STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Valley Healthcare Center	371 North Weston Pl Hemet, CA 92543

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to provide a homelike environment, for one of 21 residents (Resident 4), when Resident 4 was placed in the activity room when the resident was readmitted back to the facility for five days. This failure had the potential to negatively affect the resident's emotional and social well-being. Findings: On February 20, 2025, at 09:05 a.m., an unannounced visit to the facility was conducted to investigate a complaint regarding infection control. On February 20, 2025, Resident 4's record was reviewed. Resident 4 was readmitted to the facility on [DATE], with diagnoses which included acute - on chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), hydrocephalus (abnormal accumulation of cerebrospinal fluid in the brain), psychosis (a mental disorder where there is a severe loss of contact with reality), and tracheostomy (a hole surgically created in the windpipe to relieve an obstruction to breathing). A review of Resident 4's Progress Note Inquiry, indicated Resident 4 was placed in the activity room on the following dates; - February 6, 2025, at 8:30 p.m., indicated, .Resident admitted to room [ROOM NUMBER]A but actually placed in activity room . - February 7, 2025, at 12:55 p.m., .Morning rounds completed, awake and watching TV (television) in activity room .Transferred back to Subacute .resident was placed in activity room at this time . - February 8, 2025, at 11;13 a.m., .Resident is temporarily in Activity room . - February 9, 2025, at 10;58 a.m., .resting comfortably on her bed in lowest position in the activity room . A review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), recorddated February 13, 2025, indicated Resident 4 have unclear speech but could understand others. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 20, 2025, at 12:53 p.m., the Infection Preventionist (IP) was interviewed. The IP stated the facility had a Covid -19 (coronavirus - a contagious respiratory diseases) outbreak on February 5, 2025. The IP stated the residents were moved to different rooms to allow cohorting (grouping) of Covid positive residents. The IP stated that Resident 4 was readmitted to the facility and was placed in the activity room for about two to three days because there was no available female room. The IP stated all the furnitures in the activity room were moved to the other side of the room. On February 20, 2025, at 3:30 p.m., Licensed Vocational Nurse (LVN 1) was interviewed. LVN 1 stated Resident 4 stayed in the activity room during the Covid outbreak because another resident occupied her room. On February 20, 2025, at 5:30 p.m., a follow up interview was conducted with the IP. The IP stated Resident 4 was transferred out to the acute hospital on January 28, 2025. The IP stated another resident was moved to Resident 4's room during the outbreak while Resident 4 was on bed hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility). The IP stated Resident 4's bed hold ended on February 4, 2025. The IP confirmed Resident 4 was readmitted back to the facility and was placed in the activity room on February 6, 2025, and was placed back to her previous room on February 11, 2025 (five days later). On February 20, 2025, at 5:50 p.m., during an interview with the Director of Nursing (DON), the DON confirmed Resident 4's physician kept asking for Resident 4 to be admitted back to facility. The DON stated residents were admitted to the activity room for a short period of time during the pandemic. The DON stated she approved the admission of Resident 4 to the activity room because it was safe. On February 21, 2025, at 10:25 a.m., Respiratory Therapist (RT) 2 was interviewed inside the activity room. RT 2 stated he cared for Resident 4 when she was admitted to the activity room. RT 2 stated that Resident 4 was alert but nonverbal but can communicate basic needs by nodding or shaking her head to a yes or no questions. RT 2 stated that all large pieces of furniture stayed in the activity room with Resident 4 for five days. The activity room was observed to have the following inside: - Two long and heavy wooden tables with metal legs; - Five large black office chairs; - Four blue plastic chairs with metal legs; - A black metal standing fan with dust-colored particles on the stand; - Three to four black and metal multi leveled carts with television monitors placed on top; - Stacks of bins piled on top of each other at the back left corner which contained art and crafts supplies; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Pink cabinets were mounted to the wall back wall and contained many arts and crafts supplies; and - Several emergency oxygen tanks (long and heavy metal tanks containing oxygen) by the window side. RT 2 stated staff had to go to the activity room if needed to get items for activities even if Resident 4 was inside the activity room. RT 2 stated all the items observed inside the activity room were present in the activity room while Resident 4 was in there, they were just moved to the side. RT 2 stated there was no privacy curtains placed while Resident 4 was inside the activity room. RT 2 stated there was no urgent need for Resident 4 to be admitted back to the facility. On February 21, 2025, at 1:10 p.m., a follow up interview was conducted with the DON. The DON stated she was not aware all the large furnitures, chairs, and tables remained in the room while Resident 4 stayed in the activity room. The DON stated she also did not know that Resident 4 stayed in the room for five days, stated that was too long. The DON stated with all the clutter in the activity room, and staff coming in and out of the activity room, the facility failed to provide a home-like environment for Resident 4. The DON stated she could understand the frustration if she were to put herself in the patient's shoes. The DON stated although Resident 4 could not fully communicate her frustration or needs, she was alert and was aware of her surroundings. The DON stated there was no urgent need for the resident to be admitted back to the facility and they could have asked the hospital to wait until the outbreak was over or facilitate another transfer to another sub-acute unit. A review of facility's policy and procedure titled Residents Rights, revised March 2024, indicated, .The resident has the right .To a dignified existence, self-determination .inside and outside the facility .To be treated with consideration, respect and full recognition of his or her dignity and individuality .To be provided by the facility with a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible .To reside and receive services in the facility with reasonable accommodation of individual needs and preferences .

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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 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** 40000 Based on interview and record review, the facility failed to ensure a care plan (a detailed written document that outlines a resident's healthcare needs, goals, and treatment strategies) was developed, for four of four residents (Residents 2, 14, 16, and 17) , when the residents had COVID -19 (coronavirus - a contagious respiratory infection) infection. This failure had the potential for the staff not to be aware of the appropriate interventions needed to be implemented to address the resident's changes in health condition. Findings: On February 20, 2025, at 09:05 a.m., an unannounced visit to the facility was conducted to investigate a complaint regarding infection control and nursing services. On February 20, 2025, at 12:43 p.m., the Infection Preventionist (IP) was interviewed. The IP stated the facility had a Covid outbreak on the evening shift of February 5, 2025. The IP stated Residents 2, 14, 16, and 17, were positive for COVID-19 on February 5, 2025. On February 20, 2025, at 3:30 p.m., Licensed Vocational Nurse (LVN 1) was interviewed. LVN 1 stated that care plans were being updated by the Registered Nurse (RN). LVN 1 stated he was unsure when care plans get updated. On February 21, 2025, Residents 2, 14, 16, and 17 records were reviewed. The record review indicated the following: a. Resident 2 was admitted to the facility on [DATE], with diagnoses which included respiratory failure (lung failure). Resident 2's Progress Note Inquiry, dated February 5, 2025, at 11:04 p.m., indicated, .Resident tested positive for Covid . b. Resident 14 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. Resident 14's Progress Note Inquiry, dated February 5, 2025, at 10:51 p.m., indicated, .Resident tested positive for Covid . c. Resident 16 was admitted to the facility on [DATE], with diagnoses which included kidney failure. Resident 16's Progress Note Inquiry, dated February 5, 2025, at 9:24 p.m., indicated, .Resident tested positive for Covid . d. Resident 17 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. Resident 17's Progress Note Inquiry, dated February 5, 2025, at 9:59 p.m., indicated, .Resident tested positive for Covid . Further review of Residents 2, 14, 16, and 17's record indicated no care plan was developed to address Covid infection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 21, 2025, at 4:24 p.m., during an interview with the IP, the IP stated the RN was the one responsible to update the care plan upon admission and when there is a resident's change of condition. The IP stated that they would update the care plans using the backside of the sheet. The IP stated she was not very familiar with care plans. On February 21, 2025, at 4: 28 p.m., during an interview with RN 1, RN 1 stated the care plan was to be updated on a regular basis. RN 1 stated care plans were to be developed when there was a new admit, any new diagnosis, and any change of condition. RN 1 stated four residents tested positive for Covid-19 on February 5, 2025. RN 1 stated she did not do the care plan for any of the four COVID positive residents. RN 1 stated she should have developed a care plan for Residents 2, 14, 16, and 17 to address COVID-19 infection. A review of the facility's policy and procedure titled Resident Care Plan, revised March 2024, indicated, . provide an individual plan of care for each Sub-Acute resident that is updated .at the time of admission, after the nursing assessment is completed . Plan of care will be initiated within 24 hours and documented on the Care Plan form. This .will be reviewed weekly by nursing staff, quarterly in care conference or as dictated by the resident's condition and nursing diagnosis. Any changes to the plan may be made by any member of the interdisciplinary team including: Physician, nursing staff, physical therapy, occupational therapy, social service, respiratory therapy, pharmacists, case management, speech therapy, and dietician .

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to ensure infection control practices were observed, and the facility policies and procedures related to infection control were implemented when: 1. The facility did not report to the California Department of Public Health (CDPH- state agency responsible for public health in California, enforcing some of the laws affecting healthcare facilities) of a COVID 19 (coronavirus - a contagious respiratory infection) outbreak when the facility had one COVID-19 positive staff and four COVID-19 positive residents on February 5, 2025. This failure resulted in the state agency being unaware of the presence of a COVID-19 outbreak in the facility and had the potential of delayed implementation of infection control measures to address COVID-19; and 2. The facility did not implement Enhanced Barrier Precautions (EBP - a strategy recommending the use of gown and gloves during provision of high-contact resident care activities (dressing, bathing, transferring, providing hygiene, linen change, assisting with toileting, indwelling device [a medical device that remains inside the body] care, and wound care) to the residents with wounds, indwelling devices, and colonized (the presence of microorganisms [such as bacteria, viruses, or fungi] on or in a person's body without causing any apparent symptoms or disease) MDRO [multidrug resistant organisms -germ that is resistant to many antibiotics] infection to reduce the spread of MDRO transmission), according to Centers for Disease and Prevention Control (CDC) guidelines, for 17 of 21 residents (17 residents had indwelling medical devices [Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, and 21], five of 17 residents [Residents 5, 15, 17, 18, 21] had colonized (the presence and multiplication of microorganisms (such as bacteria, viruses, or fungi) on or in a body surface without causing any apparent signs or symptoms of infection) MDRO infection, and one of 17 residents (Resident 11) had pressure injuries [bed sores]). In addition, the facility did not have a policy and procedure with the use of EBP. On February 20, 2025, at 8 p.m., the Director of Nursing (DON) and the Quality Assurance Officer (QA) were verbally notified of the Immediate Jeopardy (IJ - situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident), due to the facility's failure of not implementing Enhanced Barrier Precautions while providing high contact care activities to 17 residents (Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, and 21) with indwelling devices. The facility's failure to implement EBP during provision of high contact resident care activities had the potential to result in the spread of MDROs to the immunocompromised residents, and could cause serious harm, and aggravate the already vulnerable and compromised health conditions of the residents. On February 21, 2025, at 4:38 p.m., the QA and the DON presented an acceptable removal plan which included the following: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Members of the Governing Board and MEC (Medical Executive Committee) were notified immediately of the findings by the COO (Chief Operating Officer); - On February 20, 2025, the DON identified all residents with colonized MDROs, those at increased risk to acquire MDRO infection, and those that require high contact care activities for which EBP should be used; - On February 21, 2025, the DON validated the facility had appropriate and adequate levels of PPE (Personal Protective Equipment - protective clothing or equipment worn by healthcare workers to minimize exposure to hazards and prevent illnesses) to use for EBP. The DON contacted central supply to ensure levels were justified and supplies were available at all times; - On February 21, 2025, all residents currently on the unit were evaluated by the DON to ensure no adverse effects occurred. EBP was implemented immediately for all residents if applicable by the DON/designee; - On February 21, 2025, appropriate signage for EBP was created by the DON and placed by the room entrances of residents for whom EBP should be used to aid in identifying and reminding staff to use EBP when providing high contact care activities to the residents; - On February 21, 2025, the DON rounded on all resident's' rooms to ensure the appropriate signage for EBP is in place as per facility policy. Any missing signage was immediately placed in applicable rooms; - On February 21, 2025, the Medical Director (MD) of the subacute unit was notified of the IJ and was advised of the findings. The MD will continue to collaborate with the leadership team to create and implement the appropriate infection control measure; - On February 21, 2025, the resident and/or resident representatives of all residents impacted by the deficiency were notified of the incident via phone by the DON/designee; - On February 21, 2025, the DON/RN Charge Nurse immediately started staff education on EBP and hand hygiene using 1:1 education and group education during huddles. The staff will receive the education before the start of their next shift; - On February 21, 2025, providers for the residents impacted by this deficiency were contacted and orders obtained to include the use of EBP. The care plans of the affected residents impacted by this deficiency were updated by the DON/RN to include the use EBP; - On February 21, 2025, the DON reviewed the policy on EBP and revised it to ensure compliance with current regulations and best practices. The policy reviewed and approved by the Medical Director of the subacute unit and Medical Director of infection control; - On February 21, 2025, all staff present were educated on the revised EBP policy by the DON/designee. Staff not present will be educated on the revised policy before the start of their next shift. All staff will be educated to the policy by February 23, 2025. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On February 25, 2024, at 4:26 p.m., the immediate jeopardy was removed in the presence of the DON, upon onsite verification of the implementation of the plan of actions. Findings: On February 20, 2025, at 9:05 a.m., an unannounced visit was conducted at the facility to investigate a complaint regarding infection control. 1.On February 20, 2025, at 12:53 p.m., during an interview with the Infection Preventionist (IP), the IP stated there was a COVID-19 outbreak in the facility which began on February 5, 2025, with one COVID-19 positive staff and four COVID-19 positive residents. On February 20, 2025, a review of the facility's COVID-19-line listing indicated Residents 2, 14, 16, and 17, and Certified Nursing Assistant (CNA) 7 were tested positive on February 5, 2025. The IP stated she reported the outbreak to the county public health officer but not to CDPH. The IP further stated the COVID-19 outbreak should have been reported to the CPDH. On February 21, 2025, Residents 2, 14, 16, and 17 records were reviewed. The record review indicated the following: a. Resident 2 was admitted to the facility on [DATE], with diagnoses which included respiratory failure (lung failure). Resident 2's Progress Note Inquiry, dated February 5, 2025, at 11:04 p.m., indicated, .Resident tested positive for Covid . b. Resident 14 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. Resident 14's Progress Note Inquiry, dated February 5, 2025, at 10:51 p.m., indicated, .Resident tested positive for Covid . c. Resident 16 was admitted to the facility on [DATE], with diagnoses which included kidney failure. Resident 16's Progress Note Inquiry, dated February 5, 2025, at 9:24 p.m., indicated, .Resident tested positive for Covid . d. Resident 17 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. Resident 17's Progress Note Inquiry, dated February 5, 2025, at 9:59 p.m., indicated, .Resident tested positive for Covid . A review of the facility's policy and procedure titled, Outbreak Investigation and Management, revised December 2022, indicated, .to control the spread of infection or disease and to identify factors that contributed to the outbreak in order to develop and implement measures to prevent similar outbreaks in the future .The Infection Prevention Committee (IPC) shall have the responsibility for investigating outbreaks . Any suspected outbreak shall be reported to the (name of county) Department of Public Health and the appropriate Public Health licensing and certification department . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of AFL (All Facilities Letter- a CDPH communication letter to all facility types including Skilled Nursing Facilities [Nursing Homes]) 23-08, dated January 18, 2023, indicated, .This AFL reminds providers of the requirements to report outbreaks and unusual infectious disease occurrences to the local public health officer and the California Department of Public Health (CDPH) and provides definitions and updated examples of reportable incidents .Health facilities licensed by CDPH Licensing and Certification (L&C) are required to report outbreaks (occurrence of cases of a disease or condition above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group) and unusual infectious disease occurrences to the local public health officer and their respective District Office (DO) .Examples of Reportable Incidents .Facility outbreak of COVID-19, influenza (lung infection caused by influenza viruses), pneumonia (bacterial lung infection), other respiratory viral pathogen (e.g., respiratory syncytial virus), or gastroenteritis (e.g., norovirus- virus causing abdominal symptoms) . A review of the Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) and the Council of State and Territorial Epidemiologists' (CSTE) article titled Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings, dated January 2, 2024, indicated thresholds for reporting to Public Health for Long Term Care Facilities (LTCFs- includes nursing homes) is two or more cases of probable or confirmed COVID-19 among residents identified within seven days, OR two or more cases of suspect, probable, or confirmed COVID-19 among health care providers (facility staff) and one or more case of probable or confirmed COVID-19 among residents . 2. On February 20, 2025, beginning at 9:50 a.m., an observation of the facility from Rooms 401 to 410 was conducted. The following were observed: - Residents 5 and 6 were both observed to have tracheostomies (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck). Respiratory Therapist 1 was observed providing respiratory care at bedside to Resident 5 while wearing a surgical mask and gloves, no gown was in use. There was no EBP sign outside Residents 5 and 6's room; - Concurrently, one female staff was observed moving around Resident 6's bed through the privacy curtain. After rendering care, the female staff drew the curtain halfway open and upon coming through the curtains, staff was observed not wearing a mask or gown, and proceeded to remove and discard her gloves in the trash can; - Residents 1, 2, 3, and 13's rooms were observed to have a sign outside the door indicating Contact Precautions (infection control measures used to prevent the spread of infectious diseases that are transmitted through direct contact with the patient or their contaminated environment requiring use of PPE such as mask, gown, gloves), and instructions to wear specific PPE. - There was no sign for EBP by the door of Residents 4, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, and 21's rooms. - Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, and 21, were observed to have indwelling devices such as tracheostomies and gastrostomy (GT - tube that is inserted into the stomach through the abdominal wall to provide nutrition, hydration, or medicine). Residents 11 and 15 had an indwelling catheter (a thin, flexible tube inserted into the urinary bladder to collect and drain urine). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On February 20, 2025, at 10:03 a.m., during an interview with the IP, she stated the following residents were placed on contact precautions due to the presence of MDRO infection: - Resident 1; CRPA (carbapenem-resistant pseudomonas aeruginosa - a type of bacterial infection that is resistant to many antibiotics) in the sputum; - Resident 2; CRPA in the urine; - Resident 3; CRPA in the wound; - Resident 13; MRSA (methicillin-resistant staphylococcus aureus - a type of bacteria resistant to several antibiotics) in the wound. The IP further stated there were no residents placed on EBP. On February 20, 2025, at 11:01 a.m., Certified Nursing Assistant (CNA)1 was interviewed. CNA 1 stated she did not know what EBP was and had never heard of it before. On February 20, 2025, at 11:18 a.m., CNA 2 was interviewed. CNA 2 stated she had no awareness of what EBP was. On February 20,2025, at 12:53 p.m., a follow up interview was conducted with the IP. The IP stated there were no residents in the facility who were placed on EBP. On February 20, 2025, at 3:21 p.m., Licensed Vocational Nurse (LVN) 1 was interviewed. LVN 1 stated he was not aware what EBP was and had never cared for any residents who were placed on EBP in the unit. LVN 1 further stated he never received any in-services regarding EBP, but always wore gloves and masks for any kind of patient care since all the residents were trached (had tracheostomies). LVN 1 could not articulate what type of PPEs were to be used when a resident was placed on EBP. On February 20, 2025, beginning at 4:10 p.m., the following were observed: - There were still no EBP signs by the door of the rooms not placed on contact isolation; - LVN 2 entered Residents 17 and 18's room and provided care to the residents. LVN 2 was observed wearing only gloves, did not put on a gown or mask prior to entering and while providing care to Residents 17 and 18; - CNA 3 entered Residents 17 and 18's room wearing a mask, but did not put on any gown or gloves prior to entering and was observed to change the linens of the residents; - At 4:34 p.m., CNA 2 entered Residents 17 and 18's room and observed wearing gloves, but did not put on any gown or mask while assisting CNA 3 with resident care and turning the residents. On February 20, 2025, at 4:35 p.m., CNA 3 was interviewed. CNA 3 stated the facility only used EBP during COVID-19 outbreaks. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On February 20, 2025, at 4:57 p.m., LVN 2 was interviewed. LVN 2 stated she was not sure what EBP referred to and had never heard of EBP. On February 20, 2025, at 5:13 p.m., the IP was interviewed. The IP stated the staff should use gloves or gowns when providing care to residents. The IP further stated gowns were optional when doing perineal care or turning a patient when staff needed to create a barrier between staff and the resident. The IP stated they did not put EBP signs on the resident's door because all residents should be using EBP. On February 20, 2025, at 5:44 p.m., the DON was interviewed. The DON stated EBP was a new practice, and not a lot of people knew about it yet, and EBP was not being practiced at the facility. The DON stated the staff was to wear the appropriate PPEs, such as gown, gloves, when providing care to residents placed on EBP. The DON stated, the hospital doesn't understand it, and the facility staff would not know what EBP was because she had not trained them on it. The DON stated if EBP or other infection precautions were not to be followed, there would be a potential risk for spread of infections such as MDROs among the residents. The DON further stated the facility did not have a policy on EBP. On February 20, 2025, a review of residents' records indicated the following; a. A review of Resident 4's Patient Information, indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included sepsis (body's extreme response to an infection, a life-threatening medical emergency). A review of Resident 4's History and Physical, dated February 6, 2025, indicated PEG placement (percutaneous endoscopic gastrostomy- a type of feeding tube), tracheostomy, and right frontal ventricular drain (a catheter inserted into the brain through the skull to monitor and drain cerebrospinal fluid) placement. Further review of Resident 4's record did not include a physician's order and care plan for Resident 4 to be placed on EBP. b. A review of Resident 5's Patient Information, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses which included chronic (persisting for a long time) respiratory failure. A review of Resident 5's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube/GT. A review of Resident 5's Patient Care Summary, included physician's orders for tracheostomy therapy and nutritional formula feeding via GT, as well as care and maintenance orders for the feeding tube. Further review of Resident 5's record did not include a physician's order and care plan for Resident 5 to be placed on EBP. c. A review of Resident 6's Patient Information, indicated Resident 6 was admitted to the facility on [DATE], with diagnoses which included respiratory failure and anoxic (oxygen deficient) brain injury. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 6's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 6's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment. The orders also included care and maintenance orders for the feeding tube. Further review of Resident 6's record did not include a physician's order and care plan for Resident 6 to be placed on EBP. d. A review of Resident 7's Patient Information, indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure s/p (status post) trach (tracheostomy) and PEG. A review of Resident 7's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 7's Patient Care Summary, dated January 31, 2025, included a physician's orders for tracheostomy care and treatment and nutritional formula feeding via J-tube (a type of GT surgically inserted into the small intestine to deliver food and medicine), as well as care and maintenance orders for the feeding tube. Further review of Resident 7's record did not include a physician's order and care plan for Resident 7 to be placed on EBP. e. A review of Resident 8's Patient Information, indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. A review of Resident 8's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 8's Patient Care Summary, dated January 31, 2025, included a physician's orders for tracheostomy care and treatment and nutritional formula feeding via GT, as well as care and maintenance orders for the feeding tube. Further review of Resident 8's record did not include a physician's order and care plan for Resident 8 to be placed on EBP. f. A review of Resident 9's Patient Information, indicated Resident 9 was admitted to the facility on [DATE], with diagnoses which included cardiopulmonary arrest (heart attack). A review of Resident 9's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 9's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment and nutritional formula feeding via GT, as well as care and maintenance orders for the feeding tube. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident 9's record did not include a physician's order and care plan for Resident 9 to be placed on EBP. g. A review of Resident 10's Patient Information, indicated Resident 10 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. A review of Resident 10's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 10's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment and nutritional formula feeding via GT, as well as care and maintenance orders for the feeding tube. Further review of Resident 10's record did not include a physician's order and care plan for Resident 10 to be placed on EBP. h. A review of Resident 11's Patient Information, indicated Resident 11 was admitted to the facility on [DATE], with diagnoses which included acute (begins and worsens quickly) respiratory failure and acute encephalopathy (group of conditions that cause brain dysfunction). A review of Resident 11's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 11's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care, urinary catheter care and treatment, and nutritional formula feeding via GT. Further review of Resident 11's record did not include a physician's order and care plan for Resident 11 to be placed on EBP. i. A review of Resident 12's Patient Information, indicated Resident 12 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure, cardiac arrest, and anoxic brain injury. A review of Resident 12's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 12's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment, nutritional formula feeding via GT, as well as care and maintenance orders for the feeding tube. Further review of Resident 12's record did not include a physician's order and care plan for Resident 12 to be placed on EBP. j. A review of Resident 14's Patient Information, indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included respiratory failure and chronic heart failure. A review of Resident 14's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 14's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment and maintenance orders for the feeding tube. Further review of Resident 14's record did not include a physician's order and care plan for Resident 14 to be placed on EBP. k. A review of Resident 15's Patient Information, indicated Resident 15 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure, and anoxic quadriplegia (paralysis of all four limbs). A review of Resident 15's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 15's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment, nutritional formula feeding via GT, care and maintenance orders for the feeding tube, and urinary catheter change. Further review of Resident 15's record did not include a physician's order and care plan for Resident 15 to be placed on EBP. l. A review of Resident 16's Patient Information, indicated Resident 16 was admitted to the facility on [DATE], with diagnoses which included kidney failure. A review of Resident 16's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 16's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment, nutritional formula feeding via GT, and care and maintenance orders for the feeding tube. Further review of Resident 16's record did not include a physician's order and care plan for Resident 16 to be placed on EBP. m. A review of Resident 16's Patient Information, indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure and acute encephalopathy. A review of Resident 17's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube/GT. A review of Resident 17's Patient Care Summary, included physician's orders for tracheostomy care and treatment, nutritional formula feeding via GT, and care and maintenance orders for the feeding tube. Further review of Resident 17's record did not include a physician's order and care plan for Resident 17 to be placed on EBP. n. A review of Resident 18's Patient Information, indicated Resident 18 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 18's History and Physical, dated May 29, 2024, indicated the physician's impression (clinical assessment) of anoxic brain injury, decubiti (pressure injury-bed sore), GT, and tracheostomy. A review of Resident 18's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 18's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment, nutritional formula feeding via feeding tube, and care and maintenance orders for the feeding tube. Further review of Resident 18's record did not include a physician's order and care plan for Resident 18 to be placed on EBP. o. A review of Resident 19's Patient Information, indicated Resident 19 was admitted to the facility on [DATE], with diagnoses which included respiratory failure. A review of Resident 19's Patient Medication Profile, dated January 31, 2025, indicated administration of medications via feeding tube. A review of Resident 19's Patient Care Summary, dated January 31, 2025, included physician's orders for tracheostomy care and treatment, and care and maintenance orders for the feeding tube. Further review of Resident 19's record did not include a physician's order and care plan for Resident 19 to be placed on EBP. p. A review of Resident 20's Patient Information, indicated Resident 20 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure, sepsis, and pneumonia (bacterial lung infection). A review of Resident 20's History and Physical, dated November 5, 2024, indicated diagnoses of tracheostomy and PEG. A review of Resident 20's Patient Care Summary, dated January 31, 2025, included physician's orders for secretion suctioning and tracheostomy care and treatment, PICC line dressing changes (peripherally inserted central catheter- a thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart), nutritional formula feeding via feeding tube, and care and maintenance orders for the feeding tube. Further review of Resident 20's record did not include a physician's order and care plan for Resident 20 to be placed on EBP. q. A review of Resident 21's Patient Information, indicated Resident 21 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure. A review of Resident 21's History and Physical, dated September 1, 2020, indicated secondary diagnoses of chronic tracheostomy and PEG status. (continued on next page)

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