STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to ensure dignity related to the use of a urinary catheter bag (a flexible, plastic tube inserted into the body, in order to drain urine to an external collection bag) was maintained for one of three residents' (Resident 218) reviewed for dignity and resident rights. This failure had the potential for Resident 218, to feel embarrassed or humiliated when the draining urine was visible to others. Findings: Resident 218 was readmitted to the facility on [DATE], with diagnoses which included urinary tract infection (infection in the urine), per the facility's Admission Record. An observation was conducted on 12/2/24 at 9:23 A.M. Resident 218 was in bed. A urinary catheter bag was clipped to the left side of the bed frame and was visible upon entering the room. The urinary catheter bag was 1/4 full of cloudy, pale colored urine. A dignity bag (a dark colored bag which covers the urine collection bag to protect a resident's dignity) was not present. A review of Resident 218's clinical record was conducted on 12/2/24. According to the physician's order, dated 11/18/24, .Catheter: Indwelling urinary (Foley) catheter is in a privacy bag . According to the care plan, dated 11/16/24, titled Indwelling Foley Catheter, listed interventions such as, .cover with dignity bag . An observation and interview was conducted with certified nursing assistant (CNA) 31 on 12/2/24 at 9:25 A.M. CNA 31 observed Resident 218 and stated there was no dignity bag covering the urinary drainage bag, and there should be one. CNA 31 stated Resident 218 returned from the hospital the night before, and someone should have placed a dignity bag when she returned. An interview was conducted with licensed nurse (LN) 32 on 12/2/24 at 9:50 A.M. LN 32 stated that all residents with urinary drainage bags should have the bag covered with a dignity bag to protect the resident's privacy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated that all residents with a urinary catheter should have their bag contained within a dignity bag for the resident's dignity. The DON stated it did not matter if the resident was alert or not, that a resident's dignity should always be protected. According to the facility's policy, titled Quality of Life, dated August 2009, .11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered; .

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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** 39111 Based on interview and record review, the facility failed to provide a written notice of transfer to a resident's responsible party (RP) and the Long-Term Care Ombudsman for one of three residents (Resident 296) reviewed for closed records. This deficient practice had the potential for the Resident 296's RP to not be aware of the resident's rights pertaining to transfers. Findings: A review of Resident 296's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 296's Alert Charting dated 9/27/24, indicated the resident was found unconscious and was transferred to the hospital for evaluation. On 12/5/24 at 11:40 A.M., an interview was conducted with the director of nursing (DON). The DON stated she reviewed Resident 296's clinical record and that there was no documentation a written notice of transfer was provided to the resident's RP, nor sent to the Long-Term Care Ombudsman. The DON stated Resident 296's written notice of discharge should have been completed by nursing staff and a copy provided to the resident's RP and the Long-Term Care Ombudsman. A review of the facility's policy titled Transfer or Discharge Notice, revised March 2021, indicated, .4. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge .d. An immediate transfer or discharge is required by the resident's urgent medical needs .5. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer .b. The effective date of the transfer .c. The location to which the resident is being transferred .d. An explanation of the resident's right to appeal the transfer .6. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to report one of one resident's (Resident 75) sampled for a Significant Change of Condition to the Centers for Medicare and Medicaid Services (CMS, a federal health care agency). This failure had the potential for CMS to not be informed of Resident 75's current health status. Findings: Resident 75 was readmitted to the facility on [DATE], with diagnoses which included sprain to left wrist secondary to fall, per the facility's Admission Record. An observation of Resident 75 was conducted on 12/2/24 at 9:42 A.M., in the activity room. Resident 75 was dressed, sitting in a wheelchair, with a plaster-type splint on top and beneath her left wrist. The splint was held in place with a [brand of gauze dressing] wrap near the left forearm. The splint had dark brown/black smudges over the top and bottom areas near the palm of her left hand and wrist. Resident 75's clinical record was reviewed on 12/2/24: According to the SBAR (Situation, Background, Assessment, Recommendation) report, dated 9/26/24, Resident 75 had an unwitnessed fall on 9/26/24 at 7:15 A.M., and complained of left wrist pain. According to the emergency room record, dated 9/26/24, the x-ray indicated soft tissue swelling with severe osteoarthrosis, (degenerative joint disease). According to the physician's order, dated 9/29/24, .Splint to left wrist for support. May remove during ADLs (activities of daily living i.e.[that is/for example], showers, eating, dressing). Check skin integrity for any redness .every shift for sprain . According to the Minimum Data Set (MDS; a clinical assessment tool), dated 10/25/24, titled Significant Change of Condition, the resident was not identified as having any falls. An interview and record review was conducted with the Minimum Data Set Nurse 1 (MDSN 1) on 12/03/24 at 3:59 P.M. MDSN 1 stated Resident 75 had a Significant Change of Condition reported to CMS on 10/25/24, for a G-Tube placement (a small tube that's surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine). MDSN 1 stated Resident 75's fall should have been captured and reported during the Significant Change of Condition report, but it was missed. The MDSN 1 stated since the fall was missed and not reported, CMS did not have an accurate picture of what was currently going on with the resident. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated she expected all MDS data to be accurate, so CMS could be informed of the resident's current status. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Resident Assessment Instrument, dated October 2019, Section J1800: any fall since admission with a six month look back period, are required to be reported to CMS. Falls with injury (except major) includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprain, any fall-related injury that causes the resident to complain of pain. According to the facility's policy, titled Falls and Fall Risk, Managing, dated March 2018, .definition: According to MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or lower level .A fall without an injury is still a fall .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to develop and implement care plans for four of 38 sampled residents (264, 283, 95, 145) when: 1. A care plan for potential fluid overload (when a resident has too much fluid in their system) was not developed for a resident who was on fluid restrictions; 2. A care plan for safe smoking was not developed; 3. A medication patch was not removed before applying a new patch; 4. A pressure relieving mattress was not set to the correct setting; and 5. A personalized care plan for activities was not developed. These failures had a potential for inconsistent care, while approaches for interventions were not being conducted by staff. Findings: 1. Resident 264 was readmitted to the facility on [DATE], with diagnoses which include emphysema, (a chronic lung disease that damages the air sacs in your lungs, making it difficult to breathe), and arteriosclerotic heart disease (a condition of reduced blood flow and oxygen to the heart muscle), per the facility's Admission Record. Resident 264's clinical record was reviewed on 12/3/24: The Minimum Data Set (a clinical assessment tool), dated 10/28/24, listed a cognitive score of 11, indicating moderate cognitive impairment. According to the physician's order, dated 9/6/24, Fluid restriction 1500 milliliters (ml)/24 hours dietary. The Medication Administration Record (MAR) was reviewed from 11/1/24 through 12/4/24. Three of the 34 days had over the limit of 1500 ml in a 24 hour period. (11/6/24 totaled 1660 ml, 11/28/24 totaled 1600 ml, and 12/2/24 totaled 1560 ml). There was no documented evidence a care plan for fluid overload, or fluid restrictions was developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and record review was conducted with licensed nurse (LN) 33 on 12/4/24 at 9:03 A.M. regarding Resident 264's fluid restriction. LN 33 stated if a resident went over their fluid limit, the nurse should have contacted the physician and document it in the nurse's notes. LN 33 reviewed Resident 264's nurse's notes for 11/6/24, 11/28/24, and 12/2/24, and stated there were no nurse's notes indicating the physician had been notified. LN 33 stated residents on fluid restrictions were at risk for respiratory problems such as their lungs filling with excess fluid. LN 33 stated the resident could also experience heart problems, and ankle swelling from too much fluid. LN 33 stated this resident did not always comply with the fluid restrictions and there should have been a care plan for non-compliance, along with the risk of fluid overload. An interview and record review of Resident 264's care plans was conducted with LN 32 on 12/04/24 at 9:19 A.M. LN 32 stated Resident 264 was on fluid restrictions and the resident's care plans were reviewed. LN 32 stated she could not locate a care plan related to fluid overload, fluid restrictions, or for non-compliance of fluid restrictions. LN 32 stated care plans were important for goals and consistent interventions. LN 32 stated by not having a care plan, the resident was at risk for respiratory problems, heart problems, and weight gain, which could put him at risk of harm. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated care plans needed to be developed and followed for consistent approaches of interventions. According to the facility's policy, titled Care Plans, Comprehensive Person-Centered, dated December 2016, . 7. The comprehensive, person-centered care plan will: .g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; .k. reflect treatment goals, timetables and objectives in measurable outcomes; .m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; . 2. Resident 283 was admitted to the facility on [DATE], with diagnoses which include chronic kidney disease (when the kidneys are damaged and cannot filter blood toxins properly), per the facility's Admission Record. An observation and interview was conducted with Resident 283 in his room on 12/2/24 at 8:29 A.M. Resident 283 was standing up, dressed, and checking his watch, stating I can go and smoke at 9 A.M. Resident 283's clinical record was reviewed on 12/03/24: According to the Minimum Data Set (a clinical assessment tool) dated 7/29/24, a cognitive score of 14 was listed, indicating cognition was intact. An initial Smoking assessment dated [DATE] was reviewed. The assessment indicated the resident was identified as a smoker and required supervision. Section 9 of the smoking assessment indicated a Plan of Care was being used to assure Resident 283 was safe while smoking. There was no documented evidence a plan of care for safe smoking had been developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and record review was conducted with licensed nurse (LN) 32 on 12/4/24 at 8:05 A.M., regarding Resident 283's care plan and smoking assessment. LN 32 stated care plans for smoking were important to identify strengths and weakness, so goals and interventions could be implemented. LN 32 reviewed Resident 283's care plans and stated she could not find any documented evidence a care plan for safe smoking had been developed. An interview and record review was conducted with Minimum Data Set Nurse (MDSN) 1 on 12/4/24 at 8:57 A. M., regarding Resident 283's smoking. MDSN 1 stated all resident's that smoke, should have had a smoking care plan. MDSN 1 reviewed Resident 283's care plans and stated he could not locate a care plan related to smoking. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated Resident 283 should have had a care plan for smoking, to ensure his safety needs were being met. According to the facility's policy, titled Care Plans, Comprehensive Person-Centered, dated December 2016, . 7. The comprehensive, person-centered care plan will: .g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; .k. reflect treatment goals, timetables and objectives in measurable outcomes; .m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; . According to the facility's policy, titled Smoking Policy-Residents, dated August 2022, .Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues . 39448 3. Per the facility's Admission Record, Resident 95 was admitted to the facility on [DATE] with diagnoses which included dementia (a mental and physical decline). On 12/2/24 at 9:22 A.M., an observation was conducted. Resident 95 was lying in bed. Two medication patches were adhered on his left shoulder. The patches were both labeled rivastigmine (a medication to treat dementia). One patch was dated 11/30, and the other was dated 12/2. Per the facility's Order Details, there was an order for Resident 95 dated 1/8/24 for, .Rivastigmine transdermal (a medication delivered through the skin) patch 24 hour .Apply 1 patch .one time a day .and remove per schedule . On 12/2/24 at 10:08 A.M., a concurrent observation and interview was conducted with Licensed Nurse (LN) 34. LN 34 stated, he thought he removed the old rivastigmine patch when he applied the new one that morning, but he might have forgotten to remove it. LN 34 further stated, when they applied a new patch of rivastigmine, they should have removed the old one, and he should only have had one patch on at a time. On 12/5/24 at 8:53 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, when a nurse placed a new medication patch, they should have removed the old one. The DON further stated, it would not have been okay for a resident to have two medication patches on at once. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy, titled Administering Topical Medications, revised October 2010, .b. Remove old patch . 4. Per the facility's Admission Record, Resident 95 was admitted to the facility on [DATE] with diagnoses that included dementia (a mental and physical decline) and contracture (a shortened muscle preventing movement of the joint) of the legs. On 12/2/24 at 9:22 A.M., an observation was conducted. Resident 95 was lying on a pressure relieving mattress which was set to 170. Per the facility's Order Details, Resident 95 had an order dated 2/1/24 for, SETTINGS: 150 Apply LAL (low air-loss. Pressure relieving) mattress for wound management/preventive measures. Check placement, settings and functionality QS (every shift). On 12/4/24 at 12:28 P.M., an interview was conducted with Licensed Nurse (LN) 34. LN 34 stated, Resident 95's pressure relieving mattress should have been set to 150. On 12/5/24 at 8:51 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, pressure relieving mattresses should have been set to the manufacturers guidance, and to the resident's weight. The facility's policy, titled Support Surface Guidelines, revised September 2013 did not have directions on what settings to use for a pressure relieving mattress. 48263 5. A review of Resident 145's Admission Record indicated Resident 145 was readmitted to the facility on [DATE] with diagnoses which included a history of adult failure to thrive (a gradual decline in overall health caused by illnesses, depression, or social isolation). On 12/2/24 at 10:27 A.M., an interview was conducted with Resident 145, in Resident 145's room. Resident 145 had a lamp table on the right side of his bed that had a compact disc (CD) case and a CD player placed on top of the table. Resident 145 stated he liked to listen to music and chat on the phone with his daughters and walk around outside, but has not done any activities for a while. Resident 145 stated he was unable to enjoy his own music at times, because he would not be able to hear it due to the roommate's music or television noise. Resident 145 stated that the facility did not give him headphones or asked if he wanted to use headphones to enjoy his music and stated that was the reason why he just wanted to lay in bed most of the time. On 12/3/24 at 3:40 P.M., an interview was conducted with Resident 145, in Resident 145's room. Resident 145 was lying in bed resting and stated he did not participate in any activities for the last two days. Resident 145 stated that his roommate's television (TV) had been on most of the day and it was a bit loud but he did not notify the staff about the noise because, no one listens. On 12/3/24 at 3:54 P.M., an interview was conducted with Certified Nurse Assistant (CNA) 53. CNA 53 stated that she had been assigned to Resident 145 on more than one occasion and that Resident 145 also liked to listen to music just like his roommate. CNA 53 stated that Resident 145 did not have headphones. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 8:36 A.M., an interview was conducted with Resident 145, in Resident 145's room. Resident 145 denied doing any activities that he enjoyed and stated he had not chatted with his daughters because the facility phone was out of reach and not on top of his lamp table until that day. Resident 145 stated that he really wanted to go outside to enjoy the outdoors instead of being in his room most of the day. On 12/4/24 at 3:31 P.M., a concurrent interview and record review was conducted with the Activities Assistant (AA) and the Activities Director (AD). The AA stated Resident 145 did not participate in any group activities from November to December of this year. The AA stated Resident 145 liked listening to his music CD's but did not have headphones to enjoy them without disturbing his other roommates. The AA stated if she were in Resident 145's shoes (place/situation) and was unable to enjoy the music she wanted, this would make her feel sad. The AD stated that Resident 145's preferred activities should have been incorporated into his care plan for personalization. The AD stated that care plans were revised quarterly and should have been based on the activities that Resident 145 enjoyed. The AD stated that the care plan was last updated on 10/11/24, but was generic and did not include person-centered activities such as music, outdoor, and physical activities that Resident 145 liked to do. On 12/5/24 at 9:31 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 145's care plan should have reflected the activities that he enjoyed, such as his music, outdoors activities, telephone/visits with his daughters. The DON stated Resident 145's care plan should have been person-centered and not generic. A review of the facility's policy and procedure, titled CAREPLANS, COMPREHENSIVE PERSON-CENTERED, Revised March 2022, indicated .7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation, interview, and record review, the facility failed to update a care plan to include a positioning aide to prevent falls for one of 38 sampled residents (273). As a result, the positioning aide may not have been used consistently among staff caring for Resident 273. Findings: Per the facility's Admission record, Resident 273 was admitted to the facility on [DATE] with diagnoses which included dementia (a mental and physical decline), weakness, and repeated falls. On 12/3/24 at 3:50 P.M., an observation of Resident 273 was conducted. Resident 273 was lying in bed. A pillow was under the sheet at the exit of the bed. On 12/4/24 a review of Resident 273's medical record was conducted. There were no orders or care plans that included instructions to place a pillow under the sheet, or for a positioning aide to prevent the resident from falling out of the bed. On 12/4/24 at 10:01 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated, he often placed a pillow under the sheet. CNA 3 stated, if the pillow were not there, Resident 273 would have gotten out of bed and fallen to the ground. On 12/4/24 at 10:06 A.M., an interview was conducted with Licensed Nurse (LN) 4. LN 4 stated, Resident 273 was at high risk for falls, and placing a pillow under the sheet was necessary to keep him from falling out of bed. On 12/4/24 at 3:52 P.M., an interview was conducted with CNA 22. CNA 22 stated, she did not place a pillow under the sheet when she worked with Resident 273. On 12/5/24 at 1:42 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, staff were placing a pillow under Resident 273's sheet as a positioning aide to keep him from falling out of bed. The DON further stated, the care plan should have been updated to include the positioning aide. Per the facility's policy, titled Care Plans, Comprehensive Person-Centered, revised March 2022, .The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest .well-being .

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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** 49330 Based on observation, interview and record review, the facility failed to provide a low air loss (LAL) mattress (a specialized mattress designed to prevent and treat pressure related wounds) for one of two residents (Resident 105) reviewed for pressure injuries (injury to the skin caused by pressure, usually over bony areas). As a result, there was a potential for Resident 105 to develop new wounds and/or for his pressure injuries to become worse. Findings: According to the Admission Record, Resident 105 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (weakness on one side of the body) affecting left non-dominant side, pressure ulcer of the back, left upper back, and left hip. On 12/3/24 at 9:35 A.M., Resident 105 was observed laying on his back in bed, on a regular mattress. A review of Resident 105's physician's orders dated 10/22/24 indicated, Apply LAL mattress for wound management/preventive measures. Check placement, settings and functionality QS (every shift). On 12/3/24 at 3:13 P.M., an interview was conducted with the Treatment Nurse (TN). The TN stated Resident 105 needed a low air loss mattress due to multiple pressure injuries. The TN acknowledged Resident 105 did not have a low air loss mattress, but should have had one when he was admitted because it was a physician's order. The TN stated, .It looks like he was overlooked . On 12/4/24 at 11:32 A.M., an interview was conducted with the Wound Nurse Practitioner (WNP). The WNP stated a low air loss mattress was important for Resident 105, .to help distribute the weight and pressure points (bony areas of the body prone to pressure injuries) throughout the body. It would've benefited [Resident 105] to have a low air loss mattress . On 12/5/24 at 10:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for the nurses to follow the physician's order for a low air loss mattress. The DON stated, [Resident 105] came in with multiple wounds .if there are wounds present, we don't want the patient to regress (worsen) . A review of Resident 105's care plan dated 10/22/24 indicated, Resident is at risk for pressure injury development and skin breakdown r/t (related to) bony prominences (pressure points) .hx (history) of pressure injury, immobility (difficulty moving) .Apply Low Air Loss Mattress as ordered to relieve pressure points & (and) check placement QS . A review of the facility's policy titled Support Surface Guidelines, revised 9/2013 indicated, .Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as .air-loss . when lying in bed .

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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** 39220 Based on observation, interview, and record review, the facility failed to complete a quarterly safe Smoking Assessment, and ensure a resident's meal was set to ensure safety while eating, for two of 38 sampled resident's (283, 259). As a result, residents were placed at an increased risk of injury. Findings: 1. Resident 283 was admitted to the facility on [DATE], with diagnoses which include chronic kidney disease (when the kidneys are damaged and cannot filter blood toxins properly), per the facility's Admission Record. An observation and interview was conducted with Resident 283 in his room on 12/2/24 at 8:29 A.M. Resident 283 was standing up, dressed, and checking his watch, stating I can go and smoke at 9 A.M. Resident 283's clinical record was reviewed on 12/3/24: According to the Minimum Data Set (MDS; a clinical assessment tool) dated 7/29/24, a cognitive score of 14 was listed, indicating cognition was intact. An initial Smoking assessment dated [DATE] was reviewed. The assessment indicated the resident was identified as a smoker and required supervision. There was no documented evidence a quarterly safe Smoking Assessment (due 10/2024) had been conducted after the initial assessment (7/29/24). An interview and record review was conducted with Licensed Nurse (LN) 32, on 12/4/24 at 8:05 A.M., regarding Resident 283's smoking assessment. LN 32 stated she did not see a quarterly smoking assessment, only the initial smoking assessment was completed. LN 32 stated quarterly assessments were important to ensure the resident could smoke safely and to identify any deterioration in their function, such as holding cigarettes. LN 32 stated Minimum Data Set Nurse (MDSN) 1 was responsible for quarterly assessments. An interview and record review was conducted with MDSN 1 on 12/4/24 at 8:57 A.M., regarding smoking assessments. MDSN 1 stated the Activities Director, conducted the quarterly smoking assessments, since they were the ones who monitored the resident who smoked. MDSN 1 stated quarterly smoking assessments needed to be completed because a resident's condition could have deteriorated, which would put them at a higher risk for injury, while smoking. MDSN 1 reviewed Resident 283's assessments and stated a quarterly smoking assessment was due on 10/29/24, and he could not see that one was completed. MDSN 1 stated all residents who smoked should have had quarterly smoking assessments completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the Activities Director (AD) on 12/4/24 at 9:49 A.M. The AD stated she did (completed/conducted) all quarterly smoking assessments for residents who smoked, which was every four months. The AD stated she observed the residents during smoking sessions, noted any changes, and then she discussed the observations with LNs and the social worker. The AD reviewed Resident 283's assessments and stated Resident 283 should have had a quarterly smoking assessment completed in October 2024, and she could not see that one was completed. The AD stated, I missed it. The AD stated Resident 283's health could have declined. The AD stated by not completing the quarterly smoking assessment, Resident 283 could have been harmed. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated by not completing a quarterly Smoking Assessment, there could have been a safety issue and potential harm occurring to Resident 283. According to the facility's policy, titled Smoking Policy-Residents, dated August 2022, .8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (Physical or cognitively) and as determined by staff . 39448 2. Per the facility's Admission Record, Resident 259 was admitted to the facility on [DATE] with diagnoses which included mild neurocognitive disorder (a decline in mental abilities), malnutrition (a lack of nutrients), and gout (a disorder of joint pain). On 12/2/24 at 8:57 A.M., an observation and interview was conducted with Resident 259. Resident 259 stated that she had problems with her balance. Resident 259 was observed to be standing in her room moving unsteadily from side to side. Certified Nursing Assistant (CNA) 25 came into Resident 259's room and placed a meal tray on the table at the foot of the bed. The table was in the low position and there was no place to sit near the table. CNA 25 left the tray on the table without adjusting the table's position, or asking Resident 259 where she wanted to eat her meal. Resident 259 walked to the table, bent down to reach her plate, and cut and ate her pancakes while standing in a hunched over position. Resident 259 stated that she wished she could sit while eating, but sometimes staff set her meal tray so that she had to stand, bend over her tray, and try to maintain her balance while eating. On 12/2/24 at 9:12 A.M., an interview was conducted with CNA 25. CNA 25 stated, Resident 259 had a problem with her foot which made it difficult for her to walk, and she primarily used a wheelchair when she needed to go somewhere further than across the room. CNA 25 further stated, she thought that Resident 259 would have told her if she wanted to sit while eating. On 12/4/24 at 4:02 P.M., an interview was conducted with CNA 2. CNA 2 stated, Resident 259 ate her meals while sitting in the wheelchair or on the bed, but never standing. CNA 2 further stated, Resident 259 wobbled while standing and had an increased risk for falls. CNA 2 stated, she did not think it was safe for Resident 259 to eat while standing and leaning over the table. On 12/5/24 at 8:48 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, a resident could eat while standing if they requested it, but otherwise the CNA should have set up Resident 259's meal so that she could safely sit while eating. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not have a policy on setting up resident meal trays.

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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** 50175 Based on observation, interview, and record review, the facility failed to ensure a physician's order was followed for one of four residents observed during medication administration, when Resident 58's medication was held (not administered) without an order. This failure had the potential for Resident 58's needs to go unmet. Findings: Resident 58 was admitted to the facility on [DATE] with a diagnosis including hypertensive chronic kidney disease (a cycle where kidney damage leads to high blood pressure and high blood pressure leads to kidney damage) per the Admission Record. A medication administration observation was conducted on 12/4/24 at 9:49 A.M. Licensed Nurse (LN) 13 administered medications to Resident 58. However, LN 13 did not administer prazosin (a medication used to treat high blood pressure in patients with kidney disease) to Resident 58. A review of Resident 58's active physician's orders was conducted on 12/4/24, which indicated prazosin was ordered starting on 6/27/24. There were no hold parameters ordered (a physician's order indicating when a licensed nurse would not give the medication). A review of Resident 58's medication administration record indicated the medication was scheduled to be given at 9 A.M. An interview with LN 13 was conducted on 12/4/24 at 11:42 A.M. LN 13 stated that prazosin was held even though there were no hold parameters. LN 13 stated he had not yet notified the physician that prazosin was held. An interview with the Director of Nursing (DON) was conducted on 12/5/24 at 9:20 A.M. The DON stated it was their expectation for the nurse to notify the physician right away if a medication was held and there were no hold parameters, so as not to delay the administration of the medication. A review of the facility's policy, titled Administering Medications, revised 4/2019, indicated .4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to ensure one of 38 sampled residents' (145) medication was properly stored when a medication was left unattended at the bedside. This failure had the potential for medication misuse and/or unauthorized person to have access, take/use the medication wrongfully. Findings: Resident 145 was readmitted to the facility on [DATE] with diagnoses which included a history of atherosclerotic heart disease (a condition that could lead to heart attacks), per the Admission Record. On 12/3/24 at 8:04 A.M., an observation and interview was conducted with Licensed Nurse (LN) 56, in Resident 145's room. Resident 145 was asleep with bed linens covering his head. Next to Resident 145's bed was his bedside table, that had two cups containing red juice, and an unlabeled medication cup that contained an oval shaped yellow pill. LN 56 stated that the medication cup with the pill should not have been left unattended because that was not a safe practice. LN 56 stated leaving a medication unattended could also be a safety concern for other residents or anyone visiting Resident 145's room because someone might take the pill without permission and have an allergic reaction. LN 56 stated LN's should not leave the medications unattended because it was their responsibility to make sure that the medications prescribed had been taken according to the five rights (common nursing guidance on how to administer resident medications to match the correct resident, route, dosage, reason, and documentation) of medication administration, and monitored to prevent for any side effects. On 12/5/24 at 8:29 A.M., an interview was conducted with LN 52. LN 52 reviewed a picture of Resident 145's bedside table with an unattended medication. LN 52 stated medications should not have been left unattended for any reason. LN 52 stated it was important to witness Resident 145 take the medication for his safety. LN 52 stated that leaving an unattended medication at the bedside would be a safety concern because someone else could have taken the medication. LN 52 further stated, if the medication was documented as being given but was actually not, staff would not know if they were giving the resident the correct amount of medication. On 12/5/24 at 9:26 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations for the LN's was to not leave any medications unattended at the bedside and to store medications appropriately for safety. The DON stated medications left unattended caused a safety concern for other residents, visitors or staff. The DON further stated, unattended medication may cause a medication divergence (medication is taken for use by someone other than whom it is prescribed) and/or cause an allergic reaction if someone else took the medication other the prescribed resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled STORAGE OF MEDICATIONS, revised November 2020, indicated .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to provide food that accommodated resident's preferences for one of 38 sampled residents (51). This failure resulted with Resident 51 receiving coffee which was listed as a food the resident disliked. Findings: Resident 51 was readmitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), per the Admission Record. On 12/2/24 at 11:55 A.M., an interview was conducted with Resident 51, in Resident 51's room. Resident 51 stated that he did not eat his breakfast because he liked to eat pancakes with two butter packets. Resident 51 stated that he preferred to be given two butter packets on his breakfast tray but they [the facility staff] always forget. On 12/2/24 at 1:10 P.M., an observation and interview was conducted with Resident 51, in Resident 51's room. Resident 51 was in bed sitting in an upright position with his food tray on his bedside table. Resident 51 had coffee on his food tray and stated, it says right here on my meal ticket, dislikes coffee, and they still serve it to me. A clinical chart review of Resident 51's nutritional evaluation, dated 10/30/23, titled Food Preference, indicated, Food Intolerances . coffee. On 12/5/24 at 8:35 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 54. CNA 54 stated he was assigned to Resident 51 and stated it was important to double check any facility residents' meal tickets to make sure their preferences were accommodated. CNA 54 stated that the nursing staff were the ones placing coffee on the food trays prior to passing the food trays to the facility residents. CNA 54 reviewed a picture of Resident 51's food tray and meal ticket that was taken on 12/2/24 and stated, it was inappropriate to place coffee on Resident 51's food tray because it was on Resident 51's dislikes list. CNA 54 stated Resident 51 would get mad and that it was common sense to make sure not to place coffee on his food tray because Resident 51 had prior episodes of getting mad when his preferences were not honored. On 12/5/24 at 8:42 A.M., an interview was conducted with CNA 55. CNA 55 stated she was familiar with Resident 51 and stated, he does not like coffee. CNA 55 stated that the CNAs were responsible for pouring out the coffee for residents and that the CNAs should have been looking at the meal tickets to make sure that preferences were accommodated and not served with dislikes. CNA 55 stated coffee should not have been placed on Resident 51's food tray because he would get mad at the staff who gave it to him. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 8:47 A.M., an interview was conducted with Licensed Nurse (LN) 52. LN 52 stated it was the CNAs and not the kitchen staff that passed out coffee. LN 52 stated it was important to check Resident 51's meal ticket to make sure they didn't serve him coffee because it was on his dislikes list. LN 52 stated Resident 51 had been assigned to her for a while and she knew that Resident 51 did not like coffee and that he would get upset because he was very particular with his meals. On 12/5/24 at 9:45 A.M., an interview was conducted with the Director of Nursing (DON). The DON reviewed a picture of Resident 51's meal ticket and food tray taken on 12/2/24. The DON stated it was her expectations for the nursing staff to honor Resident 51's food preference and not have the coffee placed on his food tray. The DON stated Resident 51 would get upset and it was understandable that Resident 51 yelled at the nursing staff. A review of the facility's policy and procedure titled MENUS revised October 2017, indicated .Menus are developed and prepared to meet resident choices .Menu items and available snacks reflect the . preferences of the residents .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to ensure safe food handling practices when: 1. Fruit was not labeled and dated when prepared and placed in one of four refrigerators (reach-in refrigerator #1); 2. Food was not labeled and dated when placed in one of five resident refrigerators (Station 5); 3. A temperature log for one of five resident refrigerators (Station 3) was incomplete; and, 4. Dishwasher (DSWH) 1 and DSWH 2 did not perform hand hygiene after disposing trash. These failures had the potential to cause food-borne illness to residents. Findings: 1. An interview and observation of the kitchen's reach-in refrigerator #1 was conducted with the Registered Dietician (RD) during the initial kitchen tour on [DATE] at 7:42 A.M. On the bottom right of the refrigerator were two clean plastic containers with lids. One container contained a ,d+[DATE] cut and peeled cantaloupe. The second larger container contained two large chunks of cut and peeled watermelon. No dates were on either container, indicating when the fruit was received, cut, prepared, and placed in the refrigerator. The RD stated the fruit could have been expired and no one would have known, since it was not dated and labeled. According to the facility's policy, titled Labeling and Dating of Food, dated 2023, .All prepared foods need to be covered, labeled, and dated. Produce is to be dated with received date. Leftovers will be covered, labeled, and dated . 2. An interview and observation of Station 5's refrigerator was conducted with Certified Nursing Assistant (CNA) 32 on [DATE] at 3:12 P.M. Inside the resident refrigerator was a glass container, labeled cheese dip. The jar was ,d+[DATE] consumed and on the outside, written in black felt pen was #5XX, E. BXXX. CNA 32 stated the cheese dip jar was not labeled with the date of when it was opened and room [ROOM NUMBER]XX had a different resident in it. CNA 32 stated she did not know who E. BXXX was, and most likely that resident had been discharged . CNA 32 stated the resident food was not labeled correctly and should have been thrown away. An interview was conducted with the RD on [DATE] at 9:35 A.M. The RD stated all resident food needed to be dated and labeled with the resident's name, when placed in the resident refrigerator. The RD stated since the cheese dip jar was not dated when it was opened, no one knew how long it had been sitting in the refrigerator and it could have been unsafe to eat. According to the facility's undated policy, titled Bringing in Food for a Resident, .Food or Beverages should be labeled and monitored .Unused food will be discarded within 2 days . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An interview and observation of the temperature log for Station 3's resident refrigerator was conducted with licensed nurse (LN) 34 on [DATE] at 3:24 P.M. The temperature log had no entries for [DATE], PM shift (3 P.M.-11:30 P.M.) and on the A.M. shift (7 A.M.-3:30 P.M.). LN 34 stated the harm for not documenting the temperature on the temperature log was that the refrigerator temperature could have been on the wrong setting, and the food would have spoiled, possibly causing harm if ingested. An interview was conducted with the RD on [DATE] at 9:35 A.M. The RD stated the resident refrigerator temperatures should have been checked in the morning and evening by staff, and documented to ensure the food was safe for consumption. The RD stated if the temperatures were not maintained at a safe level, residents could have become sick from food-borne illness. 4. An observation of trash removal from the machine dishwasher room was conducted with the RD on [DATE] at 10:02 A.M. DSWH 1 wore disposable gloves and tied off a large black trash bag. The trash bag was lifted out of the trash can and walked outside. The trash bag was tossed into a large dumpster and DSWH 1 returned to the machine dishwashing room. DSWH 1 had on the same gloves and returned to cleaning dirty dishes, without removing the gloves and performing hand hygiene. An interview and record review was conducted with the RD on [DATE] at 10:08 A.M. The RD stated DSHW 1 knew better and should have washed his hands. The RD stated that when staff did not wash their hands after trash disposal, there was a risk of cross contamination. An observation of trash removal from the three (3) -sink dishwashing room was conducted with the RD on [DATE] at 10:10 A.M. DSWH 2 removed his gloves and tied off a large black trash bag within a trash can. The trash can was wheeled outside and the plastic bag was lifted out of the trash can and tossed into a large dumpster. DSWH 2 washed out the inside of the trash can with a spray hose. DSWH 2 wheeled the trash can back into the 3-sink dishwashing room. DSWH 2 proceeded to handle pots with his bare hands and did not perform hand hygiene before returning to the 3-sink area. An interview was conducted with the RD on [DATE] at 10:20 A.M. The RD stated by DSWH 2 not performing hand hygiene when returning to the kitchen, all residents were at risk for cross contamination. According to the facility's policy, titled Handwashing/Hand Hygiene, dated [DATE], .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors .9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognize as the best practice for preventing healthcare-associated infections .

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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** 39220 Based on observation, interview, and record review, the facility failed to accurately document a resident's current status for two of 38 sampled residents (183, 105) when: 1. A post (after) dialysis (a procedure that removes toxins from the blood since the kidneys are unable to provide that function) assessment did not accurately reflect Resident 183's access site (a surgically created connection to the blood stream that allowed blood to be cleaned and returned to the body during dialysis), when reviewed for dialysis; 2. A low air loss mattress (pressure relieving mattress) was not accurately documented on the electronic medication administration record (eMAR) (Resident 105); This failure had to potential to not accurately represent the residents' (183, 105) current medical record. Findings: 1. Resident 183 was admitted to the facility on [DATE], with diagnoses which included acute kidney failure (a sudden decline in kidney function), per the facility's Admission Record. Resident 183's clinical record was reviewed on 12/4/24: According to the physician's order, dated 5/20/24, ., monitor tunneled access site on right chest wall for sign/symptoms of infection, bleeding, redness, pain, discharge .Dialysis: when patient RETURNS from dialysis check dressing and access site for any bleeding and REINFORCE dressing . The facility's Dialysis Communication sheets were reviewed from 11/1/24 through 12/4/24. On the post (when resident returns from dialysis) Dialysis Communication sheets dated 11/6/24 and 11/20/24, the right chest wall central (an access site that goes directly into a large vein) line, was documented to have a thrill (a buzz-like or vibration feel caused by blood flowing through an artery/vein surgically connected) and bruit (a whooshing sound that indicated the artery/vein connection is working properly). An interview and record review was conducted with Licensed Nurse (LN) 32 on 12/4/24 at 3:33 P.M. LN 32 stated Resident 183 went to dialysis three times a week. LN 32 stated Resident 183 had a central line and did not have a shunt (arterial/vein surgical connection as an access site). LN 32 reviewed the facility's post Dialysis Communication sheets, dated 11/6/24 and 11/20/24. LN 32 stated the access site documentation was inaccurate because Resident 183 did not have a shunt, so it was impossible to feel a thrill or listen to a bruit. LN 32 stated Resident 183 had a central line, which does not produce a thrill or a bruit. LN 32 stated, LN 36 documented the thrill and Bruit on 11/6/24, and she (LN 36) was not available. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LN 34 on 12/4/24 at 3:43 P.M., regarding post dialysis assessments for central lines versus shunts. LN 34 stated central lines had no bruit or thrill, because they were a central line inserted directly into a vein. LN 34 stated central lines needed to be monitored for infection, bleeding or pain. LN 34 stated shunts had bruit and thrills because it was a pulsing connection between an artery and a vein. LN 34 stated that one would access shunts by feeling for a thrill and listening for a bruit. An interview was conducted with the Director of Staff Development (DSD) on 12/4/24 at 3:47 P.M. The DSD stated since she had been at the facility (2 years) she had not provided any in-services related to dialysis care or post assessments. An interview and record review of Resident 183's post Dialysis Communication sheet, dated 11/20/24, was conducted with LN 37 on 12/4/24 at 4:11 P.M. LN 37 verbalized assessing a shunt for bruit/thrill and a central line for signs of infection/bleeding. LN 37 stated he had cared for Resident 183 several times and was aware the resident had a central line in his chest. LN 37 reviewed the post Dialysis Communication sheet dated 11/20/24, and stated, he must have been in a hurry, because he knew a central line did not have a thrill and bruit. LN 37 stated it was important to accurately document a resident's current condition, and he did not, on that day. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated, documentation in a resident's chart needed to be accurate in order to reflect the resident's current assessment. According to the facility's policy, titled Hemodialysis Access Care, dated September 2010, .Documentation: The Licensed Nurse should document in the resident's medical record before and after dialysis treatment as follows: 1. Location of catheter. 2 Condition of dressing .5. Observation post dialysis . 49330 2. According to the Admission Record, Resident 105 was admitted to the facility on [DATE] with diagnoses which include hemiplegia (weakness on one side of the body) affecting the left non-dominant side, pressure ulcer (wound caused by prolonged pressure) of unspecified part of back, left upper back, and the left hip. On 12/3/24 at 9:35 A.M., Resident 105 was observed laying on his back in bed, on a regular mattress. A review of Resident 105's physician's orders, dated 10/22/24 indicated, Apply LAL (low air loss, pressure relieving) mattress for wound management/preventive measures. Check placement, settings and functionality QS (every shift). On 12/3/24 at 3:13 P.M., a concurrent interview and review of Resident 105's electronic Medication Administration Records (eMAR) dated 10/23/24 to 12/1/24 was conducted with the Treatment Nurse (TN). The eMAR indicated that from 10/23/24 through 12/1/24, licensed nurses on all shifts documented that they verified the function, placement, and settings of Resident 105's low air loss mattress. The TN acknowledged Resident 105 had a physician's order for a low air loss mattress with a start date of 10/22/24, but that the mattress was not provided to the resident until 12/3/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 8:35 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 42. LN 42 acknowledged she documented the placement, settings, and function of Resident 105's low air loss mattress on the following dates: 10/24/24, 11/11/24, 11/21/24, and 11/29/24. LN 42 stated she documented (about) the low air loss mattress without checking the placement, settings and function. LN 42 stated it was important to document accurately and, .In this case it could've been very bad for him .We could've caused more wounds . LN 42 stated she should not have documented for a low air loss mattress (on 10/24/24, 11/11/24, 11/21/24, and 11/29/24) when the resident was not provided with one until 12/3/24. On 12/5/24 at 10:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for nursing documentation to be accurate and to reflect what nursing care/interventions were being provided to the resident. The DON stated, [The licensed nurses] need to verify .they're not documenting the services being provided .it's important to be accurate [when documenting] . A review of the facility policy titled Charting and Documentation, revised July 2017 indicated, All services provided to the resident .shall be documented in the resident's medical record .Documentation in the medical record will be .complete, and accurate .

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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** 39220 Based on observation, interview, and record review, the facility failed to maintain infection prevention practices for six of 38 sampled residents (218, 75, 65, 8, 147, 448) when: 1. Resident 218's urinary catheter tubing was in contact with the floor; 2. A wrist splint for Resident 75 was not maintained in a sanitary manner; 3. Oxygen tubings were undated for Residents 65 and 8; 4. Disposable gowns were not used for direct care of residents (147, 448) who were on Enhanced Barrier Precautions (EBP, infection control measures to reduce the spread of germs). These failures had the potential to spread germs to residents and staff. Findings: 1. Resident 218 was readmitted to the facility on [DATE], with diagnoses which included urinary tract infection (infection in the bladder), per the facility's Admission Record. An observation was conducted of Resident 218 in bed on 12/2/24 at 9:23 A.M. A urinary catheter bag was clipped to the left side of the bed frame and was visible upon entering the room. Approximately 12 inches of the urinary catheter tubing was in contact with the floor. A review of Resident 218's clinical record was conducted on 12/2/24. According to the physician's order, dated 11/18/24, .Catheter: Indwelling urinary (Foley) catheter . According to the care plan, dated 11/16/24, titled Indwelling Foley Catheter, listed interventions such as, .Cleanse foley catheter . An observation and interview was conducted with Certified Nursing Assistant (CNA) 31 of Resident 218 in bed on 12/2/24 at 9:25 A.M. CNA 31 observed Resident 218 and stated the catheter tubing was on the floor, which could have caused a worsening infection to the resident. An interview was conducted with Licensed Nurse (LN) 32 on 12/2/24 at 9:50 A.M. LN 32 stated the catheter tubing should have always been kept off the floor, because it exposed the resident to a higher risk of infection. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated urinary catheter tubing should have never been in contact with the floor, because infections could have occurred. According to the facility's policy, titled Catheter Care, Urinary, dated September 2014, .Infection Control .b. Be sure the catheter tubing and drainage bags are kept off the floor . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 75 was readmitted to the facility on [DATE], with diagnoses which included left wrist sprain secondary to fall, per the facility's Admission Record. An observation of Resident 75 was conducted on 12/2/24 at 9:42 A.M., in the activity room. Resident 75 was dressed, sitting in a wheelchair with a plaster-type splint over and beneath her left wrist. The splint was held in place with a [brand of gauze] dressing wrap near the left forearm. The splint had dark brown/black smudges over the top and bottom areas near the palm of her left hand and wrist. An interview was conducted with LN 32 on 12/2/24 at 9:53 A.M. LN 32 stated Resident 75 had a sprain due to osteoarthritis (a breakdown of cartilage causing degeneration of the joint). LN 32 stated the splint had been on for over a month and the physician wanted the splint to stay on. LN 32 stated she has seen the splint, and it was dirty. LN 32 stated a nurse changed the [brand of gauze] wrap last week, but the splint itself remained dirty. Resident 75's clinical record was reviewed on 12/2/24. According to the physician's order, dated 9/29/24, . Splint to left wrist for support. May remove during ADLs (activities of daily living ie [that is/for example], showers, eating, dressing) Check skin integrity for any redness .every shift for sprain. According to the Minimum Data Set (a clinical assessment tool), dated 10/25/24, the resident was dependent and required total assistance with Functional Abilities and ADLs. An observation of Resident 75 and interview with LN 33 was conducted on 12/2/24 at 11:32 A.M. in the lunch room. LN 33 stated that Resident 75's splint was filthy, but she thought someone changed the gauze last week. LN 33 stated she did not know why Resident 75 had the splint, but it should have been changed because it was dirty and could have caused cross contamination to other residents if touched. An observation of Resident 75 was conducted on 12/3/24 at 7:36 A.M. Resident 75 was sitting up in bed with no splint on, and mumbling unintelligently. A subsequent interview was conducted with LN 32 on 12/3/24 at 4:17 P.M. LN 32 stated they contacted the physician the previous day, who ordered a repeat x-ray. LN 32 stated the physician informed them they could remove the splint, after the x-ray results were reviewed. LN 32 stated the physician should have been contacted sooner, due to the dirty splint, to see if it could have been replaced with something else. LN 32 stated that since the splint was dirty, it could have caused an infection to others. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:04 A.M. The DON stated Resident 75's splint was dirty and the physician should have been contacted sooner for an alternative wrist support. The DON stated the splint could have caused cross contamination to staff, residents, and objects. The DON was unable to locate a policy related to maintaining splints and cleanliness. 49330 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. (a) Resident 65 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung failure) and chronic respiratory failure (lung failure) per the Admission Record. On 12/2/24 at 10:01 A.M., an observation was conducted in Resident 65's room. Resident 65 was wearing a nasal cannula (a tube used to deliver oxygen). The nasal cannula was connected to a portable oxygen concentrator (a device used to provide supplemental oxygen) and was undated. On 12/5/24 at 8:53 A.M., an interview was conducted with the Respiratory Therapist (RT) 42. RT 42 stated nasal cannulas were replaced every two weeks and should be dated. RT 42 stated, .the nasal cannula goes into [Resident 65's] nose and it holds moisture, especially because most are on some kind of humidifiers. It should be dated for infection control, so we know when it was replaced . An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 10:25 A.M. The DON stated it was her expectation for nasal cannulas to be labeled with the date changed. The DON stated, .It's important to have a date [on the oxygen tubing] for infection control . 50175 3. (b) Resident 8 was admitted to the facility on [DATE] with diagnoses which included pulmonary fibrosis (a lung disease that causes the lungs to become scarred and stiff over time, making it difficult to breathe) and chronic obstructive pulmonary disease, per the Admission Record. An observation and interview was conducted on 12/2/24 at 9:33 A.M., with Resident 8. Resident 8 was wearing a nasal cannula. The nasal cannula was not dated. Resident 8 stated she needed oxygen continuously. An observation was conducted on 12/3/24 at 8:59 A.M. in Resident 8's room. Resident 8 was wearing a nasal cannula. The nasal cannula was not dated. An interview was conducted with LN 34 on 12/4/24 at 3:10 P.M. LN 34 stated the nasal cannula should have been changed every two weeks. LN 34 stated staff knew when a nasal cannula needed to be changed by looking at the date on the tubing. An observation and interview was conducted with LN 12 on 12/4/24 at 3:13 P.M. LN 12 observed and stated Resident 8's nasal cannula was not dated. LN 12 stated she did not know when the nasal cannula was last changed because there was no date on the nasal cannula. LN 12 stated that bacteria would grow and cause infection if the nasal cannula was not changed when it was due to be changed. A review of Resident 8's active physician's orders was conducted on 12/4/24, which indicated to administer oxygen continuously. An interview was conducted with the Director of Staff Development (DSD) on 12/4/24 at 3:34 P.M. The DSD stated oxygen tubing needed to be dated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 9:14 A.M. The DON stated nasal cannula was changed every 14 days if in continuous use. The DON stated nasal cannula should have been dated. The DON stated that if the nasal cannula was not dated, staff would not know when it was last changed. The DON stated there would be a potential for infection if the nasal cannula was not changed when it was due to be changed. A review of the facility's policy titled Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, indicated .7. Change the oxygen cannula and tubing every fourteen (14) days, or as needed . 46980 4. (a) Per the facility's Admission Record, Resident 147 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region (a skin wound at the base of the spine). Resident 147 had a tube feeding (a medical procedure that delivered nutrition, fluids and medication directly into the stomach or small intestine through a tube) and an indwelling urinary catheter (a thin, flexible tube that is inserted into the bladder to drain urine and is left in place for a period of time). On 12/2/24 at 10 A.M., an observation of Certified Nursing Assistant (CNA) 25 changing Resident 147's brief and some linens was conducted. CNA 25 was not wearing a gown during Resident 147's care. There was a sign on the wall outside of Resident 147's room indicating EBP. There was a red dot next to Resident 147's name on the wall next to the EBP sign. CNA 25 stated, I changed her brief and some linen. I should have worn a gown. I need to wear a gown to prevent infection from spreading. (b) Resident 448 was admitted on [DATE] with diagnoses that included pressure ulcer and urinary tract infection. On 12/2/24 at 8 A.M. a concurrent observation of LN 21, LN 23, and Certified Nursing Assistant (CNA) 24 and interview with LN 21 and CNA 24 were conducted at Resident 448's room. There was a sign on the wall outside of Resident 448's room that indicated, Alcohol based hand rub (a liquid gel or foam that is used to reduce the number of microorganisms on the hands), gloves, gown must be worn for dressing . transferring, changing linens (bedsheets), providing hygiene, changing briefs .A red dot was next to Resident 448's name on the wall next to the sign. A set of plastic drawers containing only two clean briefs (a disposable clothing item that catches urine and stool) was outside the door. The drawers did not have any gowns in them. LN 21, LN 23, and CNA 24 were changing Resident 448's linens while not wearing gowns. An interview was conducted with LN 21 who stated, We did not wear gowns, we are at risk to cross contaminate (the transfer of harmful microorganisms from one person, object or place to another) ourselves and other residents if we don't wear a gown during care. CNA 24 stated, I did not wear a gown and gloves during care. I could catch an infection or transfer it to another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/24 at 9:50 A.M. an interview and concurrent record review were conducted with the Director of Staff Development (DSD) who stated, The IP (Infection Preventionist) and I do trainings. There was an infection control training on 1/29/24 and 6/21/24. A concurrent review of the infection control training indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs, a microorganism [germs] that is resistant to one of more types of antibiotics) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition .The following direct care activities that require PPE are as follows: dressing .changing linen .incontinent care . On 12/5/24 at 1:39 P.M. an interview was conducted with the IP who stated, It's stated on the signage with close body contact you need to wear the gowns. The expectation is they need to follow the signage. The risk is spreading MDRO's to their clothing and body then transfer it to another resident or they might get the microorganism. A review of the facility policy titled Enhanced Barrier Precautions revised August 2022 indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation, and record review, the facility failed to provide at least 80 sq. ft. (square feet) per resident in 113 of 148 multiple resident rooms. Findings: The facility has 113 resident rooms that do not meet the minimum requirement of 80 square feet per resident. The variations in room size requirements were not observed to adversely affect the resident's health, safety, quality of care or quality of life during the survey. Continuance of the room size waiver is recommended. The 113 resident rooms affected were as follows: 1. room [ROOM NUMBER] - 2 resident occupancy, 74.59 Sq. Ft. per resident, Totaling 149.17 Sq. Ft. 2. room [ROOM NUMBER] - 2 resident occupancy, 74.59 Sq. Ft. per resident, Totaling 149.19 Sq. Ft. 3. room [ROOM NUMBER] - 2 resident occupancy, 74.80 Sq. Ft. per resident, Totaling 149.6 Sq. Ft. 4. room [ROOM NUMBER] - 2 resident occupancy, 74.32 Sq. Ft. per resident, Totaling 148.68 Sq. Ft. 5. room [ROOM NUMBER] - 2 resident occupancy, 74.41 Sq. Ft. per resident, Totaling 150.81 Sq. Ft. 6. room [ROOM NUMBER] - 2 resident occupancy, 75.93 Sq. Ft. per resident, Totaling 151.85 Sq. Ft. 7. room [ROOM NUMBER] - 2 resident occupancy, 74.65 Sq. Ft. per resident, Totaling 149.29 Sq. Ft. 8. room [ROOM NUMBER] - 2 resident occupancy, 74.98 Sq. Ft. per resident, Totaling 149.79 Sq. Ft. 9. room [ROOM NUMBER] - 2 resident occupancy, 74.50 Sq. Ft. per resident, Totaling 149 Sq. Ft. 10. room [ROOM NUMBER] - 2 resident occupancy, 74.95 Sq. Ft. per resident, Totaling 149.89 Sq. Ft. 11. room [ROOM NUMBER] - 2 resident occupancy, 77.21 Sq. Ft. per resident, Totaling 154.42 Sq. Ft. 12. room [ROOM NUMBER] - 2 resident occupancy, 77.21 Sq. Ft. per resident, Totaling 157.35 Sq. Ft. 13. room [ROOM NUMBER] - 2 resident occupancy, 74.26 Sq. Ft. per resident, Totaling 148.51 Sq. Ft. 14. room [ROOM NUMBER] - 2 resident occupancy, 74.52 Sq. Ft. per resident, Totaling 149.03 Sq. Ft. 15. room [ROOM NUMBER] - 2 resident occupancy, 74.66 Sq. Ft. per resident, Totaling 149.31 Sq. Ft. 16. room [ROOM NUMBER] - 2 resident occupancy, 75.10 Sq. Ft. per resident, Totaling 150.17 Sq. Ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	17. room [ROOM NUMBER] - 2 resident occupancy, 74.89 Sq. Ft. per resident, Totaling 149.77 Sq. Ft. 18. room [ROOM NUMBER] - 2 resident occupancy, 75.03 Sq. Ft. per resident, Totaling 150.06 Sq. Ft. 19. room [ROOM NUMBER] - 2 resident occupancy, 74.79 Sq. Ft. per resident, Totaling 150.06 Sq. Ft. 20. room [ROOM NUMBER] - 2 resident occupancy, 74.68 Sq. Ft. per resident, Totaling 149.35 Sq. Ft. 21. room [ROOM NUMBER] - 2 resident occupancy, 74.84 Sq. Ft. per resident, Totaling 149.68 Sq. Ft. 22. room [ROOM NUMBER] - 2 resident occupancy, 75.17 Sq. Ft. per resident, Totaling 150.33 Sq. Ft. 23. room [ROOM NUMBER] - 2 resident occupancy, 74.95 Sq. Ft. per resident, Totaling 149.90 Sq. Ft. 24. room [ROOM NUMBER] - 2 resident occupancy, 75.09 Sq. Ft. per resident, Totaling 149.90 Sq. Ft. 25. room [ROOM NUMBER] - 2 resident occupancy, 78.91 Sq. Ft. per resident, Totaling 157.82 Sq. Ft. 26. room [ROOM NUMBER] - 2 resident occupancy, 74.61 Sq. Ft. per resident, Totaling 149.22 Sq. Ft. 27. room [ROOM NUMBER] - 2 resident occupancy, 75.38 Sq. Ft. per resident, Totaling 150.76 Sq. Ft. 28. room [ROOM NUMBER] - 2 resident occupancy, 74.76 Sq. Ft. per resident, Totaling 149.52 Sq. Ft. 29. room [ROOM NUMBER] - 2 resident occupancy, 75.26 Sq. Ft. per resident, Totaling 150.52 Sq. Ft. 30. room [ROOM NUMBER] - 2 resident occupancy, 75.15 Sq. Ft. per resident, Totaling 150.29 Sq. Ft. 31. room [ROOM NUMBER] - 2 resident occupancy, 75.30 Sq. Ft. per resident, Totaling 150.60 Sq. Ft. 32. room [ROOM NUMBER] - 2 resident occupancy, 74.37 Sq. Ft. per resident, Totaling 148.74 Sq. Ft. 33. room [ROOM NUMBER] - 2 resident occupancy, 74.61 Sq. Ft. per resident, Totaling 149.22 Sq. Ft. 34. room [ROOM NUMBER] - 2 resident occupancy, 74.63 Sq. Ft. per resident, Totaling 149.25 Sq. Ft. 35. room [ROOM NUMBER] - 2 resident occupancy, 74.62 Sq. Ft. per resident, Totaling 149.24 Sq. Ft. 36. room [ROOM NUMBER] - 2 resident occupancy, 74.62 Sq. Ft. per resident, Totaling 149.24 Sq. Ft. 37. room [ROOM NUMBER] - 2 resident occupancy, 74.95 Sq. Ft. per resident, Totaling 149.89 Sq. Ft. 38. room [ROOM NUMBER] - 2 resident occupancy, 74.75 Sq. Ft. per resident, Totaling 149.50 Sq. Ft. 39. room [ROOM NUMBER] - 2 resident occupancy, 74.41 Sq. Ft. per resident, Totaling 148.82 Sq. Ft. 40. room [ROOM NUMBER] - 2 resident occupancy, 74.89 Sq. Ft. per resident, Totaling 149.78 Sq. Ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	41. room [ROOM NUMBER] - 2 resident occupancy, 74.68 Sq. Ft. per resident, Totaling 149.35 Sq. Ft. 42. room [ROOM NUMBER] - 2 resident occupancy, 75.03 Sq. Ft. per resident, Totaling 150.06 Sq. Ft. 43. room [ROOM NUMBER] - 2 resident occupancy, 74.74 Sq. Ft. per resident, Totaling 149.47 Sq. Ft. 44. room [ROOM NUMBER] - 2 resident occupancy, 74.86 Sq. Ft. per resident, Totaling 149.71 Sq. Ft. 45. room [ROOM NUMBER] - 2 resident occupancy, 74.85 Sq. Ft. per resident, Totaling 149.70 Sq. Ft. 46. room [ROOM NUMBER] - 2 resident occupancy, 74.29 Sq. Ft. per resident, Totaling 148.58 Sq. Ft. 47. room [ROOM NUMBER] - 2 resident occupancy, 76.73 Sq. Ft. per resident, Totaling 153.45 Sq. Ft. 48. room [ROOM NUMBER] - 2 resident occupancy, 76.04 Sq. Ft. per resident, Totaling 152.08 Sq. Ft. 49. room [ROOM NUMBER] - 2 resident occupancy, 74.86 Sq. Ft. per resident, Totaling 149.79 Sq. Ft. 50. room [ROOM NUMBER] - 2 resident occupancy, 74.78 Sq. Ft. per resident, Totaling 149.55 Sq. Ft. 51. room [ROOM NUMBER] - 2 resident occupancy, 74.60 Sq. Ft. per resident, Totaling 149.20 Sq. Ft. 52. room [ROOM NUMBER] - 2 resident occupancy, 74.46 Sq. Ft. per resident, Totaling 148.91 Sq. Ft. 53. room [ROOM NUMBER] - 2 resident occupancy, 74.90 Sq. Ft. per resident, Totaling 149.79 Sq. Ft. 54. room [ROOM NUMBER] - 2 resident occupancy, 74.85 Sq. Ft. per resident, Totaling 149.69 Sq. Ft. 55. room [ROOM NUMBER] - 2 resident occupancy, 74.67 Sq. Ft. per resident, Totaling 149.33 Sq. Ft. 56. room [ROOM NUMBER] - 2 resident occupancy, 75.43 Sq. Ft. per resident, Totaling 150.86 Sq. Ft. 57. room [ROOM NUMBER] - 2 resident occupancy, 76.80 Sq. Ft. per resident, Totaling 153.59 Sq. Ft. 58. room [ROOM NUMBER] - 2 resident occupancy, 76.10 Sq. Ft. per resident, Totaling 152.19 Sq. Ft. 59. room [ROOM NUMBER] - 2 resident occupancy, 74.88 Sq. Ft. per resident, Totaling 149.75 Sq. Ft. 60. room [ROOM NUMBER] - 2 resident occupancy, 74.67 Sq. Ft. per resident, Totaling 149.34 Sq. Ft. 61. room [ROOM NUMBER] - 2 resident occupancy, 74.67 Sq. Ft. per resident, Totaling 149.46 Sq. Ft. 62. room [ROOM NUMBER] - 2 resident occupancy, 75.16 Sq. Ft. per resident, Totaling 150.32 Sq. Ft. 63. room [ROOM NUMBER] - 2 resident occupancy, 74.74 Sq. Ft. per resident, Totaling 149.48 Sq. Ft. 64. room [ROOM NUMBER] - 2 resident occupancy, 74.61 Sq. Ft. per resident, Totaling 149.21 Sq. Ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	12/05/2024

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	65. room [ROOM NUMBER] - 2 resident occupancy, 74.46 Sq. Ft. per resident, Totaling 148.92 Sq. Ft. 66. room [ROOM NUMBER] - 2 resident occupancy, 75.03 Sq. Ft. per resident, Totaling 150.05 Sq. Ft. 67. room [ROOM NUMBER] - 2 resident occupancy, 73.88 Sq. Ft. per resident, Totaling 147.76 Sq. Ft. 68. room [ROOM NUMBER] - 2 resident occupancy, 74.56 Sq. Ft. per resident, Totaling 149.12 Sq. Ft. 69. room [ROOM NUMBER] - 2 resident occupancy, 74.25 Sq. Ft. per resident, Totaling 148.49 Sq. Ft. 70. room [ROOM NUMBER] - 2 resident occupancy, 74.82 Sq. Ft. per resident, Totaling 149.63 Sq. Ft. 71. room [ROOM NUMBER] - 2 resident occupancy, 74.68 Sq. Ft. per resident, Totaling 149.36 Sq. Ft. 72. room [ROOM NUMBER] - 2 resident occupancy, 74.87 Sq. Ft. per resident, Totaling 149.73 Sq. Ft. 73. room [ROOM NUMBER] - 2 resident occupancy, 74.62 Sq. Ft. per resident, Totaling 149.23 Sq. Ft. 74. room [ROOM NUMBER] - 2 resident occupancy, 75.22 Sq. Ft. per resident, Totaling 150.44 Sq. Ft. 75. room [ROOM NUMBER] - 2 resident occupancy, 74.90 Sq. Ft. per resident, Totaling 149.80 Sq. Ft. 76. room [ROOM NUMBER] - 2 resident occupancy, 74.66 Sq. Ft. per resident, Totaling 149.31 Sq. Ft. 77. room [ROOM NUMBER] - 2 resident occupancy, 74.51 Sq. Ft. per resident, Totaling 149.02 Sq. Ft. 78. room [ROOM NUMBER] - 2 resident occupancy, 74.79 Sq. Ft. per resident, Totaling 149.58 Sq. Ft. 79. room [ROOM NUMBER] - 2 resident occupancy, 74.89 Sq. Ft. per resident, Totaling 149.78 Sq. Ft. 80. room [ROOM NUMBER] - 2 resident occupancy, 74.54 Sq. Ft. per resident, Totaling 149.08 Sq. Ft. 81. room [ROOM NUMBER] - 2 resident occupancy, 74.53 Sq. Ft. per resident, Totaling 149.05 Sq. Ft. 82. room [ROOM NUMBER] - 2 resident occupancy, 74.53 Sq. Ft. per resident, Totaling 149.05 Sq. Ft. 83. room [ROOM NUMBER] - 2 resident occupancy, 74.54 Sq. Ft. per resident, Totaling 149.08 Sq. Ft. 84. room [ROOM NUMBER] - 2 resident occupancy, 74.82 Sq. Ft. per resident, Totaling 149.64 Sq. Ft. 85. room [ROOM NUMBER] - 2 resident occupancy, 74.78 Sq. Ft. per resident, Totaling 149.56 Sq. Ft. 86. room [ROOM NUMBER] - 2 resident occupancy, 74.91 Sq. Ft. per resident, Totaling 149.56 Sq. Ft. 87. room [ROOM NUMBER] - 2 resident occupancy, 78.38 Sq. Ft. per resident, Totaling 156.76 Sq. Ft. 88. room [ROOM NUMBER] - 2 resident occupancy, 75.50 Sq. Ft. per resident, Totaling 150.99 Sq. Ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	89. room [ROOM NUMBER] - 2 resident occupancy, 74.79 Sq. Ft. per resident, Totaling 149.57 Sq. Ft. 90. room [ROOM NUMBER] - 2 resident occupancy, 74.95 Sq. Ft. per resident, Totaling 149.89 Sq. Ft. 91. room [ROOM NUMBER] - 2 resident occupancy, 74.95 Sq. Ft. per resident, Totaling 149.90 Sq. Ft. 92. room [ROOM NUMBER] - 2 resident occupancy, 75.37 Sq. Ft. per resident, Totaling 150.74 Sq. Ft. 93. room [ROOM NUMBER] - 2 resident occupancy, 75.03 Sq. Ft. per resident, Totaling 150.05 Sq. Ft 94. room [ROOM NUMBER] - 2 resident occupancy, 75.04 Sq. Ft per resident, Totaling 150.07 Sq. Ft. 95. room [ROOM NUMBER] - 2 resident occupancy, 75.17 Sq. Ft. per resident, Totaling 150.33 Sq. Ft. 96. room [ROOM NUMBER] - 2 resident occupancy, 74.89 Sq. Ft. per resident, Totaling 149.77 Sq. Ft. 97. room [ROOM NUMBER] - 2 resident occupancy, 74.83 Sq. Ft. per resident, Totaling 149.66 Sq. Ft. 98. room [ROOM NUMBER] - 2 resident occupancy, 74.96 Sq. Ft. per resident, Totaling 149.92 Sq. Ft. 99. room [ROOM NUMBER] - 2 resident occupancy, 74.49 Sq. Ft. per resident, Totaling 148.97 Sq. Ft. 100. room [ROOM NUMBER] - 2 resident occupancy, 74.44 Sq. Ft. per resident, Totaling 148.82 Sq. Ft. 101. room [ROOM NUMBER] - 2 resident occupancy, 75.16 Sq. Ft. per resident, Totaling 150.31 Sq. Ft. 102. room [ROOM NUMBER] - 2 resident occupancy, 74.36 Sq. Ft. per resident, Totaling 148.72 Sq. Ft. 103. room [ROOM NUMBER] - 2 resident occupancy, 74.51 Sq. Ft. per resident, Totaling 149.01 Sq. Ft. 104. room [ROOM NUMBER] - 2 resident occupancy, 74.54 Sq. Ft. per resident, Totaling 149.08 Sq. Ft. 105. room [ROOM NUMBER] - 2 resident occupancy, 74.96 Sq. Ft. per resident, Totaling 149.92 Sq. Ft. 106. room [ROOM NUMBER] - 2 resident occupancy, 74.82 Sq. Ft. per resident, Totaling 149.63 Sq. Ft. 107. room [ROOM NUMBER] - 2 resident occupancy, 74.57 Sq. Ft. per resident, Totaling 149.14 Sq. Ft. 108. room [ROOM NUMBER] - 2 resident occupancy, 74.42 Sq. Ft. per resident, Totaling 148.84 Sq. Ft. 109. room [ROOM NUMBER] - 2 resident occupancy, 74.67 Sq. Ft. per resident, Totaling 149.34 Sq. Ft. 110. room [ROOM NUMBER] - 2 resident occupancy, 74.76 Sq. Ft. per resident, Totaling 149.52 Sq. Ft. 111. room [ROOM NUMBER] - 2 resident occupancy, 75.92 Sq. Ft. per resident, Totaling 151.83 Sq. Ft. 112. room [ROOM NUMBER] - 2 resident occupancy, 75.79 Sq. Ft. per resident, Totaling 151.58 Sq. Ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	113. room [ROOM NUMBER] - 2 resident occupancy 75.05 Sq. Ft. per resident, Totaling 150.09 Sq. Ft.