

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555605	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Glenhaven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 212 West Chevy Chase Drive Glendale, CA 91204	
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 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** Based on observation, interviews, and record review the facility failed to implement proper food sanitation and infection control practices as indicated in the facility's policy and procedure titled Hand Hygiene and Personal Hygiene for 3 of 3 sampled residents (Residents 6,10 and 29) and 41 residents served meals from the kitchen by failing to ensure: 1.Certified Nursing Assistant (CNA1) involved in food handling and resident care performed proper hand washing techniques prior to and after dispensing meal trays to the residents (Residents 6,10 and 29). 2. The [NAME] (Cook 1) covered his beard while preparing food in the kitchen food preparation area for 41 residents that were served meals from the kitchen. These deficient practices had the potential for the residents to develop a result in food born illness (an illness when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and result in a widespread infection in the facility. Findings: 1a. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on 9/27/2024, with a diagnosis of diabetes (high blood sugar), heart disease (a group of conditions that affect the heart and blood vessels) and hypertension (high blood pressure). During a review of Resident 6's History and Physical (H&P) dated 12/9/2025, the H&P indicated resident has the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 12/9/2025, the MDS indicated resident is cognitively intact (meaning oriented and able to recall information , and can follow questions appropriately) but requires maximum assistance with most activities of daily life such as oral hygiene, toileting and showering. 1b. During a review of Resident 10's AR, the AR indicated the facility admitted Resident 10 on 12/11/2025, with a diagnosis of Diabetes (high blood sugar), hypertension (high blood pressure), and schizoaffective disorder (mental illness with symptoms of hallucinations (sensing things that aren't real) , delusions(believing things that are not true) , and disorganized thinking (thoughts come out confused). During a review of resident 10's H&P dated 12/12/2024, the H&P indicated Resident 10 has the capacity to understand and make decisions. During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 has moderate cognitive impairment (some difficulty with memory, recall, or orientation). 1c. During a review of Resident 29's AR, the AR indicated the facility admitted Resident 29 on 07/25/2025 with a diagnosis of diabetes, chronic kidney disease (long term abnormal kidney function), and osteomyelitis (infectious inflammation of the bone marrow). During a review of Resident 29's H&P dated 11/22/2025, the H&P indicated Resident 29 has the capacity to understand and make decisions. During a review of Resident 29's MDS dated [DATE], the MDS indicated resident was cognitively intact (meaning oriented and able to recall information and can follow questions appropriately) completes activities of eating, personal, and oral hygiene by self. 2. During an observation on 1/6/2026 at 11:32 AM in the facility's kitchen, [NAME] 1 was observed with thick mustache that was not covered or a facial covering to over his mustache while preparing resident's food. During another observation on 1/6/2026 at 11:45 AM the cook started to put food on the meal plates for the tray line without facial hair cover for mustache. During an interview on 01/6/2025 at 11:58AM with Dietary Supervisor (DS), the DS stated she was unsure if facial hair, such as [NAME] (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1's mustache, required to be covered during meal preparations. The DS stated she would need to check the policy. During a concurrent interview and record review on 1/6/2026 at 12:10 PM with Director of Nursing (DON), the facility's policy and procedure (P&P) titled Personal hygiene, dated April 2017 was reviewed. The DON stated the mustache was a type of body hair that required to be covered during the preparation of food to prevent hair from dropping into food and causing contamination. During an observation on 1/6/2026 at 12:42 PM, certified nurse assistant (CNA 1) was observed bringing Resident 6's meal tray to his bedside table and assisting the resident into a sitting position making physical contact during the assistance. CNA 1 then exited the room without performing hand hygiene. During an observation on 01/06/2026 at 12:43 PM, CNA1 was observed removing Resident 29's meal tray from the meal tray cart and placing the tray onto the resident's bedside table. CNA 1 then touched the resident's blankets and proceeded to set up the Resident 29's meal tray. CNA 1 then exited the resident's room without performing hand hygiene. During an observation on 01/02/2026 at 12:44 PM, CNA 1 was observed collecting Resident 29's meal tray from the resident's bedside table and then left the room without performing hand hygiene. During an interview on 01/06/2026 at 12:45 PM with CNA 1, CNA 1 was too busy and had forgotten to perform hand hygiene. CNA 1 further stated she should have performed hand hygiene after and before providing care to each resident. During an interview on 01/06/2026 at 3:30PM with Director of Nursing (DON), the DON stated the staff should perform hand hygiene before and after providing care to each resident to prevent the spread of infection. During a review of facility's policy and procedures (P&P) titled Hand Hygiene, dated August ,2017, the P&P indicated its purpose was to reduce transmission of pathogenic microorganisms to resident and personnel in the facility by following hand hygiene methods between contact with residents. During a review of facility's policy and procedures (P&P) titled Personal hygiene, dated April 2017, indicated the purpose of P&P was to promote a safe and sanitary department by ensuring beards or any body hair that may be exposed (i.e. arms) must be covered.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to document accurately in the resident's medical record in accordance with accepted professional standards and practices and facilities policy and procedure for three (3) of three sampled (Resident 1, 33 and 45) residents by failing to: 1.For Resident 1's medical record did not document Zoloft (a medication used to treat depression- a feeling of severe sadness and hopelessness) in the CAR consent (Client Authorization Request - a form completed by the licensed staff and the physician before administration of psychotropic medications). The consent form did not indicate the name of the medication the resident or responsible party was informed about the risk and benefits and side effect of medication. 2. For Resident 33, Restorative Nursing Assistant (RNA) 1 failed to accurately document in the weekly assessments on Restorative Nursing Weekly Summary as indicated in the facility's policy and procedure titled Standards for RNA Program. The RNA 1 weekly assessment was performed weekly but the documentation was not completed on 1/2/2026 due to the confusion of dates. 3. For Resident 45, Licensed Vocational Nurse (LVN) 1 documented in the resident's Medical Administration Record (MAR) that metoprolol tartrate was given which was help and not given due to low blood pressure. This deficient practice had the potential to result in the residents or responsible party not being fully informed of the correct treatments being administered, increased miscommunication between the resident/or responsible party and the medical provider. Findings: 1.During a review of Resident 1's admission Record indicated the facility admitted the resident on 9/28/2024, with a diagnosis of pneumonia (infection of the lungs making it difficult to breath) and depressive episodes (mental health condition characterized by persistent feelings of sadness, loss of interest or pleasure, and impaired daily functioning). During a review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 10/2/2025, indicated Resident 1 had moderate cognition impairment (may have difficulty with short term memory needing repetition or cues to understand information) and requires maximum assistance by helpers for most activities of daily living (ADL's) such as personal hygiene. During a review of Resident 1's CAR consent dated 12/8/2025, the CAR did not include the name of the medication that the physician was obtaining a consent for use before administration. During a review of Resident 1's History and Physical (H&P) dated 12/9/2025, indicated Resident 1 does not have the capacity to make own decision. During a review of Resident 1's Order Summary (a physician order) dated 12/8/2025, indicated an informed consent was obtained by Medical Doctor to the resident and or responsible party for the administration of an antidepressant and the IDT (interdisciplinary Team) explained the risks and benefits of an antidepressant During a review of Resident 1's Order Summary dated 12/24/205, indicated an order to administer Zoloft two tablets given by mouth, one time a day. for depression manifested by verbalizing Sadness). During a concurrent interview and record review on 1/7/2026 at 3:27 PM with Registered Nurse (RN (continued on next page)		

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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** Based on observation, interview, and record review, the facility failed provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for four of four sampled Residents (Resident 2,8,27, and 39) in accordance with the facility's policy and procedure titled Scope of Infection Control Program, by failing to ensure: 1.Resident 2's and 8's humidification bottle (bottled of water that adds moisture to the oxygen flow to reduce dryness and irritation during oxygen therapy) was observed without date, and residents name. 2.Resident 27's nasal cannula (NC-a flexible tube with two prongs that rest in the nostrils to deliver supplemental oxygen) was observed without a label or date the last time it was changed (NC are changed every seven days). 3.Resident 39's NC was observed on the floor. These deficient practices had the potential for these equipment's to harbor pathogens (bacteria and viruses that cause disease) that could result in infections to Resident 2,8,27, and 39. Findings: 1.During a review of Resident 8's admission record indicated Resident 8 was admitted to facility on [DATE], with a diagnosis of sepsis (severe blood infection), diabetes(high blood sugar) and dementia (decline in memory, thinking and behavior). During a review of Resident 8's History and Physical (H&P) dated [DATE] indicated , Resident 8 was not able to make their own decisions. During a review of Resident 8's Minimum Data Set (MDS- comprehensive screening tool) dated [DATE], indicated the resident has severely impaired cognition (very limited short-term and long &ndash; term memory) dependent on helper for all tasks of daily living such as eating , toileting, and personal hygiene. During a review of Resident 8's Medication Administration Record (MAR) for month of [DATE], indicated an order to change humidifier every week on Sundays 11-7 pm. During a review of Resident 2's admission record (AR) indicated Resident 2 was admitted to facility on [DATE], with a diagnosis of diabetes (high blood sugar) , dementia (decline in memory, thinking and behavior) and heart failure(heart can not pump enough blood to meet the body's needs). During a review of Resident 2's History and Physical (H&P) dated [DATE], indicated Resident does not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS &ndash; Comprehensive screening tool) dated [DATE], indicated the resident has moderately impaired cognition (needing frequent redirection or reminder with inconsistent short-term memory) dependent on helper for most tasks of daily living (ADL's) such as toileting hygiene and showers. During a review of Resident 2's Order summary dated [DATE], indicated a order to administer oxygen at 2-5 liters per minute via nasal canula as needed for Shortness of breath or oxygen saturation below 92 %. During a review of Resident 2's Order Summary dated 1224/2025, indicated to change humidifier (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every week (Sunday) 11/7 AM. During an observation on [DATE] at 9:41AM in resident 8's room, observed humidification bottle without date, residents name. During an observation on [DATE] at 9:54AM in resident 2's room , observed humidification bottle without date, and residents name. During a concurrent observation and interview with Registered Nurse (RN1) in shared room of Resident 8 and 2 observations of humidification bottle for both residents were made. RN1 stated the humidification bottles should be dated and labeled with resident's name. Stating if it is not dated it could be old and an infection control issue. Stated if not dated we do not know for sure when to change. During a review of the facility's policy and procedure titled Guidelines for changing of Disposable Respiratory Equipment dated August ,2017, indicated the purpose of policy was to decrease hospital acquired infections. All opened solutions are to be discarded after 24 hours and labeled with the resident's name, room number, and date changed. 2. During review of Resident 27's admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses that included chronic heart failure (the heart has trouble pumping blood through the body), acute respiratory failure (lungs cannot effectively exchange gases, oxygen and carbon dioxide from the blood), and generalized muscle weakness. During a review of Resident 27's Minimum Data Set (MDS &ndash; a resident assessment tool), dated [DATE], Resident 27 sometimes able to make self-understood (ability making concrete request) and understands (responds adequately to simple communication). MDS indicated Resident 27 required substantial/maximal assistance (helper does more than half the effort) with eating, and dependent (helper does all the effort) with toileting, bathing, dressing and personal hygiene. During a review of Resident 27's facility document titled Order Summary Report (OSR), dated [DATE], the document indicated Resident 27 was to receive oxygen at 2 to 4 liters per minute (the amount of oxygen, measured in liters, that is delivered each minute) via NC for shortness of breath or oxygen saturation below 92 percent titrate as needed. During a concurrent observation and interview on [DATE] at 9:51 AM with the Director of Nurses (DON) in Resident 27's room, Resident 27 was observed receiving oxygen via NC without a label or date of the last time it was changed. DON stated, Resident 27's NC was not labeled with date the last time it was changed to identify if the NC was new or old and changed weekly as per facility's policy. DON stated, if the NC was old or not changed weekly, it had the potential to harbor virus and/or bacteria that could cause infection and negatively affect Resident 27's quality of life. 3. During review of Resident 39's admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic heart failure, anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), and sleep apnea (condition that occurs when your breathing stops and restarts many times while you sleep). During a review of Resident 39's History and Physical Examination (H&P), dated [DATE], indicated Resident 39 was alert and oriented 1 to 2 (person and place). (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and interview, the facility failed to promote dignity and respect in accordance with the facility's policy and procedure for 1 out of 8 residents (Resident 2) who was observed wearing a soiled gown. This deficient practice had violated Resident 2's rights and the potential to result in the resident's feeling decreased self - worth, dignity that could lead to psychosocial decline. Findings: During a review of Resident 2's admission record (AR) indicated Resident 2 was admitted to facility on 7/8/2025, with a diagnosis of diabetes (high blood sugar) , dementia(decline in memory, thinking and behavior) and heart failure(heart cannot pump enough blood to meet the body's needs). During a review of Resident 2's History and Physical (H&P) dated 8/23/2025, indicated Resident does not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - Comprehensive screening tool) dated 10/29/2025, indicated the resident has moderately impaired cognition (needing frequent redirection or reminder with inconsistent short-term memory) dependent on helper for most tasks of daily living (ADL's) such as toileting hygiene and showers. During a review of a Care plan, dated 8/1/2025 indicated Resident 2 had alteration in cognition, with dementia, impaired ability to communicate and understand others and unable to make needs known. To ensure the resident's basic needs were met daily, the interventions included to provide the resident with assistance on activities of daily living and anticipating needs and to provide assistance as needed. During an observation on 1/6/2025 at 09:54 AM, in resident 2's room , Resident 2 was observed wearing a soiled gown with oatmeal colored food and liquid present on the chest area. During a concurrent observation and interview on 1/6/2026 at 10:01 AM with Registered Nurse (RN1) in Resident 2' s room, observed resident wearing gown soiled with food and liquid stains. RN1 stated the resident should not have been left in a soiled gown and that the gown should have been changed the resident's gown as soon as possible. RN1further stated that leaving the resident in a soiled gown had the potential to cause the resident to feel embarrassed. During a review of the facility' policy dated April 2018, titled Quality of Life - Dignity indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy's purpose states that all residents shall be treated with dignity and respect at all times which includes assisting in maintaining and enhancing his or herself - esteem and self - worth.		

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NAME OF PROVIDER OR SUPPLIER Glenhaven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 212 West Chevy Chase Drive Glendale, CA 91204	
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate the resident's need to ensure that the call lights (a device used by residents to signal his or her needs for assistance) was within reach for one of four sampled Resident (Resident 39) who required assistance from staff with activities of daily living and care. This deficient practice had the potential for Resident 39 not able to call when needed assistance with activities of daily living or could not call in an event of an emergency that could lead to a fall and or injury. Findings: During review of Resident 39's admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic heart failure (the heart has trouble pumping blood through the body), anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), osteoarthritis (a joint disease, in which the tissues in the joint break down over time), and bilateral artificial knee joint (artificial knee prosthesis). During a review of Resident 39's History and Physical Examination (H&P), dated 6/16/2025, indicated Resident 39 was alert and oriented to person and place, and had weak extremities (arms, legs, hands, and feet). During a review of a Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2025, indicated Resident 39 sometimes able to make herself understood (ability making concrete request) and understands (responds adequately to simple communication). MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene and dressing, and dependent (helper does all the effort) with toileting and bathing. During a review of Resident 39's care plan (CP) for risk for falls with injury related to impaired mobility and needing assistance with activities of daily living, revised 11/17/2024 indicated intervention includes place the call light within reach and prompt response to all request for assistance. During a review of Resident 39's Fall Risk Assessment dated 12/16/2025, indicated Resident 39 cannot walk unassisted, and was a high risk for fall. During a concurrent observation and concurrent interview on 1/8/2026 at 8:12 AM with the Director of Nurses (DON) in Resident 39's room, Resident 39 was observed awake and touched her chest area when asked where was her call light? Resident 39's call light was on the floor, and not within reach of the resident. DON stated, Resident 39 was not able to reach her call light which had the potential for staff not being able to attend to Resident 39's needs especially during emergency. During an interview on 1/8/2026 at 11:48 AM with the DON, DON stated, he expects call lights to be within reach of residents, it is facility policy, especially to those who can use it. DON stated, it is essential for the call light to be within reach so Residents can call for assistance especially for emergency. DON stated, for Resident 39, who was at high risk for fall was not able to use the call light for assistance had the potential for fall and/or injury from trying to get up to call for help. A review of the facility's policy and procedure (P&P) titled, Fall Prevention Program dated 12/2016, indicated: a) the facility will identify interventions related to residents specific risks and causes to try to prevent the resident from falling, b) all precautions will be implemented to protect the resident according to the fall prevention, and c) place resident care articles within reach. A review of the facility's policy and procedure (P&P) titled, Answering Call Lights dated 8/2017, indicated: a) when call lights are used to respond to needs at the time of use, b) when resident is in bed the call light will be placed within easy reach of the resident, and c) resident call lights will be answer as soon as possible.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and obtain an Advanced Directive (a legal document indicating resident preference on end-of-life treatment decisions) or properly fill out an acknowledgement of advanced directive form for two (2) of 13 sampled residents (Resident 9 and 53) in accordance with facility policy titled Advance Directives and regulatory requirements. This deficient practice has the potential for Residents 9 and 53 not to receive care and services according to the residents wishes especially during medical emergencies. Findings: 1. During a review of Resident 9's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] , and was readmitted on [DATE] , with a diagnosis of end stage renal disease(kidneys no longer work well enough to keep the person alive on their own) and dependance for Hemodialysis (HD- a machine that cleans their blood because their kidneys no longer work). During a review of Resident 9's History and Physical (H&P) dated 12/23/2025, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool) dated 12/23/2025, the MDS indicated the resident was cognitively intact (the resident is alert and oriented and can understand information , making own decisions and can provide informed consent) but requires maximal assistance with most all activities of daily life (ADL's) such as showering and dressing. During a record review of Resident 9' s medical chart, Resident 9's Advance Directive Acknowledgment Form was reviewed. The form did not indicate a date or signature by Resident 9 and did not indicate the resident's preferred intensity of care (care a resident wishes to receive or refuse if they become unable to communicate their own decisions) for authorization for treatment. During a concurrent interview and record review on 1/6/2026 at 11:10AM with the Director of Social Services (DSS) , Resident 9' s Advance Directive Acknowledgment was reviewed. DSS confirmed the advance directive acknowledgment form was not dated, signed by the physician and missing the authorization for intensity of care. DSS stated the form should have been completed upon admission. DSS stated when residents are admitted or reemitted the form must be redone and ensure that a date and signature was indicated on the form. The DSS stated the form was important to ensure residents' healthcare wishes and preferred care during medical emergencies were clearly identified, documented, and honored. 2. During a review of Resident 53's admission Record, it indicated Resident 53 was admitted on [DATE] with diagnoses that malignant neoplasm of the bladder (bladder cancer), hypertension (high blood pressure), and anxiety disorder. Resident 53 was in the facility for respite hospice care (short term inpatient service providing relief for primary caregivers of a terminally ill person) for 5 days. During a review of Resident 53's Physician Orders for Life-Sustaining Treatment (POLST), dated 10/23/2025, the POLST indicated Resident 53 has an advanced directive dated 9/29/2018. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's medical records, it did not indicate Resident 53 had a copy of the advance directive. During an interview on 1/8/2026 at 2:45 pm with the Director of Nursing (DON), the DON stated the POLST and advanced directive are different legal documents. Social Services should obtain a copy of the residents' advanced directive. During an interview on 1/9/2026 at 9:35 am with the Director of Social Services (DSS), the DSS stated a copy of the advanced directive was not in Resident 53's chart. The facility should have obtained a copy of the advanced directive. The advanced directive is to ensure that the resident's preferences in regards to care are being carried out properly. During a review of the facility's policy and procedure (P&P) titled, Advanced Directives, dated February 2017, the P&P indicated that a copy of the advanced directive must be obtained from the resident or legal representative and placed in the Resident's clinical record. The facility must document in a prominent part of the resident's clinical record whether the resident has issued an advance directive.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary assistance with good grooming and personal hygiene during routine nursing care to one (1) of four sampled residents (Resident 27) with unshaved facial hair. This deficient practice had the potential to negatively impact Resident 27's self-image, quality of life, self-esteem (overall sense of personal worth), that can lead to feelings of helplessness and diminished self-worth. Findings: During review of Resident 27's admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses that included chronic heart failure (the heart has trouble pumping blood through the body), acute respiratory failure (lungs cannot effectively exchange gases, oxygen and carbon dioxide from the blood), and generalized muscle weakness. During a review of a Minimum Data Set (MDS - a resident assessment tool), dated 12/22/2025, Resident 27 sometimes able to make self-understood (ability making concrete request) and understands (responds adequately to simple communication). MDS indicated Resident 27 required substantial/maximal assistance (helper does more than half the effort) with eating, and dependent (helper does all the effort) with toileting, bathing, dressing and personal hygiene including shaving. During a review of Resident 27's Care Plan, revised on 1/3/2026 indicated Resident 27 needed assistance with Activities with Daily Living (ADLs) that included personal hygiene. The intervention included the staff will provide assistance with ADLs as needed. During and observation on 1/6/2026 at 9:51 AM in Resident 27's room, Resident 27 was in lying in bed rubbing his thick facial hair. When asked if he wanted to have his facial hair shave, Resident 27 agreed and nodded yes. During a concurrent observation on 1/6/2026 at 3:45 PM with Certified Nurse Assistant (CNA) 3, in Resident 27's room, Resident 27 was observed with thick facial hair remained unshaven. During an interview on 1/6/2026 at 4 PM with Registered Nurse (RN) 1, RN 1 stated, part of the routine morning care was to ensure all resident that needs assistance with ADLs are clean and well-groomed which includes shaving the resident's facial hair. RN 1 stated, not providing assistance with grooming during morning care had the potential to negatively affect Resident 27's self-esteem. A review of the facility's policy and procedure (P&P) titled, Routine Nursing Care dated 2/2017, indicated, Residents to receive the necessary assistance to maintain good grooming and personal hygiene. A review of the facility's policy and procedure (P&P) titled, Standards of Care: Activities of Daily Living dated 2/2017, indicated: a) dependence on others for ADL assistance can lead to feeling of helplessness, isolation, and diminished self-worth, and b) assist the resident to keep clean, neat well-groomed including nail care and shaving.		

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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** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services for one of one sampled resident (Resident 52) who received the incorrect tube feeding (a liquid form of food when unable to eat or drink by mouth) formula. Resident 52 received Jevity 1.5 calorie (a type of tube feeding/nutritional formula) instead of Jevity 1.2 calorie that was ordered by the physician. This failure had the potential to result in Resident 52 to receive added calories that could lead to unplanned weight gain and/or not achieve the goal to received adequate nutrients to maintain the ideal weight. Findings: During a review of Resident 52's admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), gastrostomy (GT-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of the History and Physical (H&P) Resident 52 had the capacity to understand and make decisions. During an observation on 1/6/2026 at 9:45 am in Resident 52's room, Resident 52 was receiving Jevity 1.5 calorie at 45 milliliters (a unit of measurement) per hour with the GT tubing was dated 1/5/2026. During a concurrent interview and record review of Resident 52's on 1/6/2026 at 4 PM with Licensed Vocational Nurse (LVN) 1, Resident 52's physician's order indicated to start Jevity 1.2 via feeding pump (a machine used to deliver tube feeding formula to the resident to the GT). LVN 1 stated Resident 52 was receiving the wrong tube feeding formula and it can lead weight gain. During an interview on 1/8/2026 at 10:50 AM with the Director of Nursing (DON), the DON stated, providing the incorrect tube feeding formula can lead the resident to nutritional deficiencies or surpluses, slow wound healing, weight gain and electrolyte imbalances (essential minerals in the body are not balanced). During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding Via Pump Administration, dated December 2017, the P&P indicated that all tube feedings should be compared against the physician's order.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide continuous supplemental oxygen therapy as ordered by the physician for one of two sampled residents (Resident 39) who was ordered to receive oxygen at 2-4 liters per minute (a unit volume flow rate) continuously via nasal cannula (NC-a flexible tube with two prongs that rest in the nostrils to deliver supplemental oxygen). Resident 39's NC was on the floor and not connected to the resident. This deficient practice had the potential to result in Resident 39's lack of oxygenation and lead to respiratory decompensation (when respiratory system fails to meet the body's oxygen needs, requiring immediate intervention like oxygen) shortness of breath (SOB) and respiratory distress, that could negatively affect the resident. Findings: During review of Resident 39's admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic heart failure (the heart has trouble pumping blood through the body), anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), and sleep apnea (condition that occurs when your breathing stops and restarts many times while you sleep). During a review of Resident 39's History and Physical Examination (H&P), dated 6/16/2025, indicated Resident 39 was alert and oriented to person and place. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2025, Resident 39 sometimes able to make self-understood (ability making concrete request) and understands (responds adequately to simple communication). MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene and dressing, and dependent (helper does all the effort) with toileting and bathing. During a review of Resident 39's facility document titled Order Summary Report (OSR), dated 12/4/2025, indicated to administer oxygen 2 to 4 liters per minute via nasal cannula may titrate (adjust) every shift for shortness of breath (SOB) or oxygen saturation below 92 percent (normal range 90-100%) continuously. During a review of Resident 39's care plan (CP) for risk for ineffective airway clearance related to the diagnosis of sleep apnea, revised 12/16/2025 indicated intervention includes administer oxygen 2 to 4 liters per minute via nasal cannula continuously. During an observation on 1/7/2026 at 9: 15 AM in Resident 39's room at bedside, Resident 39 was in bed with eyes closed, was observed for at least five minutes not receiving her oxygen due to NC was on the floor. During a concurrent observation and interview on 1/7/2026 at 9: 20 AM in Resident 39's room with the Director of Nurses (DON), Resident 39's oxygen NC was on the floor. DON stated, Resident 39 needed continuous oxygen due to her sleep apnea and she does not know why the NC was on was on the floor. DON explained if Resident 39 did not receive oxygen for five minutes she had the potential to experience respiratory distress. During an interview on 1/7/2026 at 1:40 PM with the DON, DON stated, it is the facility's policy to provide oxygen support to maintain adequate oxygenation to the facility's respiratory compromised residents. DON stated Resident 39's respiratory status was compromised and should have been receiving oxygen supplement as ordered. DON stated, since Resident 39 was not receiving oxygen for five minutes the resident had the potential to result in lack of oxygenation that could lead to respiratory decompensation, that may lead to SOB and respiratory distress, that could negatively affect Resident 39's quality of life. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, Delivery Device dated 8/2017, indicated: a) facility to provide oxygen support when indicated via appropriate delivery device to achieve or maintain adequate oxygenation to the respiratory compromised resident, b) to maintain tissue oxygenation in the chronically - hypoxic resident. and c) check the oxygen setup regularly to prepare proper functioning.		

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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** Based on observation, interview, and record review, the facility failed to ensure resident's bedrooms measured at least 80 square feet (sq. ft., a unit of measurement) per resident in the room with multiple residents in the bedrooms for 12 of 16 rooms. Resident Rooms 2, 3, 4, 7, 8, 9, 10, 11, 12, 14, and 15 measured less than 80 sq. ft per resident. This deficient practice had the potential to have insufficient space for staffs and residents that can impact the ability to provide safe nursing care and privacy to the residents. Findings: During a review of the facility ' s Client Accommodation Analysis (CAA, a form used to identify the room sizes and number of beds in a room) form, dated 1/6/2026, the CAA form indicated 12 resident bedrooms did not measure 80 sq. ft per resident as listed below: room [ROOM NUMBER] - 155.6 sq ft with two (2) beds and two (2) occupied beds room [ROOM NUMBER] - 292 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 155.6 sq ft with two (2) beds and two (2) occupied beds room [ROOM NUMBER] - 292 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 286.5 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 292 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 289.5 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 292. 4 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 286.5 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 286.1 sq ft with four (4) beds and four (4) occupied beds room [ROOM NUMBER] - 291.9 sq ft with four (4) beds and four (4) occupied beds During a concurrent observation and interview on 1/8/2026 at 8:30 AM with Resident 40, in Resident 40' s room (room [ROOM NUMBER]), Resident 40 in her wheelchair, able to propel self in her room. Resident 40 stated, she had no issues with the room, she was able to move around, and nurses can care for her without any concern. During an Interview on 1/8/2026 at 8:40 AM with Resident 16, in Resident 16's room (room [ROOM NUMBER]), Resident 16 stated, she did not have any concern about her room size, the nurses are able to care for just fine. During an Interview on 1/8/2026 at 8:45 AM with Resident 10, in Resident 10's room (room [ROOM NUMBER]), Resident 10 stated, he is fine with his room size. During an Interview on 1/8/2026 at 9:30 AM with Certified Nurse Assistant (CNA) 2, CNA 2 stated, she was able to do her work , and she had enough space to care residents in the above-mentioned room, even with wheelchairs. During an Interview on 1/8/2026 at 9:40 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, she had no concerns with above-mentioned room size, she was able to do her residents care and treatments as needed. During a concurrent observation and interview on 1/8/2026 at 9:57 AM with the Maintenance Supervisor (MS), MS measured sampled rooms [ROOM NUMBER]. MS stated, room [ROOM NUMBER] was 155 sq. ft for two beds, room [ROOM NUMBER] was 292 sq. ft for four beds, and room [ROOM NUMBER] was 292 sq. ft for four beds. MS stated, he did not hear any concern about the room size with residents. During the re-certification survey between 1/6/2026 until 1/9/2026, the above listed rooms had sufficient space for the residents ' freedom of movement. Each resident in the rooms listed above had Individual bedside tables and over the bed tables. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not present any adverse effect on the residents' personal space, nursing care, and comfort. During a review of the facility's Room Waiver Request, dated 1/6/2026, the request indicated the Administrator (ADM), and the Director of Nursing (DON) will screen admissions, and complete room rounds to ensure only the allowed capacity of residents were allowed in the rooms listed above. The Room Waiver Request Indicated, the MS and the ADM Inspected the rooms listed above to ensure that required medical equipment such as wheelchairs, guest chairs, and the Hoyer lift (a mechanical device used to lift and/or transfer a person) did not impact the delivery of care in the residents residing in the listed rooms.		