STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555688	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Point	3415 W Ball Road Anaheim, CA 92804

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and the facility P&P review, the facility failed to ensure four nonsampled residents (Residents 38, 103, 110, and 144) were safe to self-administer the medications. * The facility failed to ensure a bottle of Refresh eyedrops (used to relieve dry and irritated eyes) was not in Resident 110's nightstand. Resident 110 stated she administered the eyedrops by herself; however, Resident 110 was not assessed for the safe self-administration of the medication. * The facility failed to ensure a container of Biofreeze pain relief cream (a topical rubefacient used to ease muscle and joint aches and pain) was not in Resident 103's nightstand drawer. Resident 103 stated he administered the cream by himself; however, Resident 103 was not assessed for the safe self-administration of the medication. * The facility failed to ensure a bottle of Bactine pain-relieving cleansing spray (a maximum strength antiseptic with 4% lidocaine used to help prevent bacterial contamination and for temporary relief of pain) was not in Resident 144's nightstand drawer. Resident 144 stated she administered the cleansing spray by herself; however, Resident 144 was not assessed for the safe self-administration of the medication. * The facility failed to determine if it was safe for Resident 38 to self-administer the pain relieving creams stored at Resident 38's nightstand. These failures had the potential for Residents 38, 103, 110, and 144 to administer the medications inaccurately and develop adverse reactions from the medications, and to negatively affect the residents' well-being. Findings: Review of the facility's P&P titled Medication - Self-Administration dated 1/1/12, showed the following: - The facility will allow a resident to self-administer medications when determined capable to do so by the IDT and the resident's attending physician; (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Upon admission to the facility, the resident will be informed of his/ her right to self-administer the medications; - If a resident wants to self-administer the medications, the IDT will assess the resident's cognitive, physical, and visual ability to carryout this responsibility based on a review of an assessment by a licensed nurse. The licensed nurse uses the Assessment for Self-Administration of Medications form for the assessment and submit the results to the IDT; - For a final determination of the resident's ability to self-administer medications, the assessment for self-administration of medications will be presented to the resident's attending physician. The resident may not begin self-administration of medications prior to the approval of the IDT and attending physician. The attending physician must provide a written order permitting the resident to self-administer the medication; - If the IDT and attending physician approved the self-administration of the medications, the medications will be placed in a secured drawer or cabinet that is easily accessible to the resident; and - The physician's order approving self-administration of medication will be maintained in the resident's medical record. The Assessment of Self-Administration of Medication form will be maintained in the resident's chart. Self-administration of the medications will be documented in the resident's care plan and the MAR. 1. On 3/3/25 at 0848 hours, during the initial tour of the facility, Resident 110 was observed lying in bed. A bottle of Refresh eye drops was observed on the resident's nightstand. Resident 110 stated she administered the eyedrops by herself. On 3/3/25 at 1107 hours, a follow-up observation for Resident 110 and concurrent interview was conducted with RN 1. RN 1 verified the bottle of Refresh eye drops was on the resident's nightstand. Medical record review for Resident 110 was initiated on 3/3/25. Resident 110 was admitted to the facility on [DATE]. Review of Resident 110's MDS dated [DATE], showed Resident 110 had a moderate cognitive impairment and no impairment to the upper extremities. Review of Resident 110's Order Summary Report failed to show a physician's order for the resident to self-administer the Refresh eyedrops medication. In addition, there was no physician's order for the Refresh eyedrops. Review of Resident 110's Plan of Care did not show a care plan problem to address Resident 110's ability to self-administer the medication. Further review of Resident 110's medical record failed to show the resident was assessed for the self-administration of the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 3/3/25 at 0822 hours, during the initial tour of the facility, Resident 103 was observed lying in bed. A container of Biofreeze pain relief cream was observed inside an opened drawer of the resident's nightstand. Resident 103 stated he applied the pain relief cream to his back for a chronic back pain. On 3/3/25 at 1105 hours, a follow-up observation for Resident 103 and concurrent interview was conducted with RN 1. RN 1 verified the container of Biofreeze pain relief cream was inside Resident 103's nightstand drawer. Medical record review for Resident 103 was initiated on 3/3/25. Resident 103 was admitted to the facility on [DATE]. Review of Resident 103's MDS dated [DATE], showed Resident 103 was cognitively intact and had no impairment to the upper extremities. Review of Resident 103's Order Summary Report failed to show a physician's order for the resident to self-administer the Biofreeze medication. In addition, there was no physician's order for the Biofreeze pain relief cream. Review of Resident 103's Plan of Care did not show a care plan problem to address Resident 103's ability to self-administer the medication. Further review of Resident 103's medical record failed to show the resident was assessed for the self-administration of the medication. 3. On 3/3/25 at 0816 hours, during the initial tour of the facility, Resident 144 was observed lying in bed. A bottle of Bactine Max pain-relieving cleaning spray was observed on Resident 144's nightstand. Resident 144 stated she applied the pain-relieving cleaning spray by herself. On 3/3/25 at 1110 hours, a follow-up observation for Resident 144 and concurrent interview was conducted with RN 1. RN 1 verified Resident 144 had a bottle of Bactine Max pain-relieving cleaning spray on the nightstand. Medical record review for Resident 144 was initiated on 3/3/25. Resident 144 was admitted to the facility on [DATE]. Review of Resident 144's Order Summary Report failed to show a physician's order for the resident to self-administer the Bactine Max medication. In addition, there was no physician's order for Bactine Max pain relieving cleaning spray. Review of Resident 144's Plan of Care did not show a care plan problem to address Resident 144's ability to self-administer the medication. Further review of Resident 144's medical record failed to show the resident was assessed for the self-administration of the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1107 hours, a follow-up interview and concurrent medical record review for Residents 103, 110, and 144 was conducted with RN 1. When asked about the facility's process regarding the self-administration of the medications and leaving the medications at the bedside, RN 1 stated if the facility had a resident who desired to self-administer the medications, the IDT would do an assessment for the self-administration of the medication. RN 1 further stated if the resident was able to self-administer the medications safely, the nurses would obtain a physician's order for the resident to self-administer the medications and develop a care plan to address the resident's self-administration of the medications. RN 1 verified Residents 103, 110, and 144 had no assessment, physician's order, and care plan to address the self-administration of the medications. 50787 4. On 3/3/25 at 1020 hours, during the initial tour of the facility, the containers of Living Well Nutraceuticals Rub On Relief fast acting all-natural topical cream (pain reliever), and Real Time Pain Relief [NAME] reliever cream (pain reliever) were observed at Resident 38's nightstand. Resident 38 stated, I have pain on my knees, I used the cream. On 3/3/25 at 1032 hours, a concurrent observation and interview was conducted with LVN 4. LVN 4 acknowledged and verified the presence of two containers of the pain relieving creams at Resident 38's nightstand. LVN 4 told Resident 38 that he would speak to the nursing supervisor to check on her and discuss with the physician. LVN 4 further stated he would remove the creams for now because the resident could not keep the creams at the bedside. Medical record review for Resident 38 was initiated on 3/4/25. Resident 38 was admitted to the facility on [DATE]. On 3/4/25 at 1244 hours, an interview was conducted with RN 1. RN 1 acknowledged and verified the findings of the two containers of the pain relieving creams at Resident 38's night stand. RN 1 stated, I was notified by LVN 4 and saw the creams. Further review of Resident 38's medical record did not show the assessment, physician's order, care plan, and documentation in the MAR for Resident 38's self-administration of the pain relieving medications. On 3/6/35 at 1415 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, and facility document review, the facility failed to ensure one of 29 final sampled residents (Resident 20) needs and preferences were accommodated. * The facility failed to provide the properly fitted diaper to Resident 20. This failure posed the risk to negatively affect the resident's physical and emotional well-being. Findings: On 3/3/25 at 930 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 20. Resident 20 stated the diaper she wore was too small, and the facility's vendor did not carry the Prevail diapers any longer. Resident 20 stated, the diaper does not fit me and my bed was soaked three times a day. Resident 20 showed her diaper and was observed to have the current diaper's waist band below her mid abdominal area and just above the pubic area. Resident 20 further stated, I'm just upset because of my diaper, I have asked them for two weeks, and I feel like I'm wearing a thong. Medical record review for Resident 20 was initiated on 3/4/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's MDS dated [DATE], showed Resident 20 had a BIMS score of 14 (cognitively intact), and always incontinent with the bladder and bowel elimination. The MDS further showed Resident 20 was 68 inches in height and weighed 405 lbs. On 3/4/25 at 1130 hours, an observation and current interview was conducted with CNA 3 in Resident 20's room. CNA 3 stated he had been taking care of Resident 20 for more than a year. CNA 3 further stated Resident 20 had been wearing the size of 6x diaper and recently had been provided with the size of 4x or 5x diapers. Resident 20 showed her diaper, and CNA 3 verified Resident 20's diaper was small and did not cover the whole area. On 3/4/25 at 1350 hours, an interview was conducted with the Central Supply In-charge. The Central Supply In-charge stated the facility's diaper supplier did not carry the Prevail diaper brand a couple of weeks ago and was replaced with a comparable diaper size. On 3/6/25 at 1415 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. The DON further stated the Prevail diapers were not available from the facility's vendor, and the facility would purchase the Prevail diapers to accommodate Resident 20's preference.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for one of three closed record sampled residents (Resident 142) reviewed. This failure had the potential for the resident to not receive appropriate treatment and/or services. Findings: Medical record review for Resident 142 was initiated on 3/6/25. Resident 142 was admitted to the facility on [DATE]. Review of Resident 142's H&P examination dated 12/3/24, showed Resident 142 had the capacity to understand and make decisions. Review of Resident 142's Order Summary Report showed a physician's order dated 12/30/24, to discharge to home with hospice services, may discharge home on 1/3/25, as per the resident and POA's request. Review of Resident 142's Discharge MDS dated [DATE], under section A of the MDS for the discharge status, showed Resident 142 was coded for the Short-Term General Hospital instead of hospice (to home/non-institutional). On 3/6/25 at 1029 hours, an interview and concurrent medical record review for Resident 142 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated the MDS Assistant coded the Discharge MDS status incorrectly. On 3/6/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37726 Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was implemented for one of 29 final sampled residents (Resident 82). * The facility failed to implement the bilateral floor mats in accordance with Resident 82's fall risk care plan. This failure placed the resident at risk of not receiving the appropriate, consistent, and individualized care. Findings: Medical record review for Resident 82 was initiated on 3/3/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's Care Plan titled At Risk for Falls/Injuries initiated on 5/17/23, showed Resident 82 was at risk for falls related to dementia, impaired cognition, and poor safety awareness. The care plan further showed Resident 82 had a long history of ongoing falls. The interventions included to provide the bilateral floor mats. On 3/3/25 at 0900 hours, an observation was conducted of Resident 82. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. On 3/3/25 at 0937 hours, an observation was conducted of Resident 82. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. On 3/3/25 at 1640 hours, an observation and concurrent interview was conducted with LVN 8. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. LVN 8 verified the findings and stated he would implement the second floor mat in accordance with Resident 82's At Risk for Falls care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of two sampled residents (final sampled resident, Resident 66) reviewed for IV antibiotic use and one of eight sampled residents (final sampled resident, Resident 394) reviewed for advance directives to attain and maintain their highest practicable well-being. * The facility failed to continuously monitor Resident 66 for the adverse reactions related to the IV antibiotics use and ESBL in the urine. * The facility failed to clearly identify the current code status for Resident 394. These failures had the potential for residents to not receive the necessary care and services in accordance with the resident's needs and treatment wishes. Findings: 1. Review of the facility's P&P titled Change of Condition Notification revised [DATE] showed a licensed nurse will notify the resident's attending physician and legal representative or an appropriate family member when there is any untoward response or reaction by the resident to a medication or treatment, and any significant change in the resident's physical, mental or psychosocial status. The licensed nurse will document each shift for at least 72 hours and the date, time and pertinent details of the incident and the subsequent assessment in the nursing notes. Medical record review for Resident 66 was initiated on [DATE]. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's H&P examination dated [DATE], showed Resident 66 had the capacity to understand and make decisions. Review of Resident 66's eInteract SBAR Summary for Providers dated [DATE], showed Resident 66's urine test results came back positive for ESBL. The primary physician was notified and ordered for Resident 66 to start on ertapenem (antibiotic medication) IV every 24 hours for 10 days. Review of Resident 66's Progress Notes from ,d+[DATE] to [DATE], failed to show documented evidence of continued monitoring of Resident 66 for any adverse reactions related to the IV antibiotic use for ESBL in the urine and further aggravating signs and symptoms of the urine infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1417 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated a new diagnosis of urine infection and the use of the IV antibiotics were considered a change of condition. LVN 2 stated for a change of condition, an assessment of the resident had to be done every shift for three days but if the resident was receiving an IV antibiotic, the assessment had to be done until the completion of the IV antibiotic. LVN 2 stated for Resident 66, the follow-up assessment was important to be done to check if Resident 66 would have any adverse reactions from the IV antibiotic and to check if the symptoms of the urinary tract infection were getting better or worse. LVN 2 further stated the change of condition documentation would also show if the nurses were providing the appropriate nursing care and measures so the condition would not aggravate. On [DATE] at 1517 hours, an interview was conducted with the ADON. The ADON stated for a change of condition such as new urine infection, the licensed nurse should include in the assessment any signs and symptoms of UTI like fever, bladder pain, hematuria (blood in the urine), and any changes in the vital signs and level of consciousness. The ADON stated for the use of IV antibiotic, the licensed nurse should assess the resident for any adverse effects of the medication. The ADON further stated the follow-up assessment for the change of condition was necessary and should be documented to know if there would be any abnormal changes in the resident and the staff would be able to notify the physician and render the necessary interventions sooner. The ADON was notified and acknowledged the above findings. 39453 2. Medical record review for Resident 394 was initiated on [DATE]. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's MDS dated [DATE], showed Resident 394 had severe cognitive impairment. Review of Resident 394's POLST (in the hospice binder), showed it was blank. Review of Resident 394's Order Summary Report failed to show a physician's order for Resident 394's code status. Review of Resident 394's plan of care did not show Resident 394's code status was addressed. On [DATE] at 1210 hours, an interview and concurrent medical record review for Resident 394 was conducted with LVN 1. When asked what Resident 394's code status was, LVN 1 reviewed Resident 394's electronic health record and did not see any copy of Resident 394's POLST, the code status was not reflected in the physician's orders, and not addressed in the care plan. LVN 1 also reviewed Resident 394's hospice binder and verified the POLST form was blank. LVN 1 further reviewed Resident 394's physical chart and did not see any copy of Resident 394's POLST, but found a copy of Resident 394's Pre-Admission Report. Review of Resident 394's Pre-Admission Report dated ,d+[DATE] showed Resident 394 had a full code status. LVN 1 stated Resident 394 was on hospice services, and one would assume that the family had come to terms and just to provide the comfort care, however, LVN 1 further stated, Resident 394 would be considered a full code because there was no POLST spelled out, so then I would provide the CPR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 394's medical record showed the POLST form was scanned and uploaded in the resident's electronic health record under the miscellenous documents. Review of the POLST dated [DATE], showed Resident 394 code status was DNR. LVN 1 verified the above findings. On [DATE] at 1250 hours, an interview and concurrent medical record review for Resident 394 was conducted with RN 1. RN 1 verified the POLST form in Resident 394's hospice binder was blank. RN 1 also verified the POLST form dated [DATE], scanned and uploaded in Resident 394's electronic health record, showed Resident 394's code status was DNR. RN 1 further verified Resident 394's DNR code status was not reflected in Resident 394's physician's orders and not addressed in his plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 29 final sample residents (Resident 82) and one nonsampled resident (Resident 643) remained free from accident hazards. * The facility failed to update the plan of care and provide the adequate supervision and necessary services for Resident 643 to prevent elopement. This failure had the potential for Resident 643 leaving the facility premises undetected. * The facility failed to implement the bilateral floor mats per the physician's order for Resident 82 who was at risk for falls. These failures had the potential to place the residents at risk for serious injury. Findings: Review of the facility's P&P titled Wandering and Elopement revised on 1/31/23, showed the facility will identify the residents at risk for elopement upon admission and when there is a change in condition to minimize the risk of elopement, to enhance the safety of the residents of the facility. Elopement was defined as a behavior that may lead to the resident leaving the facility unsupervised and/or without permission. The P&P further showed the following: 1. The Licensed nurse, in collaboration with the IDT, will assess the residents upon admission, readmission, quarterly and upon identification of a significant change in condition according to the RAI guidelines to determine their risk of elopement. 2. The resident's risk for elopement and preventive interventions will be documented in the resident's medical record and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition according to the RAI guidelines. 3. The IDT will develop a plan of care considering the individual risk factors of the resident. Review of facility's P&P titled Resident Safety revised 4/15/21, showed to provide a safe and hazard free environment. Residents will be evaluated on admission, quarterly, and whenever there is a change in condition to identify circumstance that pose a risk for the safety and wellbeing of the Resident. 1. Medical record review for Resident 643 was initiated on 3/5/25. Resident 643 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 643's H&P examination dated 2/22/25, showed Resident 643 was confused, had a diagnosis of dementia, and was unable to understand and make decisions due to dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 643's MDS dated [DATE], showed Resident 643 had severe cognitive impairment and did not use any mobility device to move from places. Review of Resident 643's Progress Notes showed the following: - dated 2/25/25 at 0318 hours, the resident was intermittently awake, wandering around the unit with unsteady gait, and stated he wanted to go home. The resident was redirected back to his room and assisted by the staff back to bed which was in the lowest position, with the call light within reach; and - dated 2/26/25 at 2158 hours, the resident was awake ambulating in the hallway, alert, oriented x 1 (to name only) with episode of confusion and forgetfulness, and - dated 3/2/25 at 2032 hours, the resident was on monitoring for episode of elopement. Review of Resident 643's Care Plan Report showed a care plan problem initiated on 3/2/25, addressing Resident 643 risk for elopement/wanderer and the episode of leaving the facility without notifying the staff. Further review of Resident 643's medical record failed to show Resident 643 was reassessed and a care plan was developed for the risk of elopement when Resident 643 was observed wandering in the hallway and verbalized wanting to go home on 2/25/25. On 3/6/24 at 0941 hours, an interview was conducted with the ADON. When asked about Resident 643, the ADON stated Resident 643 walked around, stable medically, knew his name but with severe cognitive impairment. When asked if Resident 643 had previous history of elopement, the ADON stated, 'no. However, the ADON stated on 3/2/25 at around 1830 hours, when LVN 3 was doing his rounds, LVN 3 noticed Resident 643 was not in his room. The staff started searching the facility for Resident 643. The ADON stated Resident 643 was observed at the nursing station at around 1800 hours, talking to RN 2. The ADON stated the facility got a call from the police department that they found Resident 643 and brought Resident 643 back to the facility. When asked what interventions were in placed before the incident had occurred, the ADON stated nothing specific aside from monitoring, just like what they did to the other residents at risk for elopement. The ADON further stated Resident 643 was redirectable. When asked further if Resident 643 was adequately supervised, how Resident 643 was out of facility undetected by the staff. The ADON stated, no, unfortunately he was able to get out of the building. On 3/6/25 at 1136 hours, an interview was conducted with CNA 1. When asked about Resident 643's care, CNA 1 stated the resident was continent, and able to stand, sit on chair and walk by himself. CNA 1 stated she was not aware Resident 643 was at risk for elopement, and no one told her that Resident 643 required supervision for possible risk of getting out of the facility. On 3/6/25 at 1146 hours, an interview and concurrent record review was conducted with RN 1. RN 1 was asked regarding the documentation on 2/25/25. RN 1 verified Resident 643 was intermittently waking up and wandering around the unit with unsteady gait, and stated he wanted to go home. RN 1 verified there was no revision of the care plan done. When asked if updating of the care plan was important, RN 1 stated updating the care plan would help. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1155 hours, an interview was conducted with the DON. The DON was made aware regarding the nurse's notes on 2/25/25, showing Resident 643 was intermittently waking up and wandering around the unit with unsteady gait, and stated he wanted to go home. When asked if updating the care for more adequate supervision was needed, the DON stated Resident 643 was not exit seeking, and easily redirectable. The DON further stated the facility should have provided more frequent monitoring and increased visual checks, and more activities to distract the resident and keep him busy; and those interventions should have been a part of the care plan update. 37726 2. Medical record review for Resident 82 was initiated on 3/3/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's care plan titled At Risk for Falls/Injuries initiated 5/17/23, showed Resident 82 was at risk for falls related to dementia, impaired cognition, and poor safety awareness. The care plan showed Resident 82 had a long history of ongoing falls. Review of Resident 82's Order Summary Report showed a physician's order dated 7/27/23, for bilateral floor mats for safety. On 3/3/25 at 0900 hours, an observation was conducted of Resident 82. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. On 3/3/25 at 0937 hours, an observation was conducted of Resident 82. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. On 3/3/25 at 1640 hours, an observation and concurrent interview was conducted with LVN 8. Resident 82 was observed lying in bed. Resident 82's bed was observed with a floor mat in place on one side of Resident 82's bed. The opposite side of Resident 82's bed was observed without a floor mat in place. LVN 8 verified the findings and stated he would implement the second floor mat in accordance with the physician's order. Cross reference to F656.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care was provided for one of three final sampled residents (Resident 4) reviewed for dialysis as evidenced by: * The facility failed to ensure Resident 4's dialysis access site was assessed and monitored appropriately and consistently. This failure had the potential for Resident 4 not being provided with the appropriate care and treatment and the possibility of medical complications related to the resident's dialysis access site. Findings: Review of the facility's P&P titled NP37 Dialysis Management revised 1/25/24, showed the facility should assure that each resident receives care and services consistent with professional standards of practice. The vascular access site should be assessed, observed and document care of access sites daily, as applicable, such as auscultation/palpation for pulse, bruit and thrill to assure adequate blood flow. On 3/3/25 at 1005 hours, during the initial tour of the facility, Resident 4 was observed awake and sitting on the bed. Resident 4 stated she was preparing because she would leave soon to go to the dialysis center. Resident 4 stated she received dialysis on Mondays, Wednesdays, and Fridays. Resident 4 stated her dialysis access site was located on the right arm. Medical record review for Resident 4 was initiated on 3/4/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed the following physician's orders: - dated 1/30/24, Dialysis on Monday, Wednesday, and Friday at 1230 hours; and - dated 2/8/24, to monitor the AV shunt in the right arm for bruit and thrill every shift. Review of Resident 4's Care Plan revised 3/13/24, showed a care plan focus problem addressing Resident 4's potential for complications of ESRD/dialysis. The interventions included to auscultate shunt site for bruit and palpate for thrill per protocol or every shift. Document the presence or absence. Notify the physician and dialysis center of absent thrill/bruit as soon as possible. Review of Resident 4's MAR for December 2024, January, February, and March 2025 showed the licensed staff documented Resident 4's AV shunt was - (negative) for thrill and bruit on 12/1/24 and 1/18/25; 0 (zero) on 12/12/24; X on 12/13/24 and 1/29/25; and NA on 2/23 and 3/4/25. Further review of Resident 4's medical record failed to show the physician was notified when the AV shunt was assessed without or negative for thrill and bruit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1358 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 4 had a right arm AV shunt. When asked about the assessment of the dialysis access site per shift as documented in the MAR, LVN 2 stated the positive sign + meant there was something or present, while the negative sign -, zero 0 and X meant there was none, or absent referring to the bruit and thrill noted from the resident's access site. LVN 2 stated she did not know what the NA would mean. LVN 2 verified Resident 4's AV shunt was assessed without thrill and bruit per record in the MAR but there was no documentation of the physician being notified. LVN 2 stated the licensed staff should have notified the physician because it was an emergency case if the AV shunt was assessed without thrill and bruit. On 3/6/25 at 1512 hours, an interview was conducted with the ADON. The ADON stated the negative sign - meant no thrill and bruit, the zero 0 and X could be interpreted as no thrill and bruit as well. The ADON stated the NA was meant for not applicable. The ADON stated the dialysis access site should be assessed properly to make sure it was functioning well as what was expected and if there was no thrill and bruit, the physician should have been notified as soon as possible. The ADON was notified and acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (final sampled resident, Resident 394) reviewed for side rail use remained free from accident hazards due to the use of side rails. * The facility failed to ensure Resident 394 who was assessed for no indication for the use of side rails was not provided with the side rails. Resident 394 was provided with bilateral upper 1/2 (half) side rails. In addition, Resident 394's plan of care showed a care plan problem to address grab bars, not 1/2 side rails. These failures had the potential to place Resident 394 at risk for entrapment and serious injury from side rail use. Findings: Review of the facility's P&P titled Bed Rails dated 6/12/24, showed the licensed nurse will complete the Bed Rail Evaluation prior to the use and/or installation of any bed rail, upon admission, readmission, change in bed or mattress, and a change in mobility status. On 3/4/25 at 1405 hours, Resident 394 was observed awake, lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 394 was initiated on 3/3/25. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's Order Summary Report showed a physician's order dated 2/14/25, for a bilateral 1/2 side rails as enablers. Review of Resident 394's Bed Rail assessment dated [DATE], showed the side rails were not indicated for Resident 394. Review of Resident 394's plan of care showed a care plan problem dated 2/17/25, addressing the use of the grab bars. Review of Resident 394's MDS dated [DATE], showed Resident 394 had severe cognitive impairment and dependent to the facility staff member for bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1017 hours, an observation for Resident 394 and concurrent interview and medical record review was conducted with RN 1. Resident 394 was observed in bed with the bilateral upper side rails elevated. RN 1 verified the above findings. RN 1 stated Resident 394 was under the hospice services, and Resident 394's bed was brought into the facility with the bilateral side rails already installed. RN 1 verified Resident 394's Bed Rail Assessment showed the side rails were not indicated for Resident 394. RN 1 also verified the physician's order was for the bilateral side rails; however, a care plan problem was developed to address the use of the grab bars. Cross reference to F909.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmacy services as per the facility's P&P for one nonsampled resident (Residents 34). * The facility failed to ensure the accurate and complete documentation of the controlled medication administered to Resident 34 was maintained. This failure had the potential to pose the risk for the diversion of the medications. Findings: Review of the facility's P&P titled Medication Administration revised 1/1/12, showed the licensed nurse will chart the drug, time administered and initial his/her name with each medication administration. The time and dose of the drug administered to the patient will be record in the patient's individual medication record by the person who administers the drug. Medical record review for Resident 34 was initiated on 3/4/25. Resident 34 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 34's H&P examination dated 2/10/25, showed Resident 34 had the capacity to understand and make decisions. Review of Resident 34's Order Summary Report showed a physician's order dated 2/10/25, to administer hydrocodone-acetaminophen (controlled pain medication) 10-325 mg one tablet by mouth every six hours as needed for severe pain (pain level of 7-10, using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain). Review of Resident 34's Individual Narcotic Record for the hydrocodone-acetaminophen 10-325 mg tablet showed one hydrocodone-acetaminophen 10-325 mg oral tablet was dispensed and signed out on 2/25/25 at 1808 hours, and 3/1/25 at 2000 hours. Review of Resident 34's MARs for February and March 2025, failed to show the documentation of the administration for the hydrocodone-acetaminophen 10-325 mg oral tablet dispensed on 2/25/25 at 1808 hours, and 3/1/25 at 2000 hours. On 3/4/25 at 1403 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings. On 3/4/25 at 1410 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the above findings. The DON stated the licensed nurse must document on the MAR when the medication was administered to the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were not stored at the bedside for one of 29 final sampled residents (Resident 104). In addition, the facility failed to ensure the proper disposal of the expired treatment supplies for one of five medication/treatment carts inspected for the medication storage and labeling. * The facility failed to ensure the expired culture swabs and dressing were removed from Treatment Cart 1. * Resident 104 was observed with sealed, unopened Wallgreens Redness Relief eye drops (eye redness relief) at bedside. These failures had the potential to result in unsafe medication administration and posed the risk for inaccurate test results and treatments. Findings: Review of the facility's P&P titled Medication Storage in the Facility effective date ,d+[DATE] showed the medications and biologicals are stored safely, securely, and properly, following the manufacture's recommendation or those of the supplier. The medication supply is accessible only to the licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. 1. On [DATE] at 1441 hours, an inspection of Treatment Cart 1 and concurrent interview was conducted with LVN 7. The following supplies were observed inside the treatment cart: - one culture swab (used to collect a sample for a laboratory test to identify bacteria causing an infection) inside the third drawer of the treatment cart, with an expiration date of [DATE], and - five packets of Allevyn Classic Adhesive dressing (a brand of foam dressings, specifically designed for wound care) were inside the third drawer of the treatment cart, with an expiration date of ,d+[DATE]. LVN 7 verified the above findings. LVN 7 further stated the expired culture swab and Allevyn dressing could be infective or may be contaminated if used on the residents. LVN 7 stated the expired supplies should be discarded from the treatment cart. On [DATE] at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 50787 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On [DATE] at 815 hours, during the initial tour of the facility, an observation was conducted in Resident 104's room. A sealed, unopened Wallgreens Redness Relief eye drops container was observed on the resident's nightstand. While being inside Resident 104 room, LVN 4 and Resident 104 came inside the room. An observation and concurrent interview was conducted with Resident 104 and LVN 4. When asked about the Wallgreens eyedrops at the beside, Resident 104 stated he bought the eyedrops when he was out on a pass. LVN 4 acknowledged and verified the presence of a sealed, unopened Wallgreens Redness Relief eye drops at bedside. LVN 4 stated he would ask the resident's physician if Resident 104 could have the eyedrops. LVN 4 further stated there should be no medications at the bedside. Medical record review for Resident 104 was initiated on [DATE]. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's Physician Progress notes dated [DATE], showed Resident 104 was able to understand and make treatment decisions. Review of Resident 104's MDS dated [DATE], showed a BIMS score of 12 (moderately impaired cognition). Review of Resident 104's Order Summary Report did not show a physician's order for the eyedrops for dry eyes. On [DATE] at 1415 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920 Based on observation, interview, medical record review, and facility document review, the facility failed to follow the menu when preparing food for one of 29 final residents (Resident 88). * The facility failed to ensure the recipe for chef salad was followed. Resident 88 requested a chef salad and received only lettuce with shredded carrots and purple cabbage. This failure had the potential for the resident to not receive adequate nutrition based on their diet orders. Findings: Review of the facility's Diet Count dated 3/6/25, showed 123 of 140 residents residing in the facility received food prepared in the kitchen. On 3/3/25 at 0907 hours, an observation and concurrent interview was conducted with Resident 88. Resident 88 was sitting up in bed watching TV. Resident 88 stated she was ordering more salads for her meals because she was trying to lose weight to qualify for her knee surgery. Resident 88 stated she was not receiving enough protein on her salads and did not feel like with enough food. Medical record review for Resident 88 was initiated on 3/3/25. Resident 88 was admitted to the facility on [DATE]. Review of Resident 88's Order Summary Report showed a diet order dated 11/15/25, for NAS (no added salt) diet, regular texture, regular/thin consistency. Review of Resident 88's Care Plan Report dated 11/18/25, showed the resident was admitted with NAS diet, regular texture, regular/thin consistency with the goal of maintaining weight status. The interventions included to give diet as ordered and accommodate food reasonably. On 3/3/25 at 1233 hours, a follow-up observation and concurrent interview was conducted with Resident 88. Resident 88 was sitting up in bed with her lunch tray. The lunch tray included a plate of lettuce with shredded carrots and purple cabbage. There were also a side of ranch dressing, a cup of pears, and a four oz (ounce) cup of orange juice. Resident 88 stated she was disappointed that she did not receive any protein with her salad. Review of Resident 88's lunch meal card dated 3/3/25, showed the resident's diet as NAS, lactose free, consistency regular; beverages: four oz juice; allergies: lactose, fruit, peanuts; dislikes: tomato products, watermelon; and likes: chef salad with ranch only. Review of the facility's recipe for chef salad showed the ingredients included lettuce, turkey, lean ham, cheese, tomatoes, hard cooked eggs, salad dressing, and optional beets and shredded carrots. On 3/3/25 at 1524 hours, an interview was conducted with the Dietary Supervisor and Administrator. The Dietary Supervisor reviewed the recipe card for the chef salad and verified it was incorrectly made for Resident 88.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary adaptive equipment was provided for one of 29 final sampled residents (Resident 8). * Resident 8 was not provided with built-up utensils per the physician's order. This failure had the potential for Resident 8 not having an appropriate assistive device to consume her food. Findings: Review of the facility's P&P titled Restorative Dining Program revised January 2012 showed the residents will be provided a tray with their respected diet. The special adaptive equipment may be recommended by the OT and will be provided by the facility. The equipment may include, but may not be limited to built-up handled utensils, weight utensils, large handled utensils, and angled utensils. The facility staff should consistently place the adaptive equipment in the same position on the tray and encourage use of the adaptive equipment by the resident during the meal. On 3/3/25 at 1315 hours, during the dining observation of the facility, Resident 8 was observed having lunch in the bed. Resident 8 was observed using a regular silver spoon and a light gray colored built-up fork. Resident 8's meal tab showed to have a built-up utensils and lip plate. Medical record review for Resident 8 was initiated on 3/4/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 2/21/24, showed Resident 8 had no capacity to make medical decisions. Review of Resident 8's Care Plan revised 11/6/24, showed a care plan focus problem addressing Resident 8's nutritional problem. The interventions included the use of the built-up utensils and lip plate. Review of Resident 8's Order Summary Report showed a physician's order dated 1/22/25, for the built-up utensils and lip plate with all meals. On 3/4/25 at 0815 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed having breakfast in the bed. Resident 8 was observed using a regular silver spoon, fork, and knife. Resident 8 stated it was hard to eat and grab the spoon and fork. Resident 8 was observed with contracted left hand. Resident 8 further stated her left hand was weak. Resident 8's meal tab showed for devices, to use the built-up utensils and lip plate. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 0824 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 stated Resident 8 had a history of stroke and Resident 8's left hand was contracted. LVN 6 stated the built-up utensils would help Resident 8 to have a better grip and control of the utensils since Resident 8 had a limited hand strength. LVN 6 verified Resident 8 required the use of the built-up utensil as per the physician's order. On 3/6/25 at 1615 hours, an interview was conducted with the DON. The DON was notified and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37726 Based on observation, interview, and facility P&P review, the facility failed to ensure the hair restraints were worn by the staff while in the kitchen and failed to ensure kitchen dry storage guidelines were implemented. * The DSS failed to donn a hair restraint while in the kitchen, in accordance with the facility's P&P. * A canister containing brown rice was observed without a lid inside of the dry storage room. These failures had the potential for unsafe food storage and infection control practices in a medically vulnerable resident population. Findings: Review of the facility's Diet Count dated 3/6/25, showed 123 of 140 residents residing in the facility received food prepared in the kitchen. 1. Review of the facility's P&P titled Dietary Department - Infection Control for Dietary Employees revised on 11/9/16, showed personal are required to have clean hair covered with an effective hair restraint while in all kitchen and food storage areas, and beard/mustache covering when applicable. On 3/3/25 at 0745 hours, during the initial tour of the kitchen, the kitchen staff was observed preparing breakfast for the residents. The DSS was inside the kitchen and observed with a beard and mustache, however, the DSS was not wearing a hair restraint. The DSS verified the findings and stated he should have donned a hair restraint in accordance with the facility's P&P. 2. Review of the facility's P&P titled Food Storage revised 11/1/14, showed any opened (dry storage) products should be placed in a storage containers with tight fitting lids. The dry storage guidelines include monitoring dry storage areas routinely for pest activity. On 3/5/25 at 0958 hours, an observation of the kitchen dry storage room was conducted. A canister containing the brown rice was observed without a lid, inside of the dry storage room. On 3/5/25 at 1009 hours, an observation and concurrent interview was conducted with the Cook. The [NAME] verified a canister containing the brown rice, in the dry storage room, did not have a lid in place. The [NAME] stated the canister of the brown rice should have had a lid in place to ensure the rice remained clean. On 3/5/25 at 1015 hours, an interview was conducted with the DSS. The DSS stated the canister of the brown rice, located in the dry storage room, required a lid to be in place for infection control.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 37726 Based on observation and interview, the facility failed to ensure the garbage was properly stored in two of six garbage dumpsters. This failure had the potential to attract pests/rodents that carried a disease. Findings: According to the 2022 FDA Food Code, outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 3/3/25 at 1132 hours, an observation of the facility's garbage dumpsters was conducted. Two of six dumpsters were observed with the lids open and garbage inside. The dumpsters were observed with the lids propped open by garbage, preventing the lids from fully closing. On 3/4/25 at 1601 hours, an interview was conducted with the Administrator. The Administrator verified the findings (via a photograph taken of the findings). The Administrator stated the garbage company was scheduled to pick up the garbage at the facility six times a week.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure the medical record was accurately maintained for three of 29 final sampled residents (Residents 79, 84, and 86). * Residents 79 and 84's POLST failed to show documentation as to whether the residents had formulated and advance directive. * Resident 86's medical record was found to have two other residents' medical records. These failures had the potential for the residents' care needs not being met as the medical record was inaccurate and incomplete. Findings: 1. Medical record review for Resident 79 was initiated on 3/3/25. Resident 79 was admitted to the facility on [DATE]. On 3/6/25 at 1049 hours, an interview and concurrent medical record review was conducted with LVN 2. Review of Resident 79's POLST, Section D (advance directive), dated 11/12/24, failed to show documentation as to whether Resident 79 had formulated an advance directive. LVN 2 verified the findings and stated the information specific to the advance directive would be added to Resident 79's POLST. 2. Medical record review for Resident 84 was initiated on 3/3/25. Resident 84 was admitted to the facility on [DATE]. On 3/6/25 at 1049 hours, an interview and concurrent medical record review was conducted with LVN 2. Review of Resident 84's POLST, Section D (advance directive), dated 9/5/23, failed to show documentation as to whether Resident 84 had formulated an advance directive. LVN 2 verified the findings and stated the information specific to the advance directive would be added to Resident 84's POLST. 51920 3. On 3/4/25 at 0953 hours, an interview and concurrent medical record review was conducted with RN 1. During the record review, medical records for two residents were found to be filed in Resident 86's medical record. RN 1 verified the records should not be filed in Resident 86's medical record. RN 1 removed the records of the other residents from Resident 86's medical record.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the provision of hospice services for two of three residents (final sampled residents, Residents 79 and 394), reviewed for hospice services. * Resident 79 was scheduled to receive care from a certified hospice aide twice per week; however, the medical record failed to show documentation the certified hospice aide provided care to Resident 79 twice per week as scheduled. * The facility failed to clarify the frequency of the hospice agency staff visits and to ensure the hospice aide visited and provided care to Resident 394. The facility failed to ensure the flowsheet and clinical notes from the hospice nurses and hospice aides were completed. In addition, the facility failed to ensure Resident 394's POLST and hospice agency's consents were completed. These failures had the potential to delay hospice care for the residents. Findings: Review of the facility's P&P titled Hospice Care of Residents revised 1/1/12, showed the facility and hospice staff will collaborate on a regular basis concerning the resident's care. All documentation concerning hospice services will be maintained in the resident's medical record. 1. Medical record review for Resident 79 was initiated on 3/3/25. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's Order Summary Report showed a physician's order dated 2/6/25, to admit Resident 79 to Hospice 1 under routine level of care. Review of Resident 79's Physician's Certification for Hospice Benefit effective from 2/6/25 to 4/6/25, showed Resident 79 was currently bedbound and required complete assistance with activities of daily living, with each grooming and bathing session taking approximately one hour to complete. The visit frequency of care included a certified hospice aide visit twice per week. Review of Resident 79's care plan for hospice care initiated 2/7/25, showed the facility would work cooperatively with the hospice team to ensure Resident 79's spiritual, emotional, intellectual, physical, and social needs are met. Review of Resident 79's Hospice 1 Monthly Schedule for February and March 2025 showed a certified hospice aide was scheduled to provide care to Resident 79 twice a week. Review of Hospice 1's (staff) Sign in Sheet for February and March 2025 showed the following documentation: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* For the week of 2/9/25 to 2/15/25, the certified hospice aide visited and provided care for Resident 79 on 2/10/25 (one certified hospice aide visit was missing) *For the week of 2/16/25 to 2/22/25, there was no documentation the certified hospice aide visited and provided care for Resident 79. *For the week of 2/23/25 to 3/1/25, there was no documentation the certified hospice aide visited and provided care for Resident 79. *For the week of 3/2/25 to 3/8/25, there was no documentation the certified hospice aide visited and provided care for Resident 79. Further review of Resident 79's medical record failed to show documentation the facility had coordinated with Hospice 1 regarding the missing certified hospice aide visits. On 3/6/25 at 1400 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the findings. 39453 2. Review of the Hospice Services Agreement between the facility and Hospice Provider dated 11/1/21, showed the following: - Under Patient Care section, showed the communication will be documented in the SNF resident chart between the LTC facility and the hospice provider to ensure the needs of the resident are addressed and met 24 hours per day. The clinical notes will cover any significant changes in the resident's physical, mental, social, or emotional status; - Under Documentation of Services Provided section, showed all health care professionals, including but not limited to MSW, dietitians, nurses (including RNs and LVNs), therapists, chaplains, certified hospice aide, homemakers and volunteers, shall submit a progress note with a time sheet signed by the residents. SNFs shall also document accurately in the resident chart in the SNF record, according to the policy of the particular SNF. Documentation of services provided shall include copies of any instructions to the resident. All required documentation shall be submitted within five days of providing any specified service. Medical record review for Resident 394 was initiated on 3/3/25. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's Order Summary Report showed a physician's order dated 2/17/25, to admit the resident under Hospice Provider 1. a. During the inspection of the hospice binder, the following documents from Hospice 2 were left blank and not signed by the resident/resident representative: - Comfort Medications from Hospice Provider 1; - Policy Section: Administrative Patient Practices for Mortuary; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Informed Consent and Medicare/ Medical Benefit Election Form; - Patient Notification of Hospice Non-Covered Items, Services, and Drugs; - Release of Information and Consent for Treatment; - Patient Acknowledgment; - Patient's [NAME] of Rights and Responsibilities; - Medi-Cal Hospice Program Election Notice; - Telehealth Consent Form; and - Release With Authorization to Record and Photograph b. In addition, review of Resident 394's POLST in the hospice binder showed it was blank. c. Review of Resident 394's medical record did not show the frequency of the visits from Hospice 2's skilled nursing, certified hospice aide, social services, and chaplain. Review of the Hospice 2 calendar for February 2025 showed Hospice 2's MSW visited Resident 394 on 2/18/25, and Hospice 2's RN visited on 2/18 and 2/26/25. There was no Hospice 2's calendar for March 2025. Review of the Hospice 2's Flowsheet showed the handwritten notes showing MSW assessment and RN routine visit on 2/18/25, and RN routine visit on 2/25/25. d. Further review of Resident 394's medical record failed to show documented evidence of certified hospice aide visits conducted for Resident 394 for February and March 2025. On 3/5/25 at 1210 hours, an interview and concurrent medical record review for Resident 394 was conducted with LVN 1. When asked about the Hospice 2 staff visits, LVN 1 stated he was not sure of the schedule. LVN 1 stated he checked the hospice calendar and flowsheet to know who visited Resident 394. LVN 1 verified the Hospice 2 calendar and flowsheet only showed the MSW and RN visits. On 3/5/25 at 1244 hours, an interview and concurrent medical record review for Resident 394 was conducted with Hospice 2 RN and Hospice 2 MSW. Hospice 2 RN and Hospice 2 MSW verified the hospice forms and POLST in the Resident 394's hospice binder were blank. Hospice 2 RN and Hospice 2 MSW also verified the frequency of the hospice agency staff visits were not documented. Hospice 2 RN stated the nursing visits were every Wednesdays, certified hospice aide visits were every Friday, MSW visit was one time per month, and the resident's family declined the chaplain services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1252 hours, an interview and concurrent medical record review for Resident 394 was conducted with the DON. The DON acknowledged she was the hospice coordinator. The DON verified the hospice forms and POLST in the Resident 394's hospice binder were blank. The DON also verified the frequency of the visits from Hospice 2's skilled nursing, certified hospice aide, social services, and chaplain were not documented in the physician's order nor Resident 394's plan of care. When asked about Hospice 2 calendar, the DON showed a calendar for February and March 2025 from Resident 394's EHR. Review of the Hospice Provider 1 calendar for February and March 2025 showed the following: - One physician visit, one chaplain visit, one certified hospice aide visit, one social worker visit, and two skilled nurse visits for the week of 2/16 to 2/22/25; - One skilled nursing visit and one certified hospice aide visit for the weeks of 2/23 to 3/1, 3/2 to 3/8, and 3/9 to 3/15/25; and - One social worker, one skilled nursing, and one certified hospice aide visits for the week of 3/16 to 3/22/25. The DON stated she would have to verify with Hospice 2 if the calendar was the actual or projected visits. The DON verified there was a missing skilled nursing visit on the week of 2/16 to 2/22/25, and there was no documented evidence to show the certified hospice aide visited Resident 394 for February and March 2025.

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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. 37726 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases. * The facility failed to implement the testing, monitoring, and establishment of acceptable ranges of disinfectant chemicals levels throughout the facility's water supply in accordance with the facility's water management P&P for water management, and the facility's plan for Legionella control. * The laundry room and equipment were not maintained to ensure a clean area, and free from potential contamination. These failures had the potential for the spread of infection to the residents, staff and visitors in the facility. Findings: 1. According to the CMS QSO-17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. - Develops and implements a water management program that considers the ASHRAE (American Society of Heating Refrigerating and Air-Conditioning Engineers) industry standards and the CDC (Centers for Disease Control and Prevention) toolkit; and - Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Water Management revised 5/25/23, showed the facility will develop and utilize the water management strategies, using the core elements of a water management plan, to reduce the risk of growth and spread of Legionella and other opportunistic water-borne pathogens in facility water systems. Control measures and corrective actions include quarterly measurement of the water quality throughout the system to ensure changes that may lead to Legionella growth are not occurring. Quarterly maintenance and monitoring of the disinfectant and other chemicals levels in cooling towers and hot tubs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Water Management Committee Minutes dated 2/27/25, showed the water management testing includes testing of the PH levels, chlorine levels and chloramine levels. The facility will delegate to an outside company (Company 1) to check the levels monthly, starting in March of 2025. On 3/6/25 at 1535 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the facility had yet to implement the testing and monitoring of the disinfectant chemicals (chlorine and chloramine) levels throughout the facility water supply. The IP stated the implementation would begin this month (March 2025). Additionally, the IP stated the facility would establish an acceptable ranges for the disinfectant chemicals. 45064 2. Review of facility's P&P titled Laundry Services revised dated 1/1/12, showed a clean and safe environment is always maintained. On 3/6/25 at 1530 hours, a laundry room inspection was conducted with the Housekeeping Supervisor. The following was observed in the laundry room: - the outside of Washing Machine 1's door had large amounts of brown stains and white mineral-like residue; - the pipes on the back of Washing Machine 1 had brown stain and hard white substance, mineral-like residue; and - the wall next to Washing Machine 1 showed signs of damage with cracks and gap between the wall and baseboard. The Housekeeping Supervisor verified the above findings and stated she would try to scrape the yellow stains and white mineral-like residue. The Housekeeping Supervisor further stated she would let the maintenance know to repair the damaged wall.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51367 Based on interview, facility document review, and facility P&P (Policy and Procedure) review, the facility failed to implement the antibiotic stewardship program. * The facility failed to ensure the infection control data gathered in the surveillance log was accurately documented in the Infection Control Report for January 2025. * The facility failed to provide documentation of the McGeer's criteria used to determine if the residents met the criteria for true infection. * The facility failed to ensure Resident 54 was accurately assessed for true infection when an Ampicillin (antibiotic medication to treat infection) was prescribed. These failures had the potential for inappropriate use of antibiotics and increased risk of drug-resistant organisms. Findings: According to the CDC, the antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Core Elements of Antibiotic Stewardship for Nursing Homes | Antibiotic Prescribing and Use | CDC Review of the facility's P&P titled Antibiotic Stewardship revised 5/20/21, showed the purpose of the Antibiotic Stewardship is to optimize the use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use. - The facility will implement an Antibiotic Stewardship Program to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for residents. - The facility has chosen to use Revisited McGeer's Criteria (2012) for surveillance - The IP (Infection Preventionist/Infection prevention program coordinator) is responsible for tracing the following antibiotic stewardship processes: whether or not the resident's condition met McGeer's Criteria when the antibiotic was ordered - The IP will coordinate the collection and reporting of date for the Infection Control Committee meetings from all members of the team. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 3/6/25 at 1251 hours, an interview and concurrent infection control program review was conducted with the IP. Review of the facility's Infection Prevention and Control Surveillance Log for January 2025 showed 15 residents did not meet the McGeer's criteria for true infection. However, the review of the January 2025 Infection Control Report showed a total of 17 residents who did not meet the McGeer's criteria. The IP reviewed both reports and verified the information on the surveillance log did not match the information documented on the January 2025 Infection Control Report. The IP further stated inaccurate reports affected the infection control process and the teaching and in-services to the staff, and the discussion in the QAPI meeting and the action plans. In addition, the Monthly Infection Control Report showed the facility acquired six HAI: three residents with urine infection, two residents with skin/wound infection; and one resident with eye/ear infection. However, the review of the facility's mapping for HAI infection for January 2025 failed to show the resident with eye/ear infection included in the facility's mapping for infection. The IP acknowledged and verified the findings. 2. On 3/6/25 at 1251 hours, an interview and concurrent infection control program review was conducted with the IP. During the interview, the IP was asked for the facility's process regarding the resident's assessment to determine true infection. The IP stated the facility used the McGeer's criteria. When asked for the documentation of the McGeer's criteria, the IP was not able to provide one. The IP stated she just looked at the facility's infection control surveillance log and the signs and symptoms listed. The IP further stated she referenced the long version of the McGeer's form; however, no documentation was provided. Further review of the Infection Prevention and Control Surveillance Log showed on the bottom of the form, to utilize McGeer's Criteria to determine infections for Infection Control Surveillance Purposes. Review of the facility's Infection Screening Evaluation was provided by the IP. The screening form was being used when an antibiotic was initiated. The form was asking for symptoms and at the end of the evaluation, infection analysis was listed about Loeb's Criteria and McGeer's criteria. However, the assessment screening did not show how the system came up with meeting or not meeting the McGeer's criteria. For example, the facility provided a blank McGeer's screening for GI Tract Infections. The form showed the following: Both of the following criteria must be present: 1. One of the following GI sub-criteria: a) Diarrhea: three or more liquid or watery stools above what is normal for the resident within a 24-hour period b) Presence of toxic megacolon (abnormal dilation of the large bowel, documented radiologically) 2. One of the following diagnostic sub-criteria: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) A stool sample yields a positive laboratory test for C. difficile toxin A or B, or a toxin-producing C. difficile organism is identified from a stool sample culture or by a molecular diagnostic test such as PCR b) Pseudomembranous colitis is identified during endoscopic examination or surgery or in histopathologic examination of a biopsy's specimen. Review of the facility's Infection Screening Evaluation only showed the following assessment: 1. Diarrhea (# of episodes in the last 24 hours) a. Yes, less than three liquid or watery stools (above resident's normal) b. Yes, greater than or equal to three liquid or watery [NAME] (above resident's normal) The facility's Infection Screening Evaluation was not consistent with the McGeer's screening for the GI Tract Infections. The facility's Infection Screening Evaluation was unclear on the basis of meeting or not meeting the McGeer's criteria. The IP acknowledged the findings. 3. On 3/6/25 at 1251 hours, an interview and concurrent facility document review and medical record review for Resident 54 was conducted with the IP. Medical record review for Resident 54 was initiated on 3/6/25. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's Infection Prevention and Control Surveillance Log for February 2025 showed Resident 54 had signs and symptoms of diarrhea with an onset date of 2/17/25. The surveillance log showed Resident 54 was prescribed with Ampicillin and did not meet the McGeer's criteria. Review of Resident 54's Infection Screening Evaluation dated 2/17/25, showed the resident had symptoms (new or marked increase) of diarrhea (within the last 24 hours) and the resident met the McGeer's Criteria for gastroenteritis. Review of Resident 54's medical record showed a physician's order dated 2/22/25, for Ampicillin oral capsule 500 mg one capsule by mouth every six hours for exposure to possible contaminated milk products for seven days; and to start after blood culture collected. Review of Resident 54's Late Entry Note dated 2/25/25 at 1523 hours, showed the NP was made aware regarding the resident not meeting the McGeer's criteria and per the NP, to continue the antibiotic as ordered. Resident 54's information documented in the facility's Infection Prevention and Control Surveillance Log and progress notes about not meeting the McGeer's criteria did not match the assessment on the Infection Screening Evaluation showing Resident 54 met the McGeer's criteria for gastroenteritis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555688	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Point	3415 W Ball Road Anaheim, CA 92804

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1445 hours, an interview and concurrent medical record review for Resident 54 was conducted with the DON. The DON acknowledged and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the bed inspection and entrapment assessment were conducted for one of five final sampled residents (Resident 394) reviewed for side rail use. These failures had the potential to negatively impact the resident's well-being resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Rails dated 6/12/24, under the Safety and Maintenance section showed the following: - The facility is required to follow the manufacturer's recommendations and specifications for installation and ensure the dimensions of the resident's bed are appropriate for both the resident's size and weight; and - Review of entrapment occurs upon admission, readmission or a change of bed or mattress; and On 3/4/25 at 1405 hours, Resident 394 was observed awake and lying in bed with the bilateral upper side rails elevated. (continued on next page)

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	555688	A. Building B. Wing	03/06/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 394 was initiated on 3/3/25. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's Order Summary Report showed a physician's order dated 2/14/25, for the bilateral 1/2 side [NAME] as enablers. Review of Resident 394's Bed Rail assessment dated [DATE], showed side rails were not indicated for Resident 394. Review of Resident 394's plan of care showed a care plan problem dated 2/17/25, to address the use of the grab bars. Review of Resident 394's MDS dated [DATE], showed Resident 394 had severe cognitive impairment, and dependent to the facility staff member for bed mobility. Further review of Resident 394's medical record failed to show documented evidence an entrapment assessment was completed prior to the installation of the bilateral upper side rails. On 3/5/25 at 1017 hours, an observation for Resident 394 and concurrent interview and medical record review was conducted with RN 1. Resident 394 was observed in bed with the bilateral upper side rails elevated. RN 1 verified the above findings. RN 1 stated Resident 394 was under the hospice services, and Resident 394's bed was brought into the facility with the bilateral side rails already installed. When asked about the entrapment assessment, RN 1 stated the maintenance department installed the side rails and measured the bed and side rails to assess for entrapment. On 1/24/25 at 1225 hours, a concurrent interview and facility document review for Resident 394 was conducted with the Maintenance Director and the Maintenance Assistant. The Maintenance Director stated the maintenance department was responsible for the monthly bed inspection of all the beds in the facility, where they checked the whole bed, bed functionality, frame, bed control and the side rails which could be halos, U-bars, and the half or quarter side rails. The Maintenance Director stated after the nurses obtained a physician's order for the side rails, the DON or ADON would notify the maintenance department to install the side rails. The Maintenance Assistant further stated if the maintenance department was not notified and he saw a resident bed had side rails, he would measure the bed and the entrapment zones, record in his notebook, and would document later in the log. When asked about the entrapment assessment, the Maintenance Assistant stated he used a measuring tape to measure the entrapment zones on each bed. When asked to show the documentation of the results of the bed inspection including the entrapment assessment, the Maintenance Assistant showed the Bed Side Rail Inspection Log and the Bed Entrapment Risk Checklist. Review of the Bed Side Rails Inspection Log for February 2025 showed the information included the bed make, bed serial, location/ retighten, in good repair, if the mattress size was appropriate and the date of installation of the side rails. The log did not show Resident 394's bed was inspected. Review of the Bed Entrapment Risk Checklist for February 2025 which included the seven zones of entrapment, did not show Resident 394's bed was inspected. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Maintenance Director and the Maintenance Assistant verified the above findings. The Maintenance Director and the Maintenance Assistant stated they were not informed about Resident 394's bed with side rails. On 3/6/25 at 1400 hours, an observation for Resident 394 and concurrent interview was conducted with the Maintenance Director. Resident 394 was lying in bed with the bilateral upper side rails. The Maintenance Director verified the above findings.