STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555649	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Medical Center D/P Snf	725 S. Orange Avenue West Covina, CA 91790

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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** 42781 Based on observation, interview, and record review, the facility failed to ensure the resident's indwelling catheter (foley catheter - thin, sterile tube inserted into the bladder to drain urine into a bag outside the body) bag was covered and provided the resident privacy in accordance with the facility's policy on Urinary Catheter, Insertion and Care for one of one sampled resident (Resident 17). This deficient practice had the potential to result in psychosocial (mental and emotional well-being) decline and lowered self-esteem and self-worth for the resident. Findings: During a review of Resident 17's Face sheet (FS), the FS indicated the facility initially admitted Resident 17 on 12/10/2018 and readmitted on [DATE] with diagnoses that included bladder (stores urine) disorder and urinary tract infection (UTI- infection that affects any part of the urinary tract). During a review of Resident 17's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/17/2024, the MDS indicated Resident 17 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 17 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 17's Physicians Order (PO) dated 9/30/2024, the PO indicated for licensed staff to insert foley catheter French (a type of catheter) 16 (size of the catheter) for neurogenic bladder (impaired bladder function resulting from damage to the nerves that govern the urinary tract). During a review of Resident 17's Care Plan (CP) for foley catheter initiated on 9/30/2024, the CP indicated Resident 17 had a foley catheter for neurogenic bladder. The care plan interventions included for staff to ensure a dignity bag was in placed for Resident 17. During an observation on 10/15/2024 at 10:19 am, inside Resident 17's room, Resident 17 was awake, lying in bed with foley catheter bag hanging on the right side of the bed, uncovered and without a dignity bag (privacy bag). (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	During a concurrent observation and interview on 10/15/2024 at 10:32 am with the facility's Assistant Director of Nursing (ADON), the ADON stated, foley catheter bag needed to be covered with a privacy bag to provide dignity to the resident. During an interview on 10/15/2024 at 10:51 am, Resident 17 stated I want my foley catheter bag inside the privacy bag. During a review of the facility's Policy and Procedure (P&P) titled, Urinary Catheter, Insertion and Care, revised 1/13/2024, the P&P indicated to place the drainage bag inside the dignity bag.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for two of two sampled residents (Residents 2 and 123) by failing to ensure the residents' call lights were within reach and appropriate to the resident's physical ability. These deficient practices had the potential for Residents 2 and 123 not to receive necessary care or received delayed services to meet their needs. Findings: a. During a review of Resident 123's Face Sheet (FS), the FS indicated Resident 123 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that occurs when the lungs could not exchange enough oxygen and carbon dioxide in the body) and dependence on ventilator (a medical device to help support or replace breathing). During a review of Resident 123's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/22/2024, the MDS indicated Resident 123 had severely impaired cognition (ability to understand). The MDS indicated Resident 123 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral, toileting hygiene, and personal hygiene. During a review of Resident 123's untitled Care Plan (CP) dated 9/5/2024, the CP indicated Resident 123 needed assistance with activities of daily living (ADLs). The CP indicated an approach plan to ensure the call light was within reach of the resident at all times. During a concurrent observation and interview on 10/15/2024 at 11:04 am with Certified Nurse Assistant 1 (CNA 1) inside Resident 123's room, CNA 1 stated, Resident 123's call light was hanging on the wall. CNA 1 stated the resident's call light should be placed closed to the resident's strong arm or hand so the resident could call in case of emergency. b. During a review of Resident 2's FS, the FS indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure and dependence on ventilator. During a review of Resident 2's untitled CP dated 7/14/2024, the CP indicated Resident 2 needed assistance with ADLs. The CP indicated an approach plan to ensure the call light was within reach of the resident at all times. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had an intact cognition. The MDS indicated Resident 2 was dependent with eating, oral, toileting hygiene, shower, upper and body dressing, and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/15/2024 at 11:08 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 2's room, LVN 2 stated, Resident 2's call light was hanging on the wall. LVN 2 stated the resident's call light should be placed on the resident's strong arm or hand so the resident could call for help and staff could address their needs timely. During an interview on 10/17/2024 at 12:04 pm with Assistant Director of Nursing 1 (ADON 1), ADON 1 stated Residents 2 and 123 had a touch sensitive call light because of the residents' medical condition. ADON 1 stated, the resident's call light should be placed on the resident's strong extremity so the resident could call whenever they needed help and staff would attend to their needs timely and immediately. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, reviewed 1/18/2024, the P&P indicated, The patient's call light is always to be placed within his easy reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42781 Based on interview and record review the facility failed to provide information on Advance Directive (AD- a process of communication between individuals and their healthcare agents for future healthcare decisions when individuals are no longer able to make their own healthcare decisions) for three of three sampled residents (Residents 6,14, and 20) in accordance with the facility's policy on Advance Directives. These failures had the potential for facility staff to provide medical treatment against the residents' will. Findings: a. During a review of Resident 20's Face sheet (FS), the FS indicated the facility initially admitted Resident 20 on 8/23/2024 and readmitted on [DATE] with diagnoses that included chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood) and encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing). During a review of Resident 20's Minimum Data Set Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/27/2024, the MDS indicated, Resident 20 had severe cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 20 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review of Resident 20's medical records (chart) on 10/15/2024 at 11 am with the facility's Assistant Director of Nursing (ADON), the ADON stated she could not find the Advance Directive Acknowledgement Form in Resident 20's chart. The ADON stated, there was no clinical documentation that AD was discussed and identified if Resident 20 had previous AD completed prior to admission. The ADON stated, the form needed to be in the resident's chart for accessibility to determine Resident 20's wants and wishes. 40438 b. During a review of Resident 6's FS, the FS indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure and dependence on ventilator (a medical device to help support or replace breathing) During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had severely impaired cognition. The MDS indicated Resident 6 was dependent with eating, oral, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/15/2024 at 11:40 am with the Assistant Director of Nursing 2 (ADON 2), Resident 6's Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life) dated 11/29/2023 and Advance Directive Acknowledgment of Receipt were reviewed. Resident 6's POLST indicated, Resident 6 did not have an AD. ADON 2 stated there were no documented evidence that the resident and/or responsible party was provided with information on how to formulate an AD and discussed the resident's rights to make decisions regarding care in the facility. ADON 2 stated all residents should have an AD acknowledgement receipt upon admission, for the staff to determine how to provide care to the resident while in the facility. 40037 c. During a review of Resident 14's FS, the FS indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had no speech, rarely/never understood others and made self-understood. The MDS indicated Resident 14 was dependent with personal hygiene and shower/bathing self. During a review of Resident 14's medical record, there was no AD in the resident's medical record and there was no acknowledgement provided. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, reviewed on 1/18/2024, the P&P indicated, upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive. The P&P indicated all advance directive document copies will be obtained and located (identify the same section of the resident's medical record that would be readily retrievable by any facility staff.)

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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. 42781 Based on interview and record review, the facility failed to notify the State Long Term Care Ombudsman (public advocate) of the Notice of Proposed Transfer and Discharge for one of three sampled resident's (Resident 22) transfer to the General Acute Hospital (GACH) on 8/8/2024 in accordance with facility's policy on Transfer and Discharge (Including Against Medical Advice [AMA].) This deficient practice had the potential to violate Resident 22's right to ensure for an appropriate discharge/transfer from the facility. Findings: During a review of Resident 22's Facesheet (FS), the FS indicated the facility admitted Resident 22 on 4/8/2024 with diagnoses that included encounter for attention to tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs) and pneumonia (an infection/inflammation in the lungs). During a review of Resident 22's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/18/2024, the MDS indicated Resident 22 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 22 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 22's Physicians Order (PO) dated 8/8/2024, the PO indicated to discharge Resident 22 via 9-1-1 (emergency services) for fluctuating oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage). During a concurrent interview and record review of Resident 22's Medical Records (chart) on 10/17/2024 at 10:58 am with the facility's Medical Records staff (MR), MR stated there was no Notice of Proposed Transfer/Discharge Form completed. The MR stated, there was no clinical documentation that the Notice of Proposed Transfer/Discharge Form was completed, and the State Long Term Care Ombudsman was notified of Resident 22's transfer to GACH on 8/8/2024. During a concurrent interview and record review of Resident 22's chart on 10/17/2024 at 1:22 pm with the facility's Assistant Director of Nursing (ADON), the ADON stated Resident 22 was transferred to GACH via emergency care for fluctuating oxygen saturation on 8/8/2024. The ADON stated the family member and State Long Term Care Ombudsman needed to be notified upon resident's transfer to GACH. The ADON stated the purpose of the notice was to determine where the resident will be transferred. During a review of the facility's Policy and Procedure (P&P) titled Transfer and Discharge Including AMA, dated 7/24/2024, the P&P indicated for emergency transfers/discharges, provide transfer notice as soon as practicable to resident and representative. The P&P indicated, Social Services Director or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly visit.

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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** 40037 Based on observation, interview, and record review, the facility failed to provide care and services to promote healing of pressure ulcer/injury (PU/PI, localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for one of one sampled resident (Resident 14), as ordered by the physician. This failure had the potential to result in worsening or re occurrence of pressure injury. Findings: During a review of Resident 14's Face Sheet (FS), the FS indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/27/2024, the MDS indicated Resident 14 had no speech, rarely/never understood others, and made self-understood. Resident 14 was dependent (helper does all of the effort) with personal hygiene and showering/bathing self. During a review of Resident 14's Physician Order (PO) dated 10/13/2024, the PO indicated an order for Resident 14's right middle back Stage 2 PU (partial-thickness loss of skin, presenting as a shallow open sore or wound) for licensed staff to clean the PU with normal saline, pat dry, paint with betadine (a topical antiseptic that reduces the risk of infection) and cover with Tegaderm (a transparent medical dressing) every three days for 21 days. During a PU dressing change observation on 10/17/2024 at 10:21 am, in Resident 14's room, Licensed Vocational Nurse 3 (LVN 3) changed the dressing at Resident 14's back. LVN 3 removed an old foam dressing (dated 10/17/2024) from Resident 14's right middle back stage 2 PU. LVN 3 cleaned the PU with normal saline, painted with betadine and covered with Tegaderm. During an interview on 10/17/2024 at 11:14 am, LVN 3 stated, the old dressing that LVN 3 removed from Resident 14's right middle back Stage 2 PU was a foam dressing. LVN 3 stated, the physician's order was to cover the PU with Tegaderm after treatment. LVN 3 stated, the licensed staff who previously did the dressing change/treatment to Resident 14 did not follow physician's order not to cover the PU with foam dressing. LVN 3 stated, licensed staff should follow the physician's order to cover Resident 14's PU with Tegaderm for better wound healing and to prevent worsening and infection of the PU. During an interview on 10/17/2024 at 11:45 am, Assistant Director of Nursing 2 (ADON 2) stated, licensed nursing staff should follow the physician's order to determine the effectiveness of the treatment, for better wound healing and to improve the resident's quality of life. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Wound Care, effective 7/24/2024, the P&P indicated guidelines for the care of wounds to promote healing, including to verify that there was a physician's order for the procedure. The P&P indicated to use dressing material as indicated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure Restorative Nurse Assistant (RNA, a specialized role for certified nursing assistants that involves training in rehabilitation skills) services was provided to one of one sampled resident (Resident 123) as ordered by the physician. This deficient practice had the potential for a decline in range of motion (ROM, measure of joint flexibility and functionality), stiffness and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) for Resident 123. Findings: a. During a review of Resident 123's Face Sheet (FS), the FS indicated, Resident 123 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that occurs when the lungs could not exchange enough oxygen and carbon dioxide in the body), and dependence on ventilator (a medical device to help support or replace breathing). During a review of Resident 123's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/22/2024, the MDS indicated Resident 123 had severely impaired cognition (ability to understand) and was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral/ toileting hygiene, and personal hygiene. During a review of Resident 123's Care Plan (CP) titled Care Plan for RNA Program dated 9/5/2024, the CP indicated Resident 123 needed RNA maintenance program for range of motion and splint (a medical device that immobilizes the elbow joint to promote healing after an injury or surgery) to help with mobility. The CP indicated Resident 123 had the potential for further decline in range of motion/joint mobility and the plan was for RNA to do passive range of motion (PROM, the movement of a joint when an outside force such as a therapist or machine, moves the joint while the person receiving the exercise is relaxed) exercises on bilateral (both) upper and lower extremities daily, five times a week, as ordered. During a review of Resident 123's Physician Orders (PO) dated 9/8/2024, the PO indicated Resident 123 had an order for left hand roll or carrot (a device used to position severely contracted hands), right hand roll or carrot, and left elbow; RNA to apply 4-6 hours as tolerated, five times a week and PROM to bilateral upper and lower extremities as tolerated daily, five times a week. During a review of Resident 123's Restorative Record (RR) dated 10/15/2024, the RR indicated Resident 123 received RNA services. The RR indicated left/right hand roll or carrot and left elbow splint were applied and the resident received PROM exercises on both upper and lower extremities. During a concurrent observation and interview on 10/15/2024 at 10:58 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 123's room, LVN 1 stated Resident 123 did not have left and right hand roll or carrot and did not have left elbow splint applied. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/16/2024 at 12:56 pm with Restorative Nurse Assistant (RNA), the RR dated 10/15/2024 was reviewed. RNA stated, RNA did not apply the left- and right-hand roll and left elbow splint to Resident 123 on 10/15/2024. RNA stated RNA only performed PROM exercises on both upper and lower extremities of Resident 123. RNA stated RNA signed the RR indicating the left/right hand roll and left elbow splint were applied. RNA stated RNA should sign the RR only for the services rendered. During an interview on 10/17/2024 at 11:54 am with the Assistant Director of Nursing 1 (ADON 1) , ADON 1 stated RNA services should be implemented as ordered to prevent further contractures and decrease in range of motion to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Restorative Care, reviewed 1/13/2024, the P&P indicated, The restorative nurse assistant will initial the days the resident is treated on the grid portion of their respective treatment progress forms. If, for any reason the treatment is not given, the reason why, must be documented in the narrative portion. Daily notation that all aspects of treatment were accomplished. This is either done by your initial or signature in a special place.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) site as ordered by the physician and as indicated in the plan of care for two of three sampled residents (Residents 2 and 123). These failures had the potential for complications related to tube feedings for Residents 2 and 123. Findings: a. During a review of Resident 123's Face Sheet (FS), the FS indicated Resident 123 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that occurs when the lungs could not exchange enough oxygen and carbon dioxide in the body), dependence on ventilator (a medical device to help support or replace breathing) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) malfunction. During a review of Resident 123's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/22/2024, the MDS indicated Resident 123 had severely impaired cognition (ability to understand) and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral/toileting hygiene, and personal hygiene. The MDS indicated Resident 123 required feeding tube for nutrition. During a review of Resident 123's Physician's Orders (PO), dated 9/5/2024, the PO indicated Resident 123 had an order for gastrostomy care with half strength hydrogen peroxide (H2O2) and normal saline (NS, a saltwater solution), pat dry and apply drain sponge every shift. During a review of Resident 123's Care Plan (CP) titled Resident Care Plan for Impaired Skin Integrity dated 9/7/2024, the CP indicated Resident 123 had an impaired skin integrity to the gastrostomy site. The CP indicated to provide good skin care, to keep the affected area clean and dry and to do treatment as ordered. During a review of Resident 123's Treatment Administration Record (TAR), the TAR indicated gastrostomy care was done on 10/14/2024 and 10/15/2024. During a concurrent observation and interview on 10/15/2024 at 10:58 am with licensed vocational nurse (LVN) 1 inside Resident 123's room, Resident 123 had a GT site with dislodged drain sponge dressing. LVN 1 stated the gastrostomy dressing was not clean and the GT site was red and dirty around the stoma. LVN 1 stated Resident 123's GT site should be kept clean and covered with drain sponge dressing to prevent skin irritation and infection. (continued on next page)

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	555649	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Medical Center D/P Snf	725 S. Orange Avenue West Covina, CA 91790

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 2's FS, the FS indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, dependence on ventilator, and gastrostomy. During a review of Resident 2's PO dated 7/14/2024, the PO indicated Resident 2 had an order for gastrostomy care with half strength H2O2 and NS, pat dry and apply drain sponge every shift. During a review of Resident 2's untitled CP dated 7/14/2024, the CP indicated Resident 2 had an enteral tube for feeding/hydration and/or medication. The CP indicated to keep the affected area clean and dry at all times, perform enteral tube care every shift and as needed when soiled, moist, or falls off and apply a drain sponge around the tube, secure with tape, date and initial dressing. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognition and dependent with eating, oral/ toileting hygiene, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 2 required feeding tube for nutrition. During a review of Resident 2's TAR, dated 10/15/2024, the TAR indicated gastrostomy care was done on 10/14/2024 and 10/15/2024. During a concurrent observation and interview on 10/15/2024 at 11:02 am with LVN 1 inside Resident 2's room, Resident 2 had a GT site with no drain sponge dressing in place and the GT site was not clean. LVN 1 stated Resident 2's GT site should be kept clean and covered with drain sponge dressing to prevent skin irritation and infection. During an interview on 10/17/2024 at 11:59 am with the Assistant Director of Nursing (ADON), the ADON stated GT site should be kept clean as ordered and covered with drain sponge dressing to absorb moist and leaking around the stoma and to prevent skin irritation and infection of the resident. During a review of the facility's Policy and Procedure (P&P) titled, Gastrostomy and PEG Tube Care Of and Changing, dated 1/12/2024, the P&P indicated Apply a 4 x 4 split gauze pad around the tube, and secure with paper tape. Change gauze, render skin care at bedtime or more often when soiled or moist (or per physician order).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 14) received care and service for parenteral antibiotic (a drug used to treat infections caused by bacteria and other microorganisms) consistent with professional standards of practice to label and date a peripherally inserted intravenous (IV) catheter. This failure had the potential to result in infection to the resident and worsen the resident's overall health condition. Findings: During a review of Resident 14's Face Sheet (FS), the FS indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/27/2024, the MDS indicated Resident 14 had no speech, rarely/never understood others, and made self-understood. Resident 14 was dependent (helper does all of the effort) for personal hygiene and showering/bathing self. During a review of Resident 14's Physician Order (PO), dated 10/11/2024, the PO indicated an order for IV saline lock (a small cap or short section of tubing placed at the end of the IV to keep the saline inside). During an observation on 10/15/2024 at 10:25 am, in Resident 14's room, Resident 14 was lying in bed with eyes closed. Resident 14 had an IV site on the left hand, not labeled with insertion date. During a concurrent interview with Assistant Director of Nursing 2 (ADON 2), ADON 2 stated, the IV site should be labeled with date of insertion, so that licensed nurses would know when to change the IV dressing or rotate the IV insertion site for infection control and IV patency. ADON 2 stated, infection in the IV site could worsen the resident's health condition. During a review of the facility's Policy and Procedure (P&P) titled Intravenous Infusion, reviewed 1/13/2022, the P&P indicated Sterile dressing shall be applied over the I.V. site. IV site to be initialed, dated, and timed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to: a. Ensure the oxygen cannula (tubing used to deliver oxygen) was connected to the tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person breathe) with a T-Bar (a T shaped device) for one of one sampled resident (Resident 4). b. Follow the physician's order for tracheostomy care for one of one sampled resident (Resident 16) These deficient practices placed Residents 4 and 16 at risk for complications of shortness of breath and infection. Findings: a. During a review of Resident 4's Face Sheet (FS), the FS indicated the facility admitted Resident 4 on 3/26/2024 with diagnoses that included encounter for attention to tracheostomy and pneumonia (an infection/inflammation in the lungs). During a review of Resident 4's Physician Order (PO) dated 3/26/2024, the PO indicated an order for licensed staff to apply continuous oxygen at two (2) liters per minute (L/min) via T-bar with humidifier. During a review of Resident 4's Care Plan (CP) for Gas Exchange initiated on 3/26/2024, the CP indicated Resident 4 was at risk for impaired gas exchange related to respiratory failure (a condition when the lungs cannot get enough oxygen into the blood). The care plan interventions included for staff to administer oxygen as ordered. During a review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/13/2024, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 4 was dependent (helper does all of the effort) with eating, oral hygiene and toileting hygiene. During an observation on 10/15/2024 at 12:18 pm, with Registered Nurse Supervisor 1 (RN 1), Resident 4 was awake, lying in bed. Resident 4's oxygen tubing was observed not connected to the tracheostomy T-bar. The RN 1 stated Resident 4's oxygen tubing needed to be connected to the T-bar for Resident 4 to receive the desired oxygen needed as ordered. During an interview on 10/18/2024 at 8:59 am with the facility's Assistant Director of Nursing (ADON), the ADON stated oxygen tubing needed to be connected to the T-bar to ensure the desired oxygen needed by Resident 4 was administered as ordered. During a record review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, reviewed on 1/13/2024, the P&P indicated, oxygen therapy is administered as ordered by the physician. The P&P indicated to connect cannula or Tracheostomy piece to humidifier outlet via its connecting tube or corrugated tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40037 b. During a review of Resident 16's FS, the FS indicated Resident 16 was readmitted to the facility on [DATE], with diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 16's Physician Order (PO) dated 9/8/2024, the PO indicated an order for tracheostomy care with 10 percent (%) strength hydrogen peroxide (H2O2- a chemical compound, a colorless liquid often used as a bleaching agent, antiseptic, and oxidizer) plus normal saline pat dry and apply drain sponge every shift, by Respiratory Therapist (RT- a healthcare professional who treats patients with breathing problems or lung disorders), During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16 had unclear speech, rarely/never understood others and made self-understood. Resident 16 was dependent (helper does all of the effort) for personal hygiene and showering/bathing self. During an observation on 10/15/2024 at 10:20 am, in Resident 16's room, Resident 16 was lying in bed. Resident 16 had tracheostomy and the resident's breathing was supported by a ventilator (a machine that helps a person breathe or breathe for a person). During an interview on 10/16/2024 at 12:51 pm, Respiratory Therapist 1 (RT 1) stated, RT 1 used only NS to provide tracheostomy care for Resident 16. RT 1 stated, RT 1 did not use H2O2 plus NS to clean Resident 16's tracheostomy. RT 1 stated, RT 1 was not aware that the physician ordered H2O2 and NS for Resident 16's tracheostomy care. RT 1 stated, RT 1 should check and follow Resident 16's physician's order to use H2O2 to clean Resident 16's tracheostomy. RT 1 stated, H2O2 prevent tracheostomy infection from bacteria accumulating around the surgical opening. RT 1 stated, if the resident's tracheostomy site got infected, the resident could get sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury) and result in hospitalization . During an interview on 10/16/2024 at 1:18 pm, Respiratory Therapy Supervisor (RTS) stated, RT 1 should check the physician's order first before providing tracheostomy care to Resident 16. RTS stated, H2O2 was used for cleaning to prevent infection. RTS stated, if the resident's tracheostomy was not cleaned properly, the resident could get infected. During a review of the facility's Policy and Procedure (P&P) titled Tracheostomy Stoma (surgical opening) Care, reviewed 1/13/2024, the P&P indicated Clean stoma with hydrogen peroxide and normal saline by wiping gauze from center of stoma outwards and then discard.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to act upon the consultant pharmacist's Medication Regimen Review (MRR) recommendation for one of five sampled residents (Resident 8). This failure had the potential to result in undesirable or non-therapeutic effect of the medication to the resident. Findings: During a review of Resident 8's Face Sheet (FS), the FS indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/26/2024, the MDS indicated Resident 8 had unclear speech, sometimes understood others, and made self-understood. Resident 8 was dependent (helper does all of the effort) for personal hygiene and showering/bathing self. During a review of Resident 8's Physician Order (PO) for the month of October 2024, the PO indicated Resident 8 was prescribed with Enoxaparin (used to prevent blood clots in blood vessel), 100 milligram (mg-unit of measurement), SQ (subcutaneous, an injection given into the fatty tissue beneath the skin), for Deep Vein Thrombosis (DVT- blood clot forms in a vein, deep within the body) prevention. During a review of the facility's MRR recommendations dated 9/23/2024, the MRR indicated for Resident 8 to consider asking Resident 8's physician for a term of therapy for the use of Lovenox (Enoxaparin). During a review of Resident 8's medical record, there was no documentation indicating Resident 8's MRR for Enoxaparin term of therapy use was carried out. During an interview on 10/16/2024 at 10:46 am, Assistant Director of Nursing 1 (ADON 1) stated, ADON 1 did not act upon the pharmacist's recommendation for Enoxaparin use for Resident 8. ADON 1 stated, the facility would respond to the pharmacist's recommendations within 72 hours. ADON 1 stated, ADON 1 missed the MRR and forgot to contact Resident 8's physician for a term of therapy of Enoxaparin use. ADON 1 stated, Enoxaparin was used for DVT prevention, and the side effect was bleeding. ADON 1 stated, setting up a duration of use of Enoxaparin prevents unnecessary medication given to resident. During a review of the facility's Policy and Procedure (P&P) titled Consultant Pharmacist Reports, subtitled Medication Regimen Review (monthly report), effective 6/2021, the P&P indicated Recommendations are acted upon and documented by the facility staff and or the prescriber.

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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. 42781 Based on observation, interview, and record review, the facility failed to follow it's policy and procedure on storing, preparing, distributing and serving food in accordance with professional standards for food service safety, proper sanitation and food handling practices by failing to ensure: 1. Thawed meat was stored on the top shelf in one of one refrigerator. 2. Stored food items were labeled and dated when it was first opened, in one of three kitchen freezers. These deficient practices had the potential risk for food borne illnesses (infections caused by ingesting contaminated food or beverages). Findings: 1. During an initial tour of the kitchen on 10/15/2024 at 9:34 am, together with Dietary Aid 1 (DA 1), one bag of uncooked meat and one bag of uncooked sausage being thawed were placed on the top shelf of the refrigerator. There were16 pieces of uncovered sliced bread placed on a tray on the second shelf immediately below the uncooked meat and sausage being thawed. The DA 1 stated, thawed meat should not be placed or thawed on top of the bread because blood from the thawed meat and sausage might drip on the bread. 2. During an initial tour of the kitchen on 10/15/2024 at 9:36 am, together with DA 1, one two-pound (lbs.-unit of measurement) bag of whole corn kernel, 20 lbs. of penne pasta and one gallon of liquid marinade did not have a label or date of when it was first opened. DA 1 stated all open food items should be labeled and dated once used and re stored. During an interview on 10/16/2024 at 9:49 am with Dietary Supervisor (DS), the DS stated, bread should not be stored below a raw meat for it could cross contaminate (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). The DS stated, all food items needed to have a label with date open to keep track of how long the food item was opened. During an interview on 10/16/2024 at 12:19 pm with the Kitchen District Manager (KDM), the KDM stated uncooked meat could not be mixed with ready to eat food. The KDM stated, bread should not be thawed together with uncooked meat in the refrigerator due to the risk of cross contamination. During a review of the facility's Policy and Procedure (P&P) titled, Food Preparation, dated 1/2021, the P&P indicated thawing in the refrigerator, in a drip-proof container, an in a manner that prevents cross-contamination. During a review of the facility's P&P titled, Food Storage: Cold Foods, dated 1/2021, the P&P indicated all foods will be stored wrapped or on covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Food Storage: Dry Goods, dated on 1/2021, the P&P indicated storage areas will be neat, arranged for easy identification and date marked as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure the facility staff used Personal Protection Equipment (PPE- protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) in accordance with the facility's Policy and Procedure (P&P) on infection prevention and control for one of five sampled residents (Resident 14). This deficient practice had the potential to spread infection and transmission of communicable diseases. Findings: During a review of Resident 14's Face Sheet (FS), the FS indicated Resident 14 was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 14's Physician Orders (PO) dated 8/13/2024, the PO indicated Resident 14 was on contact isolation (a medical procedure that prevents the spread of infectious diseases caused by microorganisms that can be transmitted through direct or indirect contact with a patient or their environment) for C. Auris (Candida auris, an emerging fungus that can cause severe multidrug-resistant infections). During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/27/2024, the MDS indicated Resident 14 had no speech, rarely/never understood others and made self-understood. Resident 14 was dependent (helper does all of the effort) for personal hygiene and showering/bathing self. During an observation on 10/15/2024 at 10:25 am, in Resident 14's room, Resident 14 was lying in bed. There was a sign posted outside Resident 14's door indicating Resident 14 was on contact isolation. Resident 14 had an IV (intravenous) site at Resident 14's left hand. Outside Resident 14's room, Assistant Director of Nursing 2 (ADON 2) wore mask, gown, and gloves. ADON 2 did not put ADON 2's arms inside the sleeves of the isolation gown when ADON 2 entered Resident 14's room and made direct contact with Resident 14 by checking Resident 14's IV site. ADON 2's coat touched Resident 14's clothes. During a concurrent interview, ADON 2 stated Resident 14 was on contact isolation for C. auris which was a transmittable (communicable) disease. ADON 2 stated, when entering a resident's room with contact isolation and staff planned to make direct contact with the resident, staff should wear PPE properly. ADON 2 stated staff should put arms inside the isolation gown sleeves to avoid direct contact with the resident to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 11:55 am, with the Infection Preventionist Nurse (IPN-a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated, anyone who entered a resident's room with contact isolation should wear proper PPE including mask, gown, and gloves. The IPN stated, staffs should ensure to put arms inside the gown sleeves when making a direct contact with the resident to prevent bacteria being transmitted from one resident to another. During a review of the facility's P&P titled Infection Prevention and Control, revised 7/2022, the P&P indicated gowns are to be worn by visitors and personnel to prevent direct contamination from the patients secretions, excretions or other body fluids. It is the responsibility of nursing personnel to educated and enforce proper gowning practice when relating to physicians, visitors and other hospital personnel involved in patient care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to keep an electric fan (a powered machine used to create a flow of air to cool and ventilate rooms and control humidity) in a safe, operating, and sanitary condition for one of one sampled resident (Resident 123). This failure had the potential to affect Resident's 123 quality of life and overall health. Findings: During a review of Resident 123's Face Sheet (FS), the FS indicated Resident 123 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic respiratory failure (a long-term condition that occurs when the lungs could not exchange enough oxygen and carbon dioxide in the body) and dependence on ventilator (a medical device to help support or replace breathing). During a review of Resident 123's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/22/2024, the MDS indicated Resident 123 had severely impaired cognition (ability to understand). The MDS indicated Resident 123 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral/toileting hygiene, and personal hygiene. During a concurrent observation and interview on 10/15/2024 at 10:58 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 123's room, Resident 123 had a black electric fan at bedside. LVN 1 stated, the black electric fan was wiggly (unstable) when moved, and the vents were dusty and with lint. LVN 1 stated, the electric fan was broken. LVN 1 stated electric fans inside the resident's room should be kept clean to prevent infection and cause respiratory distress on ventilator dependent residents. During an interview on 10/17/2024 at 12:04 pm with the Assistant Director of Nursing (ADON), the ADON stated, housekeeping staff needed to clean any equipment inside the resident's room every day to prevent infection. The ADON stated maintenance staff needed to fix any broken equipment for the safety of the residents. During a review of the facility's Policy and Procedure (P&P) titled, Physical Environment and Space Equipment, dated 10/15/2024, the P&P indicated, The facility will ensure the provision of sufficient space and equipment in dining, health services, recreational, and program areas that enables staff in providing residents with needed services. The facility will maintain all mechanical, electrical, and patient care equipment in a safe operational condition.