including weekends, and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The DON/Interim CNO and the Director of Sub-Acute Unit verified and acknowledged the Facility Assessment was not updated based on the latest update from CMS.

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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** 48882 Based on observation, interview, and medical record review, the facility failed to ensure the medical record for one of 13 final sampled resident (Resident 26) was accurate and complete. * The facility failed to ensure Resident 26's Restraint Assessment/Restraint Flowsheet was complete. This failure had the potential for Resident 26's care needs not being met as their medical information was inaccurate. Findings: On 1/21/25 at 0847 hours, Resident 26 was observed sleeping in bed with bilateral soft hand mittens observed. Medical record review for Resident 26 was initiated on 1/21/25. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's Patient Orders dated 1/22/25, showed a physician's order dated 10/16/24, to apply the bilateral hand mittens to prevent the resident from pulling out the medical tubing and to release every two hours for 15 minutes for circulation and skin check. Review of Resident 26's plan of care showed a care plan problem dated 10/16/24, addressing Resident 26's use of hand mittens for safety to prevent pulling out the tubes. The interventions showed to remove the hand mittens every two hours for approximately 15 minutes and to monitor the effectiveness of the hand mittens to determine continued use. Review of Resident 26's Daily Restraint Assessment/Restraint Flowsheet showed the following: - On 1/7/25, from 2000 to 0700 hours, the flowsheet was not completed by the nurse. - On 1/10/25, from 2100 to 0300 hours, the nurse documented the bilateral hand mittens were off. However, from 0400 to 0700 hours, there were no documentation to show if the bilateral hand mittens were reapplied and no documentation to show the hand mittens were released every two hours to check the circulation, movement, and sensation. Under the section for assessing the need for the continuation of the restraint, yes or no was not selected or indicated. - On 1/28/25, from 2000 to 0700 hours, the flowsheet was not completed by the nurse. On 1/22/25 at 1116 hours, an interview was conducted with LVN 4. LVN 4 stated Resident 26 had bilateral hand mittens to prevent him from pulling his medical devices. LVN 4 stated the licensed nurses were responsible for releasing the hand mittens every two hours, for 15 minutes and monitoring the skin and checking the circulation under the hand mittens. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1145 hours, an interview and concurrent medical record review for Resident 26 was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 stated the Restraint Assessment/Restraint Flowsheet should be completed for each shift. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated the nursing documentation should be accurate and complete by the end of each shift to accurately reflect the care the residents received. For the residents with hand mitten restraints, the Director Sub-Acute Unit stated she expected the staff to assess the skin and circulation status every two hours and to release the hand mittens for 15 minutes. The Director of Sub-Acute Unit stated this assessment should be documented, complete, and accurate every day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable disease and infections. * The facility failed to maintain an accurate infection control surveillance program for October 2024 through December 2024. The facility failed to ensure the Surveillance Data was complete and accurate to determine whether the resident's infection met the McGeer's criteria for true infection. * The facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases when one glucometer observed was not cleaned/disinfected per disinfecting wipes manufacturer's instructions. This failure had the potential for spreading serious blood-borne illness to residents who used shared glucometer. These failures have the potential risk for not identifying, managing, containing, and controlling the transmission of communicable disease within the facility. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program reviewed 9/2023 showed the surveillance for the hospital -acquired infections will be performed. Surveillance will include current and retroactive review of diagnostic testing, surgery reports, direct observation, medical records, and post-discharge surgical wound surveillance including 30-90 days follow up on surgical procedures. The facility will analyze and interpret surveillance data, using appropriate statistical techniques to describe, the date, calculate rates, and critically evaluate significance of findings. The Infection Control Preventionist, with guidance and support from the Chairperson of the Infection Control/Pharmacy & Therapeutics Committee has the responsibility for the daily management of infection prevention and control activities. The Infection Control Preventionist: is responsible for managing the facility-wide infection control and surveillance program. This position is accountable for the following responsibilities in collaboration with the Infection Control Chairperson as delegated by the Committee: - To identify, report, investigate, and control infections, - To monitor adherence to policies/risk identification, - Maintain logs related to infections/communicable disease, - Consultation/Educations/communication, - Quality improvement/Risk reduction/Evaluation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Infection Control Surveillance Dashboard for October through December 2024 showed the following documentation: For October 2024: - 16 residents were prescribed antibiotics, - three infections that met McGeer's criteria and 13 infections did not meet McGeer's criteria. For November 2024: - 19 residents were prescribed antibiotics, - three infections that met McGeer's criteria and 16 infections did not meet McGeer's criteria. For December 2024: - 19 residents were prescribed antibiotics, - five infections that met McGeer's criteria and 14 infections did not meet McGeer's criteria . The Infection Control Surveillance Dashboard, failed to identify which infections were HAIs and which infections were CAIs. * For Resident 26, the report showed the following: - the antibiotic treatment prescribed for Resident 26 was Merrem (antibiotic) 500 mg for seven days for pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making breathing difficult and painful). The note showed the resident was from an acute care hospital and the antibiotic was continued per the physician. - the section on the form to indicate whether the infection met the McGeer's criteria for a true infection was not selected. * For Resident 14, the report showed the following: - the antibiotic treatment prescribed for Resident 14 was Zyvox (antibiotic) 600 mg two times a day for five days for blood stream infection. - the section on the form to indicate whether the infection met the NHSN criteria for a true infection was not selected. * For Resident 2, the report showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- the antibiotic treatment prescribed for Resident 2 was Merrem 500 mg three times a day for pneumonia, until 11/28/24. The note showed the resident was sent to the ICU on 11/21/24 and was sent back on 11/26/24 with antibiotics to continue per the physician's order. - the section on the form to indicate whether the infection met McGeer's criteria for a true infection was not selected. * For Resident 17, the report showed the following: - the antibiotic treatment prescribed for Resident 17 was cefepime 2 gm three times a day for blood stream infection, until 12/7/24. - the section on the form to indicate whether the infection met the NHSN criteria for a true infection was not selected. For Resident 17, the report showed the following - the antibiotic treatment prescribed for Resident 17 was vancomycin 125 mg four times a day for c.diff infection. - the section on the form to indicate whether the infection met the McGeer's criteria for a true infection was not selected. * For Resident 27 the report showed the following: - the antibiotic treatment prescribed for Resident 27 was Merrem 500 mg three times a day for pneumonia until 12/20/24. The note showed the resident came back from ICU and antibiotic was order and continued per the physician order. - the section on the form to indicate whether the infection met the McGeer's criteria for a true infection was not selected. On 1/23/25 at 1122 hours, an interview was conducted with the IP. The IP stated he was responsible for coordinating infection control in the facility. The IP stated the monthly surveillance log included all the residents with infections and the infections that met or did not meet the McGeer's criteria. The IP stated the purpose of the log was to determine the prevalences of infections occurring in the facility and to control or contain the infections, as well as ensure adherence to the McGeer's criteria. The IP stated he determined a true infection by following the McGeer's guidelines. The IP stated once the resident developed symptoms or antibiotics are prescribed, the licensed nurses are responsible for completing the form titled Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested definitions of Infections for Surveillance Purposes. The IP stated following the completion of that form, the IP completes the Surveillance Data Form and determines if the McGeer's criteria was met, then that would indicate a true infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 1522 hours, an interview and concurrent documents review was conducted with the IP. The IP verified the above findings. The IP verified the Surveillance Data for Residents 2, 14, 17, 26, and 27 were incomplete. The IP stated he completed the section for the selection of whether the infection met the criteria for true infection only for the residents with HAIs and not for the residents with CAIs, or were already on antibiotics prior to admission to the facility. On 1/23/25 at 1702 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings. 49644 2. CDC Infection Prevention during Blood Glucose Monitoring and Insulin Administration dated 2/6/13, showed The CDC has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements: *whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions .An underappreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV, hepatitis C virus, and HIV)[Human immunodeficiency virus] through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters) are shared. Outbreaks of hepatitis B virus (HBV) infection associated with blood glucose monitoring have been identified with increasing regularity, particularly in long-term care settings, such as nursing homes ., where residents require assistance with monitoring of blood glucose levels .In the last [AGE] years alone, there have been at least 15 outbreaks of HBV infection associated with providers failing to follow basic principles of infection control when assisting with blood glucose monitoring. Due to under-reporting and under recognition of acute infection, the number of outbreaks due to unsafe diabetes care practices identified to date are likely an underestimate Blood glucose meters are devices that measure blood glucose levels. Whenever possible, blood glucose metes should be assigned to an individual person and not be shared. If he blood glucose meter must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CDC Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, undated, at www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html documented Infectious agents, such as HBV, can be transmitted through indirect contact transmission, even in the absence of visible blood. Indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated intermediate object (e.g., blood glucose meter) or person (e.g., healthcare personnel hands). With some blood glucose meters that require pre-loading of the test strip, the device may come into direct or close contact with the patient's fingerstick wound. If blood is transferred from the patient to the meter, and the meter is not cleaned and disinfected after use, subsequent patients can be exposed to this blood when the meter is used on them. Indirect contact transmission can also occur even if the patient never directly contacts the meter. Healthcare personnel hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient's finger or handling the test strip. Blood can then be transferred to the meter when healthcare personnel handle the meter to obtain the reading. If the meter is not cleaned and disinfected after use, the blood remaining on the meter can be transferred to subsequent patients via healthcare personnel hands when they handle the meter and then assist with fingerstick procedures. Numerous outbreaks have implicated this mechanism in the spread of HBV infections A multi-hospital study of blood glucose meters found that 30% were contaminated with blood; contamination was identified at the test strip insertion site as well as on the outside surfaces of meters. Further, HBV has been demonstrated to remain infectious in dried blood on environmental surfaces for at least seven days. For these reasons, blood glucose meters should be cleaned and disinfected after each use, unless they are dedicated to a single patient and appropriately stored to prevent inadvertent contamination. On 1/22/25 at 0934 hours, an observation was conducted with LVN 7. LVN 7 checked Resident 12's blood sugar with the glucometer (device used to check blood glucose by obtaining a drop of the resident's blood) labeled Accu-chek inform II SA#1. With gloved hands, LVN 7 wiped Resident 12's finger with alcohol, moved her hand in fanning motion over the resident's finger, poked finger with the lancet and then squeezed Resident 12's finger to produce a small bead of blood. LVN 7 brought the glucometer with the strip inserted to the bead of blood and glucometer reading was observed. LVN 7 then wiped resident's finger with tissue and placed the glucometer on resident's overbed table and proceeded to administer the resident's medications. After the medications were administered, LVN 7 removed the gloves and gown, washed hands and donned gloves and wiped the glucometer with two wipes from Super Sani Cloth purple top container. The glucometer was touched after 55 seconds, and it was dry to touch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 1017 hours, an interview and concurrent record review was conducted with LVN 7. LVN 7 stated there were two or three glucometers in the facility and it was used and shared by all the residents who required blood glucose checks. LVN 7 stated that it was important to clean and disinfect the glucometer because it was shared and used by multiple residents. When asked about the cleaning and disinfection of the glucometer, LVN 7 stated that she wiped the glucometer with Super Sani Cloth wipe and it needed to be used for two minutes. When asked what needed to happen during the two minutes, LVN 7 stated that you need to keep the glucometer here and can not use it for two minutes. When asked if the glucometer needed to remain wet for two minutes after wiping with the cloth wipes, LVN 7 shook her head and said, no, it does not need to remain wet for two minutes. Review of the Super Sani Cloth wipe with a purple top container label with LVN 7 showed EPA registration # 94804 and to disinfect nonfood contact surfaces only. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes. When asked if the glucometer remained wet for two minutes after she used on the resident, LVN 7 shook her head and said no. LVN 7 confirmed that because of this the glucometer was not completely cleaned and disinfected. On 1/23/25 at 1725 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit was informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48882 Based on interview, facility document review, and facility P&P review, the facility failed to implement an antibiotic stewardship program to reduce the risk of unnecessary or inappropriate antibiotic use. Residents were being treated for conditions which did not meet the McGeer's criteria (a surveillance data collection tool used in long-term care facilities to identify if residents' symptoms meet the criteria of a true infection). This had the potential to expose the residents to unnecessary antibiotic use, which may increase the residents' risk for multidrug resistant organisms (MDRO, germs that are resistant to many antibiotics). Findings: According to the CDC, antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Antibiotic Stewardship for Sub-Acute reviewed 5/2023 showed all resident's culture and sensitivity results will be monitored by the pharmacy. Intervention will proceed by informing the physician of the results and any recommendations to start or changed the antibiotic therapy. In collaboration with Infection Control, antibiotic utilization will be prescribed in accordance with the criteria established by the Infection Control unless requested otherwise by the physician. For all the residents with negative cultures that have active empiric antibiotic therapy, the pharmacist shall evaluate the appropriateness of recommending stopping the empiric antibiotic. If deemed appropriate the pharmacist shall contact the physician. This shall be documented in the resident's electronic medical record. Criteria for the infections will be outlines by Infection Control and will be based on the McGeer's criteria but finalized by Physicians, Pharmacy, Quality, Infection Control and the Medical Executive Committee. The Pharmacy will coordinate with Infection Control to determine if prescribed antibiotics and infections agree with established policies. If the residents did not meet the infection criteria, Infection Control designee must immediately inform the pharmacy to make recommendations to the physician. Review of the facility's Infection Control Surveillance Dashboard for October 2024 through December 2024 showed the following documentation: For October 2024: - 16 residents who were prescribed antibiotics, - three infections that met the McGeer's criteria and 13 infections that did not meet the McGeer's criteria. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555567	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Coast Global Medical Center D/P Snf	2701 South Bristol Street Santa Ana, CA 92704

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For November 2024: - 19 residents were prescribed antibiotics, - three infections met the McGeer's criteria and 16 infections did not meet the McGeer's criteria. For December 2024: - 19 residents were prescribed antibiotics, - five infections met the McGeer's criteria and 14 infections did not meet the McGeer's criteria. Review of Resident 27 's Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested Definitions of Infections for Surveillance Purposes showed Resident 27's onset date of 12/16/24 and Resident 27 had ESBL (Extended-Spectrum Beta-Lactamase, an enzyme that makes bacteria resistant to certain antibiotics) in the sputum, however under the section Criteria for Infection, the selections were not made. The documentation on the form showed Merrem (antibiotic) 500 mg IV every eight hours until 12/20/24, continuation from the ICU. Review of Resident 27's Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested Definitions of Infections for Surveillance Purposes showed Resident 27's onset date of 12/22/24, with an arrow to indicate gastroenteritis. The documentation on the form showed metronidazole (antibiotic) 500 mg IV every eight hours for 14 days, and Vancomycin (antibiotic) 500 mg via GT four times a day for seven days, for increased WBC. The selections for type of infection or criteria for infection were not selected. Review of Resident 28's Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested Definitions of Infections for Surveillance Purposes showed Resident 28's onset date of 12/17/24, under skin/soft tissue wound, the documentation showed ceftriaxone (antibiotic) two grams IV daily for the scalp wound. The selections for type of infection or criteria for infection were not selected. On 1/23/25 at 1122 hours, an interview was conducted with the IP. The IP stated he was responsible for coordinating the infection control in the facility. The IP stated the monthly surveillance log included all the residents with infections and the infections that met or did not meet the McGeer's criteria. The IP stated the purpose of the log was to determine the prevalences of the infections occurring in the facility and to control or contain the infections, as well as to ensure adherence to the McGeer's criteria. The IP stated he determined a true infection by following the McGeer's guidelines. The IP stated once the resident developed symptoms or antibiotics were prescribed, the licensed nurses were responsible for completing the form titled Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested Definitions of Infections for Surveillance Purposes. The IP stated following the completion of that form, the IP completed the Surveillance Data Form and determined if the McGeer's criteria was met, which indicated a true infection. (continued on next page)

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	555567	A. Building B. Wing	01/23/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 1522 hours, a follow up interview and concurrent facility document review was conducted with the IP. The IP verified the above findings. The IP stated the licensed nurses completing the Healthcare associated Infections (HAI) in Skilled Nursing Facilities (SNF) Suggested Definitions of Infections for Surveillance Purposes form should have accurately completed the form and selected all the boxes. On 1/23/25 at 1648 hours, an interview was conducted with the Director of Sub-Acute Unit. The Director of Sub-Acute Unit stated the licensed nurses were responsible for completing the screening process for the residents with infections. The Director of Sub-Acute Unit stated before the initiation of the antibiotics or at the time the antiobiotic was orderded by the physician, the licensed nurse should complete the screening tool accurately and completely. Following the completion of the screening tool, the IP would review and determinie whether the infection met the McGeer's criteria for a true infection. On 1/23/25 at 1559 hours, an interview was conducted with the Director of Sub-Acute Unit and the DON. The Director of Sub Acute Unit was asked about the high prevalence of the residents on antibiotic therapy who did not meet the McGeer's criteria. The Director of Sub Acute Unit stated the issue was discussed in the QAPI Meeting in July 2024 and the Medical Director was aware and had contacted the physicians. When asked about the monitoring of the antibiotic use since then, the Director of Sub-Acute Unit stated in August 2024 there were five infections that met the McGeer's criteria and 17 that did not meet; in September 2024 there were two infections that met the criteria and 28 that did not meet; and in October 2024 there were three infections that met the criteria and 16 that did not meet. When the Director of Sub-Acute Unit was asked about the action taken for these surveillance data, the Director of Sub-Acute Unit stated she monitored for the antibiotic stewardship compliance by ensuring the licensed nurses were documenting the physicians were informed, with no new orders, when the McGeer's criteria were not met. The Director of Sub-Acute Unit stated the purpose of the antibiotic stewardship program was to prevent the unnecessary use of antibiotics and prevent the potential resistance to antibiotics. The Director if Sub-Acute Unit agreed she was incorrectly tracking the antibiotic stewardship. On 1/23/25 at 1702 hours, the Director of Sub-Acute Unit was informed and acknowledged the above findings.