STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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. 43988 Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for two of two sampled residents (Residents 55 and 70) investigated under the dignity care area by: 1. Failing to ensure Certified Nursing Assistant 11 (CNA 11) was at eye level with Resident 55 while providing feeding assistance for Resident 55. 2. Failing to ensure Resident 70 did not disrobe (removing clothing) within public view. These deficient practices had the potential to result in a decrease in the residents' psychosocial well-being and loss of dignity. Findings: 1. During a review of Resident 55's Admission Record, it indicated the facility admitted the resident on 8/29/2020 with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty in walking. During a review of Resident 55's History and Physical (H&P) dated 3/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 55's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/7/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision/touching assistance with mobility, and upper body dressing; total assistance from staff with eating; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's care plan titled, Resident has self-care deficits: need assistance with ADLs, initiated 8/29/2020 last revised 6/26/2024, the care plan indicated the resident required dependent assistance with eating. The care plan indicated the following interventions but not limited to: - Assist with ADLs as needed. - Maintain resident's privacy and respect their rights. During an observation on 7/24/2024 at 8:30 a.m., observed Resident 55 in the wheelchair and CNA 11 standing over the resident and not within eye level while assisting the resident with eating. During an interview on 7/24/2024 at 8:35 a.m., with CNA 11, CNA 11 stated that she should be sitting on a chair and at eye level while assisting Resident 55 with eating. CNA 11 stated it was important to sit and interact with the resident while assisting with eating for respect, maintain their dignity, and safety to ensure they can chew the food properly to prevent choking incident. During an interview on 7/26/2024 at 11:15 a.m., the Director of Nursing (DON), the DON stated when assisting resident with eating, the best practice is for staff to sit at eye level with the resident to maintain respect and dignity. During a review of the facility's policy and procedure titled, Dignity, last reviewed 1/10/2024, it indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's policy and procedure titled, Resident Rights, last reviewed 1/10/2024, it indicated employees shall treat all residents with kindness, respect, and dignity. The policy indicated: - Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: A dignified existence. Be treated with respect, kindness, and dignity. 49947 2. During a review of Resident 70's Admission Record, it indicated the facility admitted Resident 70 on 9/8/2023 with diagnoses including, but not limited to, dementia (loss of memory, language, and other thinking abilities that interfere with daily life and gets worse over time), Alzheimer's Disease (a common type of dementia), major depressive disorder (a persistent feeling of sadness and loss of interest), and anxiety disorder (excessive worry and feelings of fear and uneasiness). During a review of Resident 70's History and Physical (H&P), dated 11/8/2023, it indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 70's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/13/2024, the MDS indicated Resident 70 had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and needed maximum assistance with upper body dressing, lower body dressing, toileting, hygiene, and bathing. During a review of Resident 70's Care Plan on 7/23/2024, a plan of care with interventions (action to help or change a situation) for the behavior of disrobing was not found. During an observation on 7/23/2024 at 11:10 a.m., outside of Resident 70's room, Resident 70 could be viewed from the hallway disrobed from the waist up; the privacy curtain was partially drawn. Upon entering Resident 70's room, Resident 70 was up in her wheelchair with her shirt off, exposing her breasts while other residents were passing by the room. Resident 70 yelled out nonsensically (not making sense) when interview was attempted. During a concurrent observation and interview on 7/23/2024, at 11:15 a.m., inside Resident 70's room, with Restorative Nursing Assistant (RNA) 1, RNA 1 assisted Resident 70 back into her shirt and stated that Resident 70 had the behavior of disrobing in the past. RNA 1 further explained the behaviors are to be reported to the charge nurse. When asked about privacy, RNA 1 confirmed the curtain was not completely closed and pulled the curtain over to provide privacy. RNA 1 further stated he will report the behavior to the charge nurse. During an interview on 7/25/24 at 8:30 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she cared for Resident 70 approximately 4 times in the last month and Resident 70 disrobed once or twice. CNA 7 further stated she reported to the charge nurse each time the resident had the behavior of disrobing but does not remember which date or charge nurse she reported it to. During a concurrent interview and record review on 7/25/24 at 9:15 a.m., with the Director of Staff Development (DSD), reviewed the MAR and care plan of Resident 70. The DSD stated on 7/23/2024 she was covering as the charge nurse for the first shift (7:00 a.m.- 3:30 p.m.) in station two (the station that covers the area of Resident 70) and did not remember if the behavior of disrobing was reported to her that day. The DSD stated she remembers Resident 70 disrobing her shirt since she was admitted to the facility and any new identified behaviors are to be reported to the supervising registered nurse. The DSD further stated the behaviors are tallied in the MAR, but disrobing was not listed as a behavior to monitor in the MAR. The DSD continued by stating the behavior could affect Resident 70's dignity and privacy because anyone walking by can see her undressed. During a concurrent interview and record review on 7/25/2024 at 9:55 a.m. with Registered Nurse (RN 2), reviewed the MAR, care plan and notes of Resident 70. RN 2 stated the disrobing behavior was not reported to her and if the behavior was not in the MAR, it was not care planned. RN 2 confirmed disrobing was not mentioned in any notes, care plans or the MAR in Resident 70's chart. RN 2 further stated there are a lot of males in the facility and it can affect resident 70's dignity as well as privacy. (continued on next page)

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F 0550 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, Dignity, last reviewed 1/10/2024, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. The P&P further indicated staff shall promote, maintain, and protect resident privacy, including bodily privacy.

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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** 49947 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences to five out of twelve residents (Resident 25, 52, 61, 7, and 135) investigated during review of environment facility task by failing to ensure: 1. The call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was available for Resident 25. 2. The call light was within reach for Resident 52, 31, 57, and 35. These deficient practices had the potential to result in the resident not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect resident's comfort and well-being. Findings: 1. During a review of Resident 25's Admission Record, it indicated the facility admitted the resident on 4/28/2017, with diagnoses including but not limited to dementia (loss of memory, language, and other thinking abilities that interfere with daily life and gets worse over time), Alzheimer's Disease (a common type of dementia), adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and anxiety disorder (excessive worry and feelings of fear and uneasiness). During a review of Resident 25's History and Physical (H&P), dated 10/7/2023, it indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/19/2024, the MDS the resident had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and was dependent on staff for toileting, eating, dressing, showering, and personal hygiene. During a review of Resident 25's Care Plan (CP) titled, (Resident 25) has self-care deficits, initiated 4/3/2018 and revised on 6/4/2024, the CP indicated a goal to minimize the risk of decline. The CP further indicated to provide a safe environment and place the call light within reach and attend to needs promptly. During a review of Resident 25's CP titled, (Resident 25) has cognitive and communication deficit . initiated 4/3/2018 and revised on 6/4/2024, the CP indicated to keep the call light within reach. During a review of Resident 25's CP titled, Actual Fall .factors: severe to no regards to his safety awareness due to advanced dementia, impaired cognition, confused and disoriented, initiated 4/3/2018 and revised on 5/6/2024, the CP indicated to provide resident with a safe environment, and to keep call light within easy reach and encourage resident to use it to get assistance. (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 7/23/2024 at 9:40 a.m. in Resident 25's room, Certified Nursing Assistance (CNA) 6 entered the room and confirmed Resident 25 did not have a call light available for use. CNA 6 stated having a call light available and within reach of the resident prevent accidents. During an interview on 7/25/2024 at 6:25 p.m., the Director of Nursing (DON), the DON stated without a call light, it can cause a delay of care and the facility policy indicates call lights should be within reach of all the facility residents. During a review of the facility policy and procedure titled, Call Lights, last reviewed 1/10/2024, it indicated the purpose of the policy was to assure residents receive prompt assistance. Nursing and care duties include ensuring the call light is within the resident's reach when in his/her room. 44244 2. During a review of Resident 52's Admission Record, it indicated the facility admitted the resident on 5/12/2023 and readmitted the resident on 7/15/2024 with diagnoses that included intervertebral disc degeneration (the breakdown of the cushion between the bones of the spine) lumbar region (lower back), muscle weakness, history of falling, psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) and unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 52's MDS dated [DATE], the MDS indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, dressing, and mobility. During a review of Resident 52's H&P, dated 7/15/2024, it indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52's CP titled, (Resident 52) has self-care deficits, initiated 5/12/2023, the CP indicated a goal to minimize the risk of decline. The CP further indicated to provide a safe environment and place the call light within reach and attend to needs promptly. During a review of Resident 52's CP titled, (Resident 52) has cognitive and communication deficit . initiated 5/12/2023, the CP indicated to keep the call light within reach. During a review of Resident 52's CP titled, Actual Fall .factors: severe to no regards to his safety awareness due to advanced dementia, impaired cognition, confused and disoriented, initiated 6/4/2023, the CP indicated to attach the call to the bed within access of resident. During an observation on 7/23/2024 at 9:25 a.m., Resident 52 was lying in bed with the call light clipped to the sheet of the bed on the left upper corner of the mattress. Observed the call light dangling behind the bed and out of reach of the resident while unattended by staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/23/2024 at 9:37 a.m., CNA 8 entered Resident 82's room and stated the call light was clipped to the mattress at the top left corner of the resident's bed. Observed CNA 8 move the call light and clipped it to the pillow. CNA 8 stated she moved the call light because it was not withing reach of the resident. CNA 8 stated it was important to have the call light within reach of the resident. During an interview on 7/25/2024 at 1:19 p.m., with Registered Nurse 2 (RN 2), RN 2 stated every single resident in the facility should have the call light within reach because residents have fluctuating capabilities and at some point, they may use it. RN 2 stated the call light should always be within reach of the resident while in bed or in the wheelchair in the resident's room. RN 2 stated when the call light is not within reach, the resident could potentially try to get up unassisted and the resident could fall resulting in injuries like a brain bleed, a broken hip, or a broken arm. During an interview on 7/25/2024 at 2:31 p.m., with the DON, the DON stated the facility policy indicates call lights should be within reach of all the facility residents. A review of the facility policy and procedure titled, Call Lights, last reviewed 1/10/2024, indicated the purpose of the policy was to assure residents receive prompt assistance. Nursing and care duties include ensuring the call light is within the resident's reach when in his/her room. 3. During a review of Resident 31's Admission Record, it indicated the facility admitted the resident on 6/23/2021 and readmitted the resident on 2/4/2022 with diagnoses that included psychotic disturbance (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), mood disturbance (mental health condition marked by disruptions in emotions), anxiety (feeling of worry, nervousness, or restlessness [uneasiness]), muscle weakness, history of falling, and syncope(a loss of consciousness for a short period of time) and collapse. During a review of Resident 31's MDS dated [DATE], the MDS indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident required partial/moderate assistance from staff for oral hygiene, toileting, showering, dressing, and transferring from sit to stand. During a review of Resident 31's H&P, dated 6/13/2024, it indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 31's CP titled, (Resident 31) is at risk for falls/injury . initiated 7/1/2023, the CP indicated to keep the call light within easy reach and encourage the resident to use it to get assistance. During a review of Resident 31's CP titled, Actual Fall . status post fall from bed to floor pad . initiated 3/23/2024, the CP indicated to attach the call light to bed within access of resident. During an observation on 7/23/2024 at 9:48 a.m., observed Resident 31 sitting in a wheelchair facing the window at the foot of the resident's bed. Observed the call light clipped to the sheet at the head of the right side of the bed while the resident was unattended by staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/23/2024 at 9:55 a.m., CNA 8 entered Resident 31's room and stated the resident was not able to move herself in the wheelchair. CNA 8 stated the call light did not reach the resident while sitting in the wheelchair and the call light was not within reach of the resident. CNA 8 stated the call light only needed to be within reach of the resident when the resident was in bed. During an interview on 7/25/2024 at 1:19 p.m., with RN 2, RN 2 stated every single resident in the facility should have the call light within reach because residents have fluctuating capabilities and at some point, they may use it. RN 2 stated the call light should always be within reach of the resident while in bed or in the wheelchair in the resident's room. RN 2 stated there is an extension that may be added to the call light in order to ensure the resident has access while in the wheelchair. RN 2 stated when the call light is not within reach, the resident could potentially try to get up unassisted and the resident could fall resulting in injuries like a brain bleed, a broken hip, or a broken arm. During an interview on 7/25/2024 at 2:31 p.m., with the DON, the DON stated the facility policy indicates call lights should be within reach of all the facility residents. A review of the facility policy and procedure titled, Call Lights, last reviewed 1/10/2024, it indicated the purpose of the policy was to assure residents receive prompt assistance. Nursing and care duties include ensuring the call light is within the resident's reach when in his/her room. 4. During a review of Resident 57's Admission Record, it indicated the facility admitted the resident on 9/4/2020 with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out the simplest tasks), unspecified dementia, and primary generalized osteoarthritis (condition that causes the joints to become very painful and stiff). During a review of Resident 57's MDS dated [DATE], the MDS indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident was dependent on assistance from staff for toileting, showering, dressing, and transferring to the toilet or tub/shower. During an observation on 7/23/2024 at 9:48 a.m., observed Resident 57 sitting in a wheelchair on the left side of the resident's bed. Observed the call light clipped to the upper right side of the resident's bed while unattended by staff. During an observation and interview on 7/23/2023 at 9:55 a.m., with Resident 57 and CNA 8, CNA 8 stated the call light did not reach the resident while sitting in the wheelchair and the call light was not within reach of the resident. Resident 57 stated she did not have a call light. During an interview on 7/25/2024 at 1:19 p.m., with RN 2, RN 2 stated every single resident in the facility should have the call light within reach because residents have fluctuating capabilities and at some point, they may use it. RN 2 stated the call light should always be within reach of the resident while in bed or in the wheelchair in the resident's room. RN 2 stated when the call light is not within reach, the resident could potentially try to get up unassisted and the resident could fall resulting in injuries like a brain bleed, a broken hip, or a broken arm. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 7/25/2024 at 2:31 p.m., with the DON, the DON stated the facility policy indicates call lights should be within reach of all the facility residents. A review of the facility policy and procedure (P&P) titled, Call Lights, last reviewed 1/10/2024, the P&P indicated the purpose of the policy was to assure residents receive prompt assistance. Nursing and care duties include ensuring the call light is within the resident's reach when in his/her room. 43988 5. During a review of Resident 35's Admission Record, it indicated the facility admitted the resident on 5/24/2023 with diagnoses including vascular dementia (a general term describing problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), hemiplegia (refers to total paralysis on one side of the body) and hemiparesis (refers to weakness or inability to move on one side of the body) following cerebral infarction (also known as stroke, a condition that refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, and altered mental status. During a review of Resident 35's H&P dated 6/10/2024, the H&P it indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 35's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 35's Fall Risk Assessments dated 5/31/2024, 5/29/2024, 2/27/2024, and 11/27/2023, the assessments indicated the resident was a high risk for falls. During a review of Resident 35's care plans, the following care plans indicated: a. Resident 35 has self-care deficits dependent assistance with all ADLS, initiated 6/4/2023, with target date 8/27/2024, indicated the following interventions but not limited to: o Assist with ADLs as needed. o Provide a safe environment. o Call light within reach and attend needs promptly. b. Resident 35 is at risk foals/injury related to poor safety awareness/judgment, and dementia initiated 5/24/2023, last revised 3/8/2024, with target date of 8/27/2024, indicated the following interventions but not limited to: o Keep call light within easy reach and encourage resident to use it to get assistance. o Keep frequently used personal items within easy reach. (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 7/23/2024 at 9:44 a.m. with CNA 2 inside Resident 35's room, observed the resident in the wheelchair parked on the right side of the bed approximately four floor tiles away. Observed the call light on top of the bed. CNA 2 verified Resident 35's call light was placed on top of the bed and was not within resident's reach. CNA 2 the call should be within reach so the resident can call for assistance when needed. CNA 2 stated Resident 3 can fall if assistance was not provided timely. During a concurrent interview and review of on 7/26/2024 at 11:27 a.m., with the DON, the DON stated all call lights should be within resident reach for safety and prompt assistance with their needs. The DON stated staff would be unable to assist the residents with their needs if the call light was not within reach and may result in an accident. During a review of the facility's policy and procedure titled, Call lights, last reviewed 1/10/2024, indicated a purpose to assure residents receive prompt assistance. The policy indicated: o All staff shall know how to place a call light for a resident and how to use the call light system. o Ensuring that the call light is within the resident's reach when in his/her room or when on the toilet. o Monitoring the lights and making sure that the lights are answered promptly, regardless of who is assigned to each resident.

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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** 44244 Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documented evidence that advance directives (AD, written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed with the residents and that the facility maintained a current copy of the resident's AD in the clinical record for three of four sampled residents (Resident 21, 52, and 57) reviewed under the Advance Directives care area. These deficient practices violated the resident's rights and/or representative's right to be fully informed of the option to formulate an AD and had the potential to cause conflict with a resident's wishes regarding health care. Findings: a. During a review of Resident 21's Admission Record, it indicated the facility admitted the resident on 5/4/2022 and readmitted the resident on 8/26/2022 with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out the simplest tasks) unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). During a review of Resident 21's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/14/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 21's Care Plan (CP) titled, Advance Directive initiated ., initiated 5/4/2022, the CP indicated to respect the resident and family's wishes. During a review of Resident 21's Advance Directive Acknowledgment form (document provided by the facility that indicates whether a resident has an advance directive, would like information regarding creation of an advance directive, or refusal to create an advance directive), dated 5/4/2023, the form indicated the resident was not capable of making preferred intensity of care decisions. The form indicated Resident 21 had executed an Advance Directive. During an interview and record review on 7/24/2024 at 11:08 a.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 21's Advance Directive Acknowledgment form, dated 5/4/2023. LVN 3 stated the form indicated the resident had an AD, but the AD was not located in the resident's chart. LVN 3 stated the AD should be in the chart, but it was not there. (continued on next page)

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 7/25/2024 at 11:07 a.m. with the Director of Staff Development (DSD), the DSD reviewed Resident 21's Advance Directive Acknowledgment form, dated 5/4/2023. The DSD stated the resident's representative completed the form and indicated the resident had an AD, but there was no AD in the resident's chart. During an interview on 7/25/2024 at 1 p.m., with Registered Nurse 2 (RN 2), RN 2 stated the AD is the resident's wishes for what they and their family want for their care including if the resident does not want to transfer to a hospital or wants to be do not resuscitate (DNR, do not perform life sustaining procedures). RN 2 stated the AD should be in the resident's chart. During an interview and record review on 7/25/2024 at 2:31 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy regarding ADs. The DON stated she was made aware that Resident 68's AD was not in the resident's chart, and they are following up with the family. The DON stated the AD should be kept in the resident's chart. The DON stated staff should have followed up to ensure the resident's AD was in the chart, but it is not there. The DON stated the importance of having the AD was to know the resident's wishes for care and if it is not available there is a potential the resident's wishes will not be followed. The DON stated the facility policy was not followed. A review of the facility policy and procedure (P&P) titled, Advance Directives, last reviewed 1/10/2024, indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directive is written instructions, such as a living will or durable power of attorney for health care, recognized by state law, relating to the provisions of health care when the individual is incapacitated. Prior to admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or representative indicates that he or she does not have an AD, the facility staff will offer assistance in establishing an AD. The resident or representative is given the option to accept or decline assistance. Nursing staff will document in the medical record the offer to assist and the decision to accept or decline. Information about whether the resident has executed an AD is displayed prominently in the medical record in a section of the record that is retrievable by any staff. If the resident has executed an AD, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The resident's wishes are communicated to the resident's direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record. A review of the facility policy and procedure titled, Resident Rights, last reviewed 1/10/2024, indicated federal and state law guarantee certain basic rights to all residents of the facility. These rights include the resident's right to self-determination. b. During a review of Resident 52's Admission Record, it indicated the facility admitted the resident on 5/12/2023 and readmitted the resident on 7/15/2024 with diagnoses that included psychosis (severe mental disorder in which thought, and emotions are so impaired that contact is lost with external reality) and unspecified dementia. (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 review of Resident 52's MDS dated [DATE], it indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, dressing, and mobility. During a review of Resident 52's History and Physical (H&P), dated 7/15/2024, it indicated the resident did not have the capacity to understand and make decisions. The H&P further indicated an Advance Directive was executed for the resident. During a review of Resident 57's Advance Directive Acknowledgment form, dated 3/20/2024, it indicated the resident was not capable of making preferred intensity of care decisions. The form indicated Resident 21 had executed an Advance Directive. During a review of Resident 52's Care Plan (CP) titled, Advance Directive initiated ., initiated 5/12/2023, the CP indicated to respect the resident and family's wishes. During an interview and record review on 7/25/2024 at 11:07 a.m. with the DSD, the DSD reviewed Resident 21's Advance Directive Acknowledgment form, dated 3/20/2024. The DSD stated the resident's representative completed the form and indicated the resident had an AD, but there was no AD in the resident's chart. During an interview on 7/25/2024 at 1 p.m., with RN 2, RN 2 stated the AD is the resident's wishes for what they and their family want for their care including if the resident does not want to transfer to a hospital or wants to be DNR. RN 2 stated the AD should be in the resident's chart. During an interview and record review on 7/25/2024 at 2:31 p.m., with the DON, reviewed the facility policy regarding ADs. The DON stated she was made aware that Resident 52's AD was not in the resident's chart, and they are following up with the family. The DON stated the AD should be kept in the resident's chart. The DON stated staff should have followed up to ensure the resident's AD was in the chart, but it is not there. The DON stated the importance of having the AD was to know the resident's wishes for care and if it is not available there is a potential the resident's wishes will not be followed. The DON stated the facility policy was not followed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure (P&P) titled, Advance Directives, last reviewed 1/10/2024, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directive is written instructions, such as a living will or durable power of attorney for health care, recognized by state law, relating to the provisions of health care when the individual is incapacitated. Prior to admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or representative indicates that he or she does not have an AD, the facility staff will offer assistance in establishing an AD. The resident or representative is given the option to accept or decline assistance. Nursing staff will document in the medical record the offer to assist and the decision to accept or decline. Information about whether the resident has executed an AD is displayed prominently in the medical record in a section of the record that is retrievable by any staff. If the resident has executed an AD, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The resident's wishes are communicated to the resident's direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record. A review of the facility policy and procedure (P&P) titled, Resident Rights, last reviewed 1/10/2024, the P&P indicated federal and state law guarantee certain basic rights to all residents of the facility. These rights include the resident's right to self-determination. c. During a review of Resident 57's Admission Record, it indicated the facility admitted the resident on 9/4/2020 with diagnoses that included Alzheimer's disease, and unspecified dementia. During a review of Resident 57's MDS dated [DATE], the MDS indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident was dependent on assistance from staff for toileting, showering, dressing, and transferring to the toilet or tub/shower. During a review of Resident 57's H&P, dated 10/17/2024, it indicated the resident did not have the capacity to understand and make decisions. The H&P indicated the resident had an AD. During a review of Resident 57's CP titled, Advance Directive initiated ., initiated 9/14/2020, the CP indicated to respect the resident and family's wishes. During a review of Resident 57's Advance Directive Acknowledgment form, dated 5/10/2021, it indicated the resident was not capable of making preferred intensity of care decisions. The form indicated a blank space on the line for the physician's signature, did not indicate a resident representative was informed of their rights to formulate an Advanced Directive, and did not indicate if the resident had executed and AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 7/25/2024 at 11:07 a.m. with the DSD, the DSD reviewed Resident 57's Advance Directive Acknowledgment form, dated 5/10/2023. The DSD stated the resident was not capable of making decisions and the representative did not complete the form. The DSD stated there was no documentation to indicate the resident's representative was informed of their right to formulate an AD and the form was not signed by the physician. During an interview on 7/25/2024 at 1 p.m., with RN 2, RN 2 stated the AD is the resident's wishes for what they and their family want for their care including if the resident does not want to transfer to a hospital or wants to be DNR. RN 2 stated the social services department gets in touch with the residents family at admission and discusses the AD and the AD Acknowledgement form is completed. During an interview and record review on 7/25/2024 at 2:31 p.m., with the DON, reviewed the facility policy regarding ADs. The DON stated she was made aware that Resident 57's AD Acknowledgment form was not completed, and they are following up with the family. The DON stated the AD acknowledgement form indicates that the family was made aware of their right to formulate an AD and without the form they do not know if the family wishes to formulate and AD or not. The DON stated the facility policy was not followed. A review of the facility policy and procedure titled, Advance Directives, last reviewed 1/10/2024, indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directive is written instructions, such as a living will or durable power of attorney for health care, recognized by state law, relating to the provisions of health care when the individual is incapacitated. Prior to admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or representative indicates that he or she does not have an AD, the facility staff will offer assistance in establishing an AD. The resident or representative is given the option to accept or decline assistance. Nursing staff will document in the medical record the offer to assist and the decision to accept or decline. Information about whether the resident has executed an AD is displayed prominently in the medical record in a section of the record that is retrievable by any staff. If the resident has executed an AD, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. The resident's wishes are communicated to the resident's direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record. A review of the facility policy and procedure (P&P) titled, Resident Rights, last reviewed 1/10/2024, the P&P indicated federal and state law guarantee certain basic rights to all residents of the facility. These rights include the resident's right to self-determination.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to notify the primary physician and responsible party of a significant change in condition (major decline or improvement in a resident's status that will not resolve itself without intervention) for one of five residents with limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns (Resident 68) and one of six sampled residents reviewed under the Infection Control task (Resident 76) by failing to: 1. Report Resident 68's refusal to participate in ROM exercises, especially to the right arm. 2. Report Resident 68's new onset pain and increased swelling in the right arm on 6/20/2024 to the primary physician and responsible party in accordance with Resident 68's care plan and the facility's policy. These failures had the potential for Resident 68 to have an undetected injury in the right arm. (Cross reference to F689 and F849.) 3. Ensure Licensed Vocational Nurse 3 (LVN 3) monitored, identified, and reported to the physician and the Infection Preventionist (IP) Resident 76's open wounds (a break in the skin) with signs and symptoms (s/s) of invasive group A streptococcus (IGAS - a severe and sometimes life-threatening infection that is spread from person to person through respiratory droplets or touching other surfaces contaminated with bacteria that may invade parts of the body where bacteria are not usually found) on the left wrist. 4. Ensure Treatment Nurse 1 (TN 1) identified and reported Resident 76's open wounds with s/s of IGAS on the left wrist. These deficient practices had the potential to result in worsening of Resident 76's wound including necrotizing fasciitis (a life-threatening soft tissue infection) and in the spread of IGAS to facility residents, visitors, and staff. Findings: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 68's Admission Record, the facility admitted Resident 68 on 6/30/2022 and readmitted on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), type 2 diabetes mellitus (high blood sugar), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), Vitamin D deficiency (not enough Vitamin D needed for strong bones and teeth), and contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to the right hand, both elbows, and both knees. The Admission Record indicated Resident 68 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/26/2024 with diagnosis of cerebral atherosclerosis (blood vessels in the brain have become blocked by fatty substances). During a review of Resident 68's care plan for spontaneous (sudden), pathological (caused by disease), stress (tiny breaks in bone) fracture (break in bone), initiated on 6/30/2022 and revised on 3/20/2024, the care plan interventions included to observe Resident 68 for sudden pain, swelling, and guarded movement (cautious with resistance, protecting against pain) of the extremity (arm or leg), handle gently and carefully during care, encourage mild exercises as tolerated and within joint limitation, and to notify the physician, responsible party, and the Hospice (specialized care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, quality of life rather than cure, and free of pain to live each day as fully as possible) Registered Nurse (Hospice RN) of changes in condition. During a review of Resident 68's physician orders, dated 4/24/2023, the physician orders indicated for the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) to provide passive range of motion ([PROM] movement of joint through the ROM with no effort from the person) to both arms, five times per week as tolerated. A review of another Resident 68's physician orders, dated 12/8/2023, indicated for the RNA to apply both elbow extension splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) and a right-hand roll (material placed in the hand to prevent the fingers from bending into the palm) for one to two hours per day, five times per week. A review of another Resident 68's physician orders, dated 2/13/2024, indicated for the RNA to provide PROM to both legs and apply a right knee extension splint for up to five hours, five times per week. During a review of Resident 68's physician orders, dated 3/7/2024, the physician orders indicated to give two tablets of acetaminophen (pain medication) 325 milligrams ([mg] unit of weight) by mouth two times per day for pain management. A review of another physician order, dated 3/7/2024, indicated to give 0.25 mg of Morphine Sulfate (pain medication for moderate to severe pain) to Resident 68 by mouth every two hours as needed for moderate to severe pain. During a review of Resident 68's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 6/10/2024, the MDS indicated Resident 68 was severely impaired for daily decision making, had ROM limitations in both arms and legs, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, toileting, upper and lower body dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Documentation Survey Report (record of nursing assistant tasks) for RNA in 6/2024, the Documentation Survey Report indicated Resident 68 refused RNA for PROM to both arms and legs, application of the right knee extension splint, and application of both arm extension splint and the right-hand roll on 6/10/2024, 6/18/2024, 6/19/2024, 6/20/2024, 6/25/2024, 6/26/2024, and 6/27/2024. During a review of Resident 68's Restorative Nursing (RNA) Weekly Summary - Range of Motion (ROM), dated 6/15/2024, 6/22/2024, and 6/29/2024, the RNA Weekly Summary - ROM indicated Resident 68 refused RNA for ROM and nursing (unknown) was notified. During a review of Resident 68's RNA Weekly Summary - Splint Care, dated 6/15/2024, 6/22/2024, and 6/29/2024, the RNA Weekly Summary - Splint Care indicated Resident 68 refused to wear the right-hand roll, right elbow extension splint, and the right knee splint and nursing (unknown) was notified. During a review of the RNA Monthly Meeting notes, dated 6/28/2024, the RNA Monthly Meeting notes indicated Resident 68 refused participating in RNA, had pain, and held the arm (unspecified) not wanting the RNA to move the arm. During a review of Resident 68's Documentation Survey Report (record of nursing assistant tasks) for RNA in 7/2024, the Documentation Survey Report indicated Resident 68 refused RNA for PROM to both arms and legs, application of the right knee extension splint, and application of both arm extension splint and the right-hand roll on 7/9/2024, 7/10/2024, 7/11/2024, 7/16/2024 7/17/2024, and 7/18/2024. The Documentation Survey Report for RNA was blank for 7/7/2024, 7/8/2024, 7/14/2024, 7/15/2024, 7/21/2024 and 7/22/2024. During a review of Resident 68's Restorative Nursing (RNA) Weekly Summary - ROM, dated 7/6/2024, 7/13/2024, and 7/20/2024, the RNA Weekly Summary - ROM indicated Resident 68 refused RNA for ROM and nursing (unknown) was notified. During a review of Resident 68's RNA Weekly Summary - Splint Care, dated 7/6/2024, 7/13/2024, and 7/20/2024 the RNA Weekly Summary - Splint Care indicated Resident 68 refused to wear the right-hand roll, right elbow extension splint, and the right knee splint and nursing (unknown) was notified. During a review of Resident 68's Hospice Skilled Nursing Visit Note, dated 7/15/2024 written by Hospice RN 1, the Hospice Skilled Nursing Visit Note indicated the facility's License Vocation Nurse (LVN) 1 notified Hospice RN 1 regarding Resident 68's right arm swelling and increased pain especially with movement. The Hospice Skilled Nursing Visit Note indicated Hospice RN 1 observed Resident 68s right arm which had whole arm swelling and pain with movement when gentle ROM was attempted. The Hospice Skilled Nursing Visit Note indicated Hospice RN 1 called Resident 68's Responsible Party (RP 1) to discuss observations during the visit, including worsening pain with movement in the right arm that prevents ROM, elevation of the arm, and adjustment to Resident 68's pain medication. During a review of Resident 68's physician orders, dated 7/15/2024, the physician orders indicated to discontinue Resident 68's two tablets of acetaminophen 325 mg by mouth two times per day. The physician order, dated 7/15/2024, indicated for Resident 68 to start taking one tablet of Norco (medication used to treatment moderate to severe pain) which included 5 mg of hydrocodone (pain medication used to treatment moderate to severe pain) and 325 mg of acetaminophen (Norco 5/325 mg), two times per day routinely, for pain management. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/23/2024 at 3:30 p.m. with Certified Nursing Assistant (CNA) 8 in the bedroom, Resident 68 was sitting up in a reclining wheelchair. Resident 68 was using the left arm to hold onto the right arm. CNA 8 stated Resident 68 had pain and swelling in the right elbow but had not fallen or had any injury. CNA 8 attempted to lift Resident 68's right arm but Resident 68 immediately used the left arm to grab and guard the right arm, had a facial wince (gesture in the face of pain), and had tears in the left eye. CNA 8 stated Resident 68 appeared to be in 10 out of 10 pain (pain scale from zero [0], indicating no pain, to 10, indicating the worst pain possible) in the right arm because Resident 68's eye was tearing up. CNA 8 stated Resident 68 complained of right elbow pain for one to two weeks. During an interview on 7/24/2024 at 7:47 a.m. with Restorative Nursing Aide (RNA) 3, RNA 3 stated the nurse (unknown) was giving Resident 68 pain medication prior to the RNA session this morning. RNA 3 stated Resident 68 was seen yesterday evening (7/23/2024) for RNA. RNA 3 stated Resident 68 did not tolerate the exercises to the right arm yesterday and did not apply the right arm splints due to Resident 68's right elbow pain and swelling. RNA 3 stated Resident 68 used the left arm to guard and hold onto the right arm. RNA 3 stated Resident 68 did not want anyone to touch her right arm due to the pain for the past month. RNA 3 stated Resident 68's right arm pain was reported to the Director of Rehabilitation (DOR) and the Director of Staff Development (DSD) during the monthly RNA Meeting. During an observation on 7/24/2024 at 8:24 a.m. with RNA 3 in the bedroom, Resident 68 was lying in bed with swelling throughout the right arm compared to the left arm. RNA 3 stood on the left side of the bed and performed exercises to Resident 68's left shoulder, elbow, and hand. RNA 3 stood on the right side of the bed, lifted the right arm at the shoulder joint, and attempted to extend the elbow. Resident 68 immediately held onto the right arm using the left hand and flexed (bent) the body as a pain response. RNA 3 stated Resident 68 was in pain. During an interview on 7/24/2024 at 9:15 a.m. with CNA 8, CNA 8 stated LVN 1 and the DSD were aware of Resident 68's right arm pain and Resident 68 was receiving pain medication. During a concurrent interview and record review on 7/24/2024 at 10:25 a.m. with the DSD, the RNA Monthly Meeting notes, dated 6/28/2024, were reviewed. The DSD stated the RNA reported Resident 68 had pain and refused RNA. The DSD stated she saw Resident 68 the next day and observed Resident 68 had swelling in the right arm and pulled the right arm away due pain when the DSD attempted to move the right arm. The DSD stated Resident 68 did not have any previous reports of pain in the right arm. During a concurrent interview and record review on 7/24/2024 at 10:42 a.m. with the DSD, Resident 68's Progress Notes, dated 6/1/2024 to 7/24/2024, and Change of Condition (COC) Assessment Forms were reviewed. The DSD stated the primary physician should be notified if a resident (in general) was in pain and refusing RNA sessions since it was a change of condition. The DSD reviewed Resident 68's Progress Notes and stated there was no documentation Resident 68's physician (MD 1) or the Hospice RN 1 was notified of Resident 68's change of condition, including right arm pain and refusing RNA. The DSD reviewed Resident 68's COC Assessment Forms and stated a COC Assessment Form was not completed for Resident 68's refusal to participate in RNA and increased pain to the right arm. (continued on next page)

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/2024 at 11:38 a.m. with the Director of Nursing (DON), Resident 68's Progress Notes, dated 6/1/2024 to 7/24/2024, and Change of Condition (COC) Assessment Forms were reviewed. The DON stated the facility provided all treatments to residents on hospice, including Resident 68. The DON stated the process when a resident (in general) refused RNA included the RNA informing the licensed nurse, who would gather more information and assess the resident. The DON stated Resident 68's refusal to participate in RNA and right arm pain was a change of condition that should have been reported to MD 1. The DON stated Resident 68's arm contractures increased Resident 68's risk for injury. The DON stated Resident 68 could be experiencing right elbow pain due to the contracture or could have an injury. The DON reviewed Resident 68's Progress Notes, dated 6/1/2024 to 7/24/2024, and the COC Assessment Forms. The DON stated Resident 68's clinical record did not include a COC Assessment Form and the Progress Notes did not indicate Resident 68 had right arm pain and refused RNA. The DON stated the licensed nurses should have completed documentation indicating Resident 68's right arm pain, refusal to participate in RNA, and a COC Form Assessment, which would have included notification to MD 1. The DON stated Resident 68's change of condition should have been monitored and addressed as a team, including the physician, nursing, and the hospice team. During a telephone interview on 7/25/2024 at 8:11 a.m. with Resident 68's Responsible Party (RP 1), RP 1 stated Hospice RN 1 usually called RP 1 regarding Resident 68's care. RP 1 stated the facility did not inform RP 1 that Resident 68 had right arm pain and refused exercises. RP 1 stated Hospice RN 1 contacted RP 1 about Resident 68's right arm swelling and changing medications but was not informed Resident 68 had right arm pain and refused exercises. RP 1 felt uncomfortable that the facility did not contact RP 1 directly and wanted to know the cause of Resident 68's right arm pain. During an interview on 7/25/2024 at 12:04 p.m. with Hospice RN 1, the Hospice physician (Hospice MD 1), and the DON, the Hospice RN 1 stated LVN 1 reported Resident 68 had more swelling, stiffness, and pain in right arm on 7/15/2024. Hospice RN 1 stated Resident 68 did have with more body stiffness and pain during the assessment on 7/15/2024. Hospice RN 1 stated Hospice RN 1 called RP 1 about the recommendation to adjust Resident 68's pain medication to Norco 5/325 mg, which Hospice MD 1 prescribed. Hospice MD 1 stated Resident 68's new onset pain and swelling could be associated with injury but would not recommend any tests since Resident 68 was on hospice care. During an interview on 7/25/2024 at 1:00 p.m. with the DON, the DON reviewed the facility's policy and procedure (P&P), titled Change of Condition. The DON stated the facility did not follow the P&P since the facility did not contact MD 1 and RP 1. During a concurrent interview and record review on 7/25/2024 at 5:29 p.m. with the DON, the DON reviewed Resident 68's Documentation Survey Report for 6/2024 and 7/2024. The DON stated the licensed nurse should have completed Resident 68's COC Assessment Form on 6/20/2024, which was Resident 68's fourth RNA refusal. The DON stated Resident 68's COC Assessment would have included communication to the DON, the hospice team, MD 1, and RP 1. The DON stated the DON knew about Resident 68's increased pain, inability to tolerate exercises with RNA, and increase in pain medication to Norco 5/325 mg on 7/15/2024 but did not further investigate the reason for Resident 68's need for increased pain medication. The DON stated the facility did not contact RP 1 because Hospice RN 1 called RP 1 on the facility's behalf. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/26/2024 at 11:30 a.m. with LVN 1, Resident 68's MAR for 6/2024 and Progress Notes, dated 6/1/2024 to 7/24/2024, were reviewed. LVN 1 stated either the CNA (unknown) or the Hospice CNA (unknown) informed LVN 1 that Resident 68 had pain the right arm which was new for Resident 68. LVN 1 stated Resident 68 moaned and grimaced with movement to the right arm on 6/21/2024 and administered Morphine. LVN 1 reviewed Resident 68's Progress Notes and stated LVN 1 contacted Resident 68's hospice when the Morphine was administered and should have documented the communication with the hospice team in Resident 68's Progress Note. LVN 1 stated Resident 68 did not have any pain if lying in bed but did have pain when moving Resident 68's right arm. LVN 1 stated the change of condition documentation, which included notifying the RN to further assess the resident, informing the resident's primary physician, and contacting the responsible party, was not completed for Resident 68's right arm pain and swelling because Resident 68 was on hospice. LVN 1 stated the facility educated LVN 1 to communicate with the hospice team if Resident 68 had any changes in condition. LVN 1 stated a COC Assessment Form should have been completed for Resident 68's right arm pain and swelling, which should have been monitored for 72 hours. LVN 1 stated she did not know Resident 68 refused RNA sessions. During a concurrent interview and record review on 7/26/2024 at 12:01 p.m. with LVN 1 and RNA 3, Resident 68's RNA Weekly Summary - ROM and Splint Care, dated 6/15/2024, 6/22/2024, and 6/29/2024, were reviewed. RNA 3 reviewed Resident 68's RNA Weekly Summaries, which indicated RNA 3 informed the licensed nurse. RNA 3 stated LVN 1 was not informed about Resident 68's refusal to participate in ROM and application of splints and did not remember which licensed nurse was informed. During a review of the facility's undated P&P titled, Change of Condition, the P&P indicated the facility ensured proper assessment and follow-through for any resident with a change in condition. The P&P indicated all changes of condition in a resident shall be handled promptly, which included prompt notification of the resident's physician, completion of the nursing report, daily assessment of the resident, and documentation of the change of condition. 44244 b. During a review of Resident 76's Admission Record, it indicated the facility admitted the resident on 4/4/2023 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities), hypertension (a condition in which the force of the blood against the artery walls is too high), and malignant neoplasm (commonly referred to as cancer [term for a diseases in which abnormal cells divide without control and can invade nearby tissues]) of skin. During a review of Resident 76's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/10/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident requires substantial/maximal assistance from staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's Care Plan (CP) titled, (Resident 76) has unspecified dermatitis. Location: generalized body rash (bilateral upper extremities, chest, back) ., initiated 6/13/2024, the CP indicated goals to promote healing without complications and will show no signs and development of infection. The CP indicated to monitor for signs and symptoms of infection (redness, presence of drainage, odor, pain), to report change in resident's kin condition to physician and resident's family, and to provide treatment as ordered. A review of Resident 76's physician orders indicated the following orders: -Monitor for symptoms and signs of IGAS: cough; sore throat; fever; skin infection (tenderness or pain, heat, swelling, serous drainage [a clear to yellow fluid that leaks out of a wound and may be a sign of infection] at affected site) and document yes/no, (if yes, indicate in the nurse's note and call physician), every shift until 8/17/2024, dated 7/17/2024. During an observation and interview on 7/23/2024 at 9:58 a.m., with Certified Nursing Assistant 9 (CNA 9) observed Resident 76 in a wheelchair (WC) outside the resident's room. Observed the resident with multiple open skin wounds on the left upper extremity and a clear dried substance crusted on the left dorsal wrist. CNA 9 stated the resident had multiple open wounds on the left arm and he did not know when it started. b.1. During a review of Resident 76's Medication Administration Record (MAR, a record of all medications taken by a resident on a day-to-day basis), the MAR indicated on 7/23/2024 for the evening shift (3 p.m. to 7 p.m.), LVN 3 documented the resident did not have any signs or symptoms of IGAS. During an observation, interview, and record review on 7/24/2024 at 11 a.m., with LVN 3, reviewed Resident 76's progress notes for July 2024. LVN 3 stated she was caring for Resident 76 on 7/23/2024 and 7/24/2024 and was not aware of any issues on the resident's skin. Observed LVN 3 assess Resident 76's left wrist while the resident sat in the WC in the hallway. LVN 3 stated the resident had open wounds with discharge on the L wrist that she was not aware of. LVN 3 stated she should do a skin assessment daily of the resident, but on 7/23/2024 and 7/24/2024 she only scanned the resident while administering his medications. LVN 3 stated she relies on the CNAs to report any skin changes. LVN 3 reviewed the resident progress notes and stated there was no documentation that the resident had a change of condition (COC, decline in a resident's status) on the skin of the left wrist. During an interview on 7/24/2024 at 11:30 a.m., with CNA 9, CNA 9 stated Resident 76 had an issue on his left wrist that was progressively getting worse. CNA 9 stated he did not know for how long the resident had the issue, but the charge nurses were aware. During an interview on 7/24/2024 at 2:09 p.m., with the Infection Preventionist (IP), the IP stated the facility currently has an Outbreak (OB, the occurrence of disease cases in excess of normal expectancy) for IGAS. The IP stated the guidance given to the facility by the Department of Public Health was to monitor all residents for signs and symptoms of IGAS including open wounds with signs of infection. The IP stated a resident identified with an open wound with signs of infection should immediately be placed in contact/droplet isolation (used to help prevent the spread of infectious agents that spread by direct or indirect contact with a resident or a resident's environment), the wound should be tested to confirm or rule out IGAS, the primary physician should be notified, and treatment should be started. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 7/24/2024 at 5:26 p.m., with the IP, reviewed Resident 76's Medication Administration Record (MAR) for 7/2024. The IP stated on 7/23/2024 evening shift LVN 3 documented that she monitored Resident 76 for s/s of IGAS and there were no s/s of skin infection present. The IP stated monitoring a resident's skin includes removing the clothing and completing a head-to-toe skin assessment. The IP stated when LVN 3 did not do a thorough skin assessment on Resident 76, LVN 3 did not identify the new skin issue and it resulted in a delay of the necessary care and treatment for the resident. During an interview on 7/24/2024 at 8:25 a.m., LVN 3 stated she did not remove Resident 76's sleeves or clothing to monitor the resident's skin. LVN 3 stated if she would have done a thorough skin assessment on 7/23/2024, she would have identified a change of condition. LVN 3 stated because she did not do a skin assessment, it resulted in a delay in care to the resident and a delay in placing the resident in isolation. LVN 3 stated things should have been done with more urgency. During an interview on 7/25/2025 at 9:42 a.m., with the IP, the IP stated anything new on a resident is a change of condition and should be reported. The IP stated LVN 3 did not follow the facility policy for monitoring for, identifying, and reporting a change of condition. During a review of the facility policy and procedure (P&P) titled, Change of Condition, last reviewed 1/10/2024, the (P&P) indicated the purpose of the policy was to ensure proper assessment and follow through for any resident with a change of condition. A change of condition is a sudden or marked difference in resident's drainage from a wound (anything abnormal), open or red areas, rashes, or skin conditions (swelling or discoloration). All changes of condition in a resident shall be handled promptly. The physician shall be called promptly. Documentation of change in condition shall be performed by the licensed nurse accordingly and a change of condition will be completed as indicated. [NAME] a review of the facility policy and procedure (P&P) titled, Charting and Documentation, last reviewed 1/10/2024, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including the date and time the procedure/treatment was provided, the assessment data and/or any unusual findings obtained during the procedure/treatment, whether the resident refused the procedure/treatment, and the notification of family, physician or other staff if indicated. b.2.During an interview on 7/24/2024 at 1:32 p.m., with TN 1, TN 1 stated she provides daily skin treatments to Resident 76's generalized body rash that includes the bilateral upper extremities (both arms). TN 1 stated the facility currently has an OB of IGAS and the public health nurse thinks the resident's rashes may be related to the OB. TN 1 stated she noticed on 7/23/2024 that Resident 76's left wrist was irritated and moist. TN 1 stated she did not report to anyone that the resident's wrist was irritated and moist. TN 1 stated Resident 76's left wrist was crustier today when she made rounds with the Wound Care Consultant (WCC) at 6:30 a.m. and the WCC verbally ordered antibiotics for an infection of Resident 76's left wrist wound. TN 1 stated any residents with open wounds that have signs and symptoms of infection are considered possibly contagious and should be placed in contact/droplet isolation. TN 1 stated she did not notify the IP or DON that Resident 76 had an open skin wound with an infection because she was very busy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's Skilled Nursing Facility Wound Care Consultant notes, dated 7/24/2024, it indicated Resident 76 had an infected wound with scant serous drainage. The notes indicated to start the resident on Keflex (a medication that treats infections) 500 milligrams (mg-unit of measurement), four times a day for seven days. During an interview on 7/24/2024 at 2:09 p.m., with the IP, the IP stated the facility currently has an OB of IGAS. The IP stated the guidance given to the facility by the Department of Public Health was to monitor all residents for signs and symptoms of IGAS including open wounds with signs of infection. The IP stated a resident identified with an open wound with signs of infection should immediately be placed in contact/droplet isolation, the wound should be tested to confirm or rule out IGAS, the primary physician should be notified, and treatment should be started. The IP stated TN 1 did not notify her there were any newly identified residents with open wounds that had signs and symptoms of infection. The IP stated TN 1 should have notified her in the morning regarding Resident 76's wound so she could have assessed the wound, placed the resident in isolation, swabbed the wound for IGAS, and started the antibiotic treatment because the facility has an OB. The IP stated they want to prevent the OB from spreading to other residents. During an interview on 7/24/2024 at 3:17 p.m., with the IP, the IP stated she just assessed Resident 76's left wrist and there is an open wound with serous drainage. The IP stated TN 1 should have identified Resident 76's change of condition on 7/23/2024 and again on 7/24/2024 when TN 1 was with the WCC. The IP stated TN 1 should have notified the IP immediately because there is an OB. The IP stated she spoke with TN 1 and TN 1 stated she did not notify the IP because she was overwhelmed. During an interview on 7/25/2025 at 9:42 a.m., with the IP, the IP stated anything new on a resident is a change of condition and should be reported. The IP stated TN 1 did not follow the facility policy for monitoring for, identifying, and reporting a change of condition. During a review of the facility policy and procedure titled, Change of Condition, last reviewed 1/10/2024, the P&P indicated the purpose of the policy was to ensure proper assessment and follow through for any resident with a change of condition. A change of condition is a sudden or marked difference in resident's drainage from a wound (anything abnormal), open or red areas, rashes, or skin conditions (swelling or discoloration). All changes of condition in a resident shall be handled promptly. The physician shall be called promptly. Documentation of change in condition shall be performed by the licensed nurse accordingly and a change of condition will be completed as indicated. During a review of the facility policy and procedure titled, Charting and Documentation, last reviewed 1/10/2024, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including the date and time the procedure/treatment was provided, the assessment data and/or any unusual findings obtained during the procedure/treatment, whether the resident refused the procedure/treatment, and the notification of family, physician or other staff if indicated. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Outbreak of Communicable Diseases, last reviewed 1/10/2024, the P&P indicated outbreaks of communicable diseases within the facility are promptly identified and managed. The infection preventionist and director of nursing are responsible for monitoring ill residents and staff and initiating transmission-based precautions as appropriate. The nursing staff are responsible for notifying the director of nursing services of newly symptomatic residents and providing infection surveillance data in a timely manner.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review the facility failed to ensure the residents were free from any physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one out of one sampled resident (Resident 46) investigated during a random observation by: 1. Failing to obtain an appropriate physician order for the use of bed pad alarm (a pressure-sensitive pad placed under the mattress or seat cushion that trigger an alarm or warning light when they detect a change in pressure). 2. Failing to assess Resident 46 quarterly for continued use of the bed pad alarm per facility policy and procedure. These deficient practices Resident 46 at risk for unnecessary prolonged use of restraints, restriction from freedom of movement which can lead to a decline in functioning. Findings: During a review of Resident 46's Admission Record, the facility admitted the resident on 8/26/2019 and readmitted on [DATE] with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood, and history of falling. During a review of Resident 46's History and Physical (H&P) dated 3/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/16/2024, the MDS indicated the resident had severe cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 46 used a bed alarm. During a review of Resident 46's Order Summary Report, it indicated the following physician's order dated 7/29/2022: - Non-Restraint. Apply pad alarm in bed as nursing intervention to alert staff for unassisted transfer and attempting to walk. Nursing staff to check proper placement and function every shift. During a review of Resident 46's care plan (CP), the CP indicated the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Risk for falls or injury related but not limited to dementia, generalized weakness, history of falls, and impaired cognition initiated on 7/4/2023 and a goal to reduce falls and injury daily with a target date 8/14/2024. The care plan indicated to apply bed pad alarm to alert staff for unassisted transfer and attempting to walk ad nursing staff to check proper placement and function every shift as one of the interventions. 2. Falling Star program: At risk for falls related to balance deficit, bladder/bowel dysfunction, cognitive impairment, history of falls, etc. initiated on 7/23/2024 and a goal to reduce risk for fall and /or injury thru appropriate interventions daily with a target date 8/14/2024, indicated bed pad alarm as one of the interventions. During a review of Resident 46's Fall Risk Assessments dated 5/16/2024, 2/12/2024, and 11/16/2023, it indicated the resident is a high risk for falls. During a review of resident 46's Restraint - Physical (Quarterly/Annual Evaluation), it indicated the facility reassessed the resident for continued use of the bed pad alarm on 2/12/2024, 11/30/2023, and 8/31/2023. There was no documented evidence Resident 46 was reassessed on 5/2024. During a concurrent observation and interview on 7/25/2024 at 10:34 a.m. with Registered Nurse 2 (RN 2) and Certified Nursing Assistant 3 (CNA 3) inside Resident 46's room, observed Resident 46 constantly moving in bed from left to right. RN 2 stated the bed pad alarm will trigger a sound when it detected a change in pressure when Resident 46 was moving from side to side. RN 2 stated the bed pad alarm was a nursing intervention and not considered a restraint. During a concurrent interview and record review on 7/26/2024 at 12:20 p.m., reviewed Resident 46's physician's order for bed alarm, informed consent, care plans, and restraint assessments with the Director of Nursing (DON). The DON stated the bed pad alarm was a nursing intervention to help prevent Resident 46 from rolling out of bed by accident and sustain injury. The DON stated the bed pad alarm is not considered a restraint by the facility as indicated in the physician's order. However, the DON stated the bed pad alarm is a restraint as it restricts the resident's movements because when the resident moves, the alarm will sound. The DON stated the physician's order should have indicated the bed pad alarm as a restraint. The DON verified there was no documented evidence of a restraint assessment/reassessment on 5/2024. The DON stated restraint assessments are supposed to be completed quarterly, annually, and as needed to evaluate necessity for continued use of the bed pad alarm. During a review of the facility's policy and procedure titled, Physical Restraints, last reviewed 1/10/2024, indicated physical restraint assessment and use shall be managed accordingly. The policy indicated the following: 1. The licensed nurse shall be responsible for obtaining an order form the attending physician, which is to include: - Specific type of restraint. - Purpose of the restraint. - Time and place of application. (continued on next page)

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Approaches to prevent decreased functioning when applicable. - Informed consent obtained from resident or from surrogate decision-maker. During a review of the facility's policy and procedure titled, Use of Restraints, last reviewed 1/10/2024, indicated retrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive method of restraints, or total restraint elimination.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49947 Based on interview and record review the facility failed to implement policies and procedures (P&P) related to screening (sometimes called background check - a process a person or company uses to verify that an individual is who they claim to be and do not possess a criminal record) procedures by failing to conduct a background check screening prior to employment of one of seven staff members (Restorative Nursing Assistant 1, [RNA 1]) investigated under the sufficient and competent nurse staffing facility task. This failure placed the residents at risk for abuse, neglect, and exploitation, and misappropriation of resident property for approximately nine months. Findings: During a concurrent interview and record review on 7/25/2024 at 3:30 p.m. with the Director of Staff Development (DSD), reviewed Restorative Nursing Aides (RNA - Certified Nursing Assistants [CNA] with specialized training to help residents regain their physical function and quality of life after illness or injury) 1's employee file. The DSD stated RNA 1 was hired on 4/9/2019 and did not have a background check screening until 1/15/2022. The background check came back with a criminal record of driving with a suspended license, misdemeanor. The DSD further stated she was unsure why the background check was completed late, and the delay put the residents at risk. During an interview on 7/25/2024 at 6:40 p.m. with the Director Of Nursing (DON), the DON stated background checks must be completed prior to employment to ensure the safety of the residents and staff. The DON further stated RNA 1 should not have started working until the background check was completed and that facility's policy was not followed. During a review of the facility's policy and procedure (P&P) titled, Hiring Process, last reviewed 1/10/2024, the P&P indicated prior to hiring of any employee, facility shall ensure provisions covering employment screening for potential history of abuse, neglect, or mistreatment of residents. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last reviewed 1/10/2024, the P&P indicated employee background checks must be conducted to prevent abuse, neglect, exploitation and misappropriation of residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49947 Based on interview and record review the facility failed to develop and implement a person-centered care plan with measurable objectives and timeframes to one out of three sampled residents (Resident 70) investigated during review of behavioral/emotional care area by failing to develop a care plan that addressed the resident's behavior of disrobing (the act of removing clothing). The deficient practice had violated Resident 70's right to maintain their highest practicable psychosocial well-being. Cross reference to F550. Findings: During a review of Resident 70's Admission Record, it indicated the facility admitted Resident 70 on 9/8/2023 with diagnoses including, but not limited to, dementia (loss of memory, language, and other thinking abilities that interfere with daily life and gets worse over time), Alzheimer's Disease (a common type of dementia), major depressive disorder (a persistent feeling of sadness and loss of interest), and anxiety disorder (excessive worry and feelings of fear and uneasiness). During a review of Resident 70's History and Physical (H&P), dated 11/8/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 70's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/13/2024, the MDS indicated Resident 70 had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and needed maximum assistance with upper body dressing, lower body dressing, toileting, hygiene, and bathing. During an observation on 7/23/2024 at 11:10 a.m., outside of Resident 70's room, Resident 70 could be viewed from the hallway disrobed from the waist up; the privacy curtain was partially drawn. Upon entering Resident 70's room, Resident 70 was up in her wheelchair with her shirt off, exposing her breasts while other residents were passing by the room. Resident 70 yelled out nonsensically (not making sense) when interview was attempted. During a concurrent observation and interview on 7/23/2024, at 11:15 a.m., inside Resident 70's room, with Restorative Nursing Assistant (RNA) 1, RNA 1 assisted Resident 70 back into her shirt and confirmed that Resident 70 had the behavior of disrobing in the past. RNA 1 further explained the behaviors are to be reported to the charge nurse. When asked about privacy, RNA 1 confirmed the curtain was not completely closed and pulled the curtain over to provide privacy. RNA 1 further stated he will report the behavior to the charge nurse. During an interview and record review on 7/23/2024, at 12:30 p.m., with the Director of Medical Records (DMR), reviewed the Clinical Chart of Resident 70. The DMR stated there were no care plan or notes for the behavior of disrobing for Resident 70. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 8:30 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she cared for Resident 70 approximately 4 times in the last month and Resident 70 disrobed once or twice. CNA 7 further stated she reported to the charge nurse each time the resident had the behavior of disrobing but does not remember which date or charge nurse she reported it to. During a concurrent interview and record review on 7/25/24 at 9:15 am with the Director of Staff Development (DSD), reviewed the MAR and care plan of Resident 70. The DSD stated on 7/23/2024 she was covering as the charge nurse for the first shift (7:00 a.m.- 3:30 p.m.) in station two (the station that covers the area of Resident 70) and did not remember if the behavior of disrobing was reported to her that day. The DSD stated she remembers Resident 70 disrobing her shirt since she was admitted to the facility and any new identified behaviors are to be reported to the supervising registered nurse. The DSD further stated the behaviors are tallied in the MAR, but disrobing is not listed as a behavior to monitor in the MAR nor was there a care plan to address the behavior of disrobing. During a concurrent interview and record review on 7/25/2024 at 9:55 a.m. with Registered Nurse (RN) 2, reviewed the MAR, care plan and notes of Resident 70. RN 2 stated the disrobing behavior was not reported to her and if the behavior is not in the MAR, it is not care planned. RN 2 confirmed disrobing is not mentioned in any notes, care plans or the MAR in Resident 70's chart. RN 2 further stated the resident could miss out on measurable goals and approaches that staff could use during care without the care plan. During a review of the facility's policy and procedure (P&P) titled, Policy: The Resident Care Plan, last reviewed 1/10/2024, the P&P indicated the resident care plan shall be implemented for each resident on admission and developed throughout the assessment process. It further indicated, although the care area assessment (CAAs) triggers most problem areas, all other problems not identified in the CAAs must also be included in the care plan. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, last reviewed 1/10/2024, the P&P indicated residents have the right to be informed of, and participate in, his or her care planning and treatment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview and record review, the facility failed to provide care in accordance with professional standards of quality by: 1. Failing to ensure the nurses were rotating (a method to ensure repeated injections are not administered in the same area) the insulin (a medication that regulates sugar in the blood) injection sites for one of two sampled residents, (Resident 10) investigated during review of insulin care area. 2. Administering insulin when the blood sugar (BS - the amount of sugar measured in the blood stream) was below the physician ordered parameters (a set of limits determining if a medication can be given) for one of two sampled residents (Resident 38) investigated during review of insulin care area. These deficient practices had the potential to result in bruising, pain, and/or lipohypertrophy (lump or accumulation of fatty tissue under skin) to Resident 10 and placed Resident 38 at risk for hypoglycemia (a condition when the blood sugar is dangerously low). Cross-reference to F760. Findings: 1. During a review of Resident 10's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 3/10/2023, with diagnoses including, but not limited to, type 2 diabetes mellitus (DM - a disease that occurs when the glucose, also called blood sugar, is too high) with unspecified complications, and long-term use of insulin. During a review of Resident 10's History and Physical (H&P), dated 3/4/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/13/2024, the MDS indicated the resident had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and required moderate assistance with eating, oral hygiene, and upper body dressing. During a review of Resident 10's Order Summary Report, printed on 7/25/2025, it indicated Resident 10 had an order increase on 7/4/2024 for Lantus (long-acting insulin) SoloStar Subcutaneous (SQ - into the fatty layer under the skin) Solution Pen-injector (a device used to administer medication into the body through a needle) 100 unit per milliliters (unit/ml, a unit of fluid volume) from 12 units to 14 units: inject 14 unit SQ at bedtime (HS). Hold if BS is less than 110. May give orange juice for BS less than 60. Rotate site. During a review of Resident 10's Medication Administration Record (MAR) for 5/2024-7/2024, indicated Lantus SoloStar SQ Solution Pen-injector; inject 14 units SQ at HS was administered on: 5/7/2024 at 8:00 p.m. on the left lower quadrant (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/8/2024 at 8:00 p.m. on the left lower quadrant 5/12/2024 at 8:00 p.m. on the abdomen 5/13/2024 at 8:00 p.m. on the abdomen 5/14/2024 at 8:00 p.m. on the abdomen 5/17/2024 at 8:00 p.m. on the right lower quadrant 5/18/2024 at 8:00 p.m. on the right lower quadrant 5/24/2024 at 8:00 p.m. on the left lower quadrant 5/25/2024 at 8:00 p.m. on the left lower quadrant 6/2/2024 at 8:00 p.m. on the abdomen 6/3/2024 at 8:00 p.m. on the abdomen 6/8/2024 at 8:00 p.m. on the abdomen 6/9/2024 at 8:00 p.m. on the abdomen 6/10/2024 at 8:00 p.m. on the abdomen 6/11/2024 at 8:00 p.m. on the abdomen 6/19/2024 at 8:00 p.m. on the left lower quadrant 6/20/2024 at 8:00 p.m. on the left lower quadrant 7/3/2024 at 8:00 p.m. on the left arm 7/4/2024 at 8:00 p.m. on the left arm 7/5/2024 at 8:00 p.m. on the left lower quadrant 7/6/2024 at 8:00 p.m. on the left lower quadrant 7/12/2024 at 8:00 p.m. on the left lower quadrant 7/13/2024 at 8:00 p.m. on the left lower quadrant 7/18/2024 at 8:00 p.m. on the left lower quadrant 7/19/2024 at 8:00 p.m. on the left lower quadrant (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/21/2024 at 8:00 p.m. on the left arm 7/22/2024 at 8:00 p.m. on the left arm During a concurrent interview and record review on 7/24/2024, at 3:00 p.m., with Registered Nurse (RN) 3, reviewed the Order Summary Report and the MAR of Resident 10 with RN 3. RN 3 stated there were multiple instances where the injection sites of the insulin were not rotated from 5/2024 to 7/2024. RN 3 stated the sites of insulin administration should be rotated to prevent bruising, hardening of the skin injection sites, and lipodystrophy (abnormal distribution of fat). During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, last reviewed on 1/10/2024, the P&P indicated to select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior and lateral areas of the thighs and abdomen. Avoid the are approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided FDA Label for Lantus SoloStar, undated, it indicated to rotate injection sites within the same area you choose each time form one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis (skin with lumps). Do not use the same spot for injection. 2. During a review of Resident 38's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/20/2019, with diagnoses including, but not limited to, type 2 diabetes mellitus without complications. During a review of Resident 38's H&P, dated 2/13/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident was severely cognitively impaired. The MDS indicated Resident 38 is dependent on eating, toileting, showers, dressing, personal hygiene, and mobility. During a review of Resident 38's Order Summary Report, printed on 7/25/2024, the Order Summary Report indicated an order for Basaglar (long-acting insulin) KwikPen Solution Pen-Injector 100 u/ml.: inject 4 units SQ one time a day. Rotate site; hold for BS less than 90. During a review of Resident 38's Care Plan (CP) focused on hypoglycemia related to DM, revised on 1/28/2024, the CP indicated to administer the medications as ordered. During a review of Resident 38's MAR for 4/2024 to 7/2024, the MAR indicated: a. Basaglar KwikPen Solution Pen-Injector 100 u/ml.: inject 4 units SQ one time a day. Rotate site; hold for BS less than 90, was administered on: 4/1/2024 at 8:00 a.m. on the right arm with a BS of 89. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2/2024 at 8:00 a.m. on the right lower quadrant with a BS of 80. During a concurrent interview and record review on 7/24/2024, at 2:30 p.m. with Licensed Vocational Nurse (LVN) 3, reviewed the Order Summary Report and the MAR of Resident 38 with LVN 3. LVN 3 stated, she gave the resident insulin with BS below 90, when it should have been held to prevent the BS from going down even lower. During an interview on 7/25/2024, at 6:25 p.m., with the Director of Nursing (DON), the DON stated the orders must be double checked; the parameters the physician ordered must always be followed to prevent hypoglycemia. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, last reviewed on 1/10/2024, the P&P indicated to check the order for the amount of insulin and the blood sugar parameter per physician order.

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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** 43988 Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial needs for one of one sampled resident (Resident 2) investigated during a random observation by: 1. Failing to ensure Certified Nursing Assistant 4 (CNA 4) did not apply the hydrocortisone (a type of medicine used for treating dermatitis [inflammation of the skin with dry skin, redness, and itchiness] and other skin conditions that cause itching) 1 percent (% - a unit of measurement) cream on the resident's abdomen, bilateral lower extremities (BLE), and bilateral breast folds. This deficient practice placed the resident at risk for adverse reactions due to CNA 4's application of the medication without physician's orders and not within the scope of CNA 4's practice. 2. Failing to ensure there was a physician's order prior to administering hydrocortisone 1% cream. These deficient practices placed Resident 2 at risk for developing adverse reactions from the topical medication such as skin irritation due to application of the medication without physician's orders. Findings: During a review of Resident 2's Admission Record, it indicated the facility admitted the resident on 9/29/2022 and readmitted on [DATE] with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dermatitis (inflammation of the skin with dry skin, redness, and itchiness), and dermatophytosis (also known as ringworm, a fungal infection of the skin that may affect the skin, hair, and nails). During a review of Resident 2's History and Physical (H&P) dated 2/20/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/5/2024, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance from staff with mobility; substantial/maximal assistance with tub/shower transfers; and supervision or touching assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 2's Order Summary Report, there was no documented evidence of an active physician's order for hydrocortisone 1% cream. The Order Summary Report indicated the following physician's order: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/9/2024: BLE rash - Cleanse with Normal saline (NS - a mixture of salt and water that can be used to rinse the sinuses, clean wounds, flush the eyes and more), pat dry, apply nystatin external cream (a type of medicine used to treat skin infections caused by fungus or yeast) 1000000 units per gram (unit/gm - a unit of measurement) to affected area, and leave open to air every day shift for fungal dermatitis for four (4) weeks. 6/26/2024: Bilateral breast fold rash - Cleanse with NS, pat dry, apply nystatin external cream 1000000 unit/gm to affected area, and leave open to air every day shift for fungal dermatitis for four (4) weeks. 6/26/2024: Abdomen rash - Cleanse with Cleanse with NS, pat dry, apply nystatin external cream 1000000 unit/gm to affected area, and leave open to air every day shift for fungal dermatitis for four (4) weeks. During a review of Resident 2's care plan (CP), the CP indicated alteration in skin integrity actual presence of rashes - fungal dermatitis on the following sites: -BLE initiated on 3/13/2024 last revised 7/8/2024 target date 8/17/2024. -Abdomen initiated on 3/27/2024 last revised 7/8/2024 target date 7/25/2024. -Bilateral breast fold initiated on 6/26/2026 2024 last revised 7/8/2024 target date 7/25/2024. The care plan indicated the following interventions but not limited to keep skin clean and dry provide skin care maintenance per MD order, provide treatment per MD order, provide ongoing assessment of treatment effectiveness and report to MD if ineffective. During a review of Resident 2's Treatment Administration Record (TAR - a report detailing the treatment, such as a drug, to a patient by a healthcare professional at a facility) for 5/2024, 6/2024, and 7/2024, there was no documented evidence Resident 2 received hydrocortisone 1% cream for rashes. During an observation on 7/23/2024 at 11:18 a.m. inside Resident 2's room, observed CNA 4 explaining to the resident regarding application of the hydrocortisone cream as requested by the resident. During an interview on 7/23/2024 at 11:27 a.m., with CNA 4, CNA 4 stated he applied the hydrocortisone cream as requested by the resident on both lower legs, abdomen, and bilateral breast folds. CNA 4 stated a nurse left the cream at the bedside (unable to tell which nurse). CNA 4 stated the hydrocortisone cream is a medication. During an interview on 7/23/2024 at 11:34 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated CNAs are not supposed to apply the hydrocortisone cream on the resident because it is a medication prescribed by the physician and applying the medication to the resident was not within the scope of the CNAs' practice. TN 1 stated the resident had an order for hydrocortisone cream as needed. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/25/2024 at 3:15 p.m., reviewed Resident 2's physician's order with TN 1. TN 1 stated there was no active physician's order for the application of hydrocortisone cream on Resident 2's rashes. TN 1 verified the current treatment order for Resident 2 was nystatin cream for the abdomen, BLE, and bilateral breast folds daily. TN 1 stated the hydrocortisone cream should not have been applied to Resident 2 as there was no physician's order and the resident can develop adverse reactions. During an interview on 7/26/2024 at 11:17 a.m., with the Director of Nursing (DON), the DON stated CNAs are not supposed to apply the hydrocortisone cream. The DON stated it is a medication prescribed by the physician and CNAs are not authorized to administer prescribed medications. The DON stated the hydrocortisone cream should not have been applied to Resident 2 as it was administering a medication without a physician's order. The DON stated if the resident had a previous order for hydrocortisone cream, the physician should have been called and obtain an order to continue the medication. During a review of the facility's Job Description for CNA dated 1/27/2022, it indicated the essential duties and responsibilities include the following but not limited to: Observe resident's skin and documentations and report skin conditions. Responsible for skin management that includes drying of skin and application of lotions, ointments, etc. ad indicated. During a review of the facility's policy and procedure (P&P) titled, Physician Orders and Telephone Orders, last reviewed 1/10/2024, the P&P indicated physician orders shall be obtained prior to the initiation of any medication or treatment from a person lawfully authorized to prescribe for and treat human illness.

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	555690	A. Building B. Wing	07/26/2024

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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. 44244 Based on observation, interview, and record review the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries (PI/PU, injuries to the skin and underlying tissue resulting from prolonged pressure) by failing to set the Low Air Loss Mattress (LALM, a mattress designed to prevent and treat PIs) in accordance with manufacturer's instructions for one randomly sampled resident (Resident 68) observed during the screening process. This deficient practice had the potential for the worsening of or development of PIs. Findings: During a review of Resident 68's Admission Record, it indicated the facility admitted the resident on 6/30/2022 and readmitted the resident on 1/13/2023 with diagnoses that included encounter for palliative care (hospice, a type of medical care for residents who are in the last stages of life), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), pressure ulcer of sacral region (at the bottom of the spine lying between the lumbar spine [L5] and the coccyx [tailbone]) stage two (the skin breaks open, wears away, or forms a wound which is usually tender and painful), and pressure induced deep tissue damage (purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue from pressure) of right heel. During a review of Resident 68's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/10/2024, the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make herself understood. The MDS further indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 68's physician orders, it indicated an order for a low airloss mattress; setting is based on the resident's current weight, adjust as indicated, for skin maintenance, dated 7/31/2023. During a review of Resident 68's Current Vital Sign form, dated 7/5/2024, it indicated the residents current weight was 77 pounds (lbs, a unit of measurement). During a review of Resident 68's Care Plan (CP) titled, Risk for developing pressure sore, and other types of skin breakdown related to: aging process, diabetes mellites (a chronic condition that affects the way the body processes blood sugar [glucose]), fragile skin, dermatophytosis (superficial skin, hair, and nail infections), pressure ulcer sacral region, pressure-induced deep tissue damage of right heel, initiated 6/30/2022, the CP indicated a goal to minimize the risk of skin breakdown/pressure sore. The CP indicated a low air loss mattress for wound care and management. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/23/2024 at 9:15 a.m., observed the door to Resident 68's room closed. Upon entering Resident 68's room observed the resident lying in bed on a LALM. Certified Nursing Assistant 8 (CNA 8) entered the resident's room and stated Resident 68's LALM pump was labeled Setting Weight: 100. CNA 8 stated the LALM pump was set to about 225 lbs. CNA 8 stated she did not set the LALM to 225 lbs. because she does not change the weight settings. Observed CNA 8 change the LALM pump setting to 100 lbs. During an observation, interview, and record review on 7/25/2024 at 11:37 a.m., with TN 1, reviewed Resident 68's Current Vital Sign form, dated 7/5/2024 and TN 1 stated Resident 68 weighed 77 lbs. TN 1 stated she sets and monitors the LALM settings for facility residents. TN 1 entered Resident 68's room and stated TN 1 labeled Resident 68's LALM pump to be set to 100 lbs., the closest setting to the resident's actual weight per the guidance provided by the company that provides the LALM. TN 1 stated Resident 68 needs a LALM because the resident had skin issues in the past and it is used for prevention. TN 1 stated the LALM has chambers that even out the weight of the resident and prevent pressure in one area of the body. TN 1 stated when the LALM is set to a weight that is too high it becomes firmer and could cause too much pressure with the potential for the development of a pressure ulcer. During an interview and record review on 7/25/2024 at 1 p.m., with Registered Nurse 2 (RN 2) reviewed Resident 68's Current Vital Sign form, dated 7/5/2024. RN 2 stated the LALM mattress is set according to the resident's weight and if the resident's weight is 77 lbs., then the LALM pump should be set to 100 lbs. RN 2 stated it was important to set the correct weight because the LALM is used for bedridden residents to prevent pressure ulcers. RN 2 stated when Resident 68's LALM was set to over 200 lbs. the LALM was incorrectly set. During a review of the facility provided LALM 1 Operation Manual, undated, it indicated the LALM 1 is designed for prevention, treatment, and management of pressure ulcers. Users can adjust air mattress to desired firmness according to the patient's weight or the suggestion from a health care professional. During a review of the facility policy and procedure (P&P) titled, Pressure-Reducing Mattress, last reviewed 1/10/2024, the P& indicated the objective of the policy was to provide the mattress that will prevent and/or minimize pressure on the skin and to provide comfort if resident prefers. During a review of the facility policy and procedure titled, Prevention of Pressure Injuries, last reviewed 1/10/2024, the P&P indicated the purpose of the policy was to ensure that all residents will receive the proper care based on their assessment to reduce the risks for pressure injuries. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. During a review of the facility policy and procedure titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, last viewed 1/10/2024, the P&P indicated the facility will assist with wound risk assessment to identify factors to ensure that all residents will receive necessary treatment and services to prevent skin breakdown and promote wound healing. The facility will implement measures for skin maintenance that may include providing a special device if needed. The pressure relieving device may include a LALM.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44244 Based on observation, interview, and record review, the facility failed to provide services to four of five sampled residents (Resident 52, 68, 21, and 69) with limited range of motion ([ROM] full movement potential of a joint where two bones meet]) and mobility (ability to move) concerns by failing to: 1. Ensure Resident 52's left (L) thumb spica wrist brace (a device to decrease movement and provide support and comfort through immobilization after an injury) was applied per physician orders. 2. Monitor the placement of Resident 52's left thumb spica wrist brace. 3. Notify Resident 52's physician regarding Resident 52's refusal to wear the left thumb spica wrist brace at all times. 4. Provide Resident 68 with ambulation (the act of walking) using a front-wheeled walker (FWW, an assistive device with two front wheels used for stability when walking), five times per week, in accordance with the physician orders, dated 11/25/2022, from 11/2022 to 12/2022. 5. Ensure Resident 68's Joint Mobility Screening (brief assessment of a resident's range of motion in both arms and both legs) - Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) and Joint Mobility Screening - Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function), dated 1/16/2023 and 1/19/2024, corresponded with the joint assessments included in the facility's policy titled, Joint Mobility Assessment. 6. Monitor Resident 68's ROM in each joint of both arms and legs during the quarterly Joint Mobility Screen, dated 4/19/2023 and 7/19/2023, in accordance with the facility's policy titled, Joint Mobility Assessment. 7. Provide Resident 68 with passive range of motion (PROM, movement of joint through the ROM with no effort from the person) to both legs, five times per week, in accordance with the physician orders, dated 3/14/2023, for the months of 5/2023, 11/2023, ad 1/2024. 8. Provide Resident 68 with PROM to both arms and the application of a right resting hand splint (material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist) and right elbow splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for one to two hours per day, five times per week, in accordance with the physician orders, dated 4/24/2023, during the months of 5/2023, 11/2023, and 1/2024. 9. Provide Resident 21 with PROM to both legs, five times per week, in accordance with the physician orders, dated 6/30/2023, during the months of 7/2023, 11/2023, 1/2024, and 3/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Provide Resident 69 with ambulation, three times per week, in accordance with the physician orders, dated 8/1/2023, during the months of 11/2023, 1/2024, 3/2024, and 4/2024. These failures had the potential for Resident 67, 21, 52, and 69 to develop ROM and mobility limitations, including development of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), decline in ambulation, and increased risk for injury. Findings: a. During a review of Resident 52's Admission Record, it indicated the facility admitted the resident on 5/12/2023 and readmitted the resident on 7/15/2024 with diagnoses that included intervertebral disc degeneration (the breakdown of the cushion between the bones of the spine) lumbar region (lower back), muscle weakness, history of falling, psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) and unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 52's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/6/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, dressing, and mobility. During a review of Resident 52's History and Physical (H&P), dated 7/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52's physician orders, it indicated an order to apply L spica wrist brace at all times, status post fall, until further clarification, dated 7/16/2024. During a review of Resident 52's CP titled, Occupational Therapist plan of care . initiated 7/16/2024, the CP indicated to apply the left thumb spica wrist brace at all times. During a review of Resident 52's CP titled, Impaired balance, transfer, ambulation, bed mobility initiated 7/16/2024, the CP indicated to apply the left thumb spica wrist brace at all times until further clarification, status post fall. During an observation on 7/23/2024 at 9:25 a.m., Resident 52 lay in bed. Observed the resident did not have a L thumb spica wrist brace applied. During an observation and interview on 7/23/2024 at 2:45 p.m., Certified Nursing Assistant 8 (CNA 8) stood next to Resident 52 sitting in a wheelchair in the hallway. CNA 8 stated Resident 52 did not have a brace on his L wrist. CNA 8 stated Resident 52 had not had a brace applied all day and she had not previously seen the resident wearing a brace on his wrist. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, interview, and record review on 7/23/2024 at 2:56 p.m., Licensed Vocational Nurse 4 (LVN 4) reviewed Resident 52's physician orders and progress notes for July 2024. LVN 4 stated the resident had a fall on 6/25/2024 and should wear the L wrist spica brace at all times. LVN 4 stated Resident 52's brace was in the nurse's station. Observed a blue brace on the desk in Nursing Station 1. LVN 4 stated the brace should be on the resident to make sure the wrist properly heals and to prevent pain. LVN 4 stated Resident 52 was noncompliant and often removed the wrist brace. LVN 4 stated when Resident 52 removes the wrist brace, staff should redirect the resident and reapply it. LVN 4 stated if the resident repeatedly refused the wrist brace, then the physician should be notified. LVN 4 stated there was no documentation by nursing staff that the resident removed the brace or that the physician was notified. During a concurrent interview and record review on 7/25/2024 at 11:56 a.m., with the Director of Rehabilitation (DOR), the DOR stated Resident 52 had a fall and needed to wear the L wrist brace until the resident was able to be seen by a hand specialist. The DOR stated the brace was a precaution to prevent further injury for a sprain in the ligament (injury to flexible bands of tissue that hold bones together). The DOR stated the physician's order for the splint would not be discontinued until the resident saw the hand specialist. During an interview on 7/25/2024 at 12:38 p.m. with Registered Nurse 2 (RN 2) reviewed Resident 52's physician orders and progress notes for July 2024. RN 2 stated on 7/23/2024 the resident had an order to wear the L spica wrist brace at all times. RN 2 stated if the resident was removing the brace the physician should have been notified and the order could have been clarified. RN 2 stated there was no documented evidence by nursing that the resident was noncompliant with the brace or that the physician was notified the resident was refusing the brace. RN 2 stated repetitive resident refusals warrants the need to make changes in the resident's plan of care. During an interview and record review on 7/25/2024 at 1:45 p.m., with the DOR, reviewed Resident 52's Occupational Therapy Treatment Encounter Notes, dated 7/16/2023 and stated it was documented that the resident refused the brace on multiple attempts and that nursing staff was notified. The DOR stated the Director of Nursing (DON) was aware the resident had repetitive behavior of refusing the brace. The DOR stated when the DON was notified the resident was refusing the brace, the expectation was that the DON would speak with the resident's physician. During a review of Resident 52's Occupational Therapy Treatment Encounter Notes, dated 7/16/2023, the notes indicated the resident was noncompliant to application of L thumb spica wrist brace and nursing was aware. During a review of Resident 52's Occupational Therapy Treatment Encounter Notes, dated 7/16/2023, the notes indicated the resident refused to apply the L hand brace despite multiple attempts and brace was given to the certified nursing assistant. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/2024 at 2:31 p.m., with the DON, the DON stated she was aware that Resident 52 had an order to wear the L spica wrist brace at all times. The DON stated there was a concern that there was no documented monitoring for the application of the brace, but there should have been. The DON stated the order was entered into the computer wrong and there was no task for monitoring. The DON stated the importance of monitoring the brace was to know if the resident had it on and to at least attempt to reapply it when it was found to not be on the resident. The DON stated when the resident repeatedly refused the treatment, the DON or the licensed nurses should have clarified the order with the physician to indicate the brace is worn as tolerated, but they did not. The DON stated the importance of monitoring for the placement of the brace, ensuring the resident was wearing the brace per the physician's order, and notifying the physician of the resident's refusal of the treatment was to promote healing and prevent further complications. During a review of the facility policy and procedure (P&P) titled, Assistive Devices and Equipment, last reviewed 1/10/2024, the P&P indicated the facility maintains and supervises the use of assistance devices and equipment for residents. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include, but are not limited to, mobility devices (splints, hand rolls, etc.). During a review of the facility policy and procedure titled, Physician Orders and Telephone Orders, last reviewed 1/10/2024, the P&P indicated physician's orders shall be obtained prior to the initiation of any treatment from a person lawfully authorized for treating human illness. All orders must be specific and complete with all necessary details to carry out the prescribed orders without any questions. 36943 b. During a review of Resident 68's Admission Record, the facility admitted Resident 68 on 6/30/2022 and readmitted on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), type 2 diabetes mellitus (high blood sugar), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), Vitamin D deficiency (not enough Vitamin D needed for strong bones and teeth), and contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to the right hand, both elbows, and both knees. The Admission Record indicated Resident 68 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/26/2024 with diagnosis of cerebral atherosclerosis (blood vessels in the brain have become blocked by fatty substances). During a review of Resident 68's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 6/10/2024, the MDS indicated Resident 68 was severely impaired for daily decision making, had ROM limitations in both arms and legs, and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, toileting, upper and lower body dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. 1. During a review of Resident 68's PT Discharge Summary, dated 11/25/2022, the PT Discharge Summary indicated Resident 68 safely ambulated 100 feet using a FWW. Resident 68's PT Discharge Summary indicated a recommendation for a RNA program for ambulation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's physician orders, dated 11/25/2022, the physician orders indicated for the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) to provide ambulation with FWW for 100 feet (unit of measure) or as tolerated. During a review of Resident 68's Documentation Survey Report (record of nursing assistant tasks) for RNA in 11/2022, the Documentation Survey Report was blank on 11/28/2022, 11/29/2022, and 11/30/2022. During a review of Resident 68's Documentation Survey Report for RNA in 12/2022, the Documentation Survey Report was blank on 12/7/2022, 12/8/2022, 12/9/2022, 12/12/2022, 12/13/2022, 12/16/2022, 12/19/2022, 12/20/2022 12/21/2022, 12/22/2022, 12/23/2022, 12/26/2022, 12/27/2022, 12/28/2022, 12/29/2022, and 12/30/2022. During an interview on 7/23/2024 at 8:52 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA (in general) was to maintain a resident's level of mobility achieved during therapy and to prevent decline. During an interview on 7/23/2024 at 12:15 p.m. with Resident 68's family member (FM 1), FM 1 stated Resident 68 used to walk upon admission to the facility but did not walk anymore. During a concurrent observation and interview on 7/23/2024 at 3:30 p.m. with Certified Nursing Assistant 8 (CNA 8) in the bedroom, Resident 68 was sitting up in a reclining wheelchair. Resident 68 did not have any active movement in the right arm but moved the left arm. CNA 8 sated Resident 68 used to walk without any assistive device upon admission to the facility but had a decline in ability to walk. During an interview on 7/26/2024 at 8:32 a.m. with the Director of Staff Development (DSD), the DSD stated a blank box in the Documentation Survey Report for RNA indicated the treatment was not completed. During a concurrent interview and record review on 7/26/2024 at 9:56 a.m. with the DSD, Resident 68's Documentation Survey Report for RNA in 11/2022 and 12/2022 were reviewed. The DSD stated the Documentation Survey Report for 11/2022 indicated RNA was not provided to Resident 68 at the end of the month. The DSD stated the Documentation Survey Report for 12/2022 indicated RNA was not provided to Resident 68 for most of the month. The DSD stated Resident 68 could potentially decline in the ability to walk without the provision of RNA services. During a review of the facility's undated policy and procedure (P&P) titled, Restorative Nursing Program, the P&P indicated the RNA program maintained the resident's functional ability and reduce further decline. The P&P also indicated the RNA would walk with resident requiring ambulation as prescribed by the physician. 2. During a review of Resident 68's Joint Mobility Screening - OT, dated 1/16/2023 and 1/19/2024, the Joint Mobility Screening - OT indicated assessments of Resident 68's PROM in each shoulder, elbow, wrist, and hand. Each joint included an assessment of full ROM, minimal loss (less than [<] 25 percent [%] ROM loss), moderate loss (26 to 50% ROM loss), severe loss (more than [>] 50% loss), and not applicable (N/A). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Joint Mobility Screening - PT, dated 1/16/2023 and 1/19/2024, the Joint Mobility Screening - PT indicated assessments of Resident 68's PROM in each hip, knee, and ankle. Each joint included an assessment of full ROM, minimal loss, moderate loss, severe loss, and N/A. During a review of the facility's P&P titled, Joint Mobility Assessment, the P&P indicated PT and OT will assess each joint for ROM and document finding on the Joint Mobility Assessment annually. The P&P indicated limitations in joint mobility will be defined as within normal limits (WNL, full range of motion without limitation), minimal loss, moderate loss, moderate/severe loss (decrease in joint mobility of 50% to 75%, 25% to 50% available range), and severe loss. During a concurrent interview and record review on 7/25/2024 at 2:46 p.m. with the DOR, Resident 68's Joint Mobility Screening - OT and PT, dated 1/16/2023 and 1/19/2024, and the facility's P&P titled, Joint Mobility Assessment, were reviewed. The DOR stated PT and OT performed Joint Mobility Screenings annually. The DOR stated the joint mobility limitation categories included in Resident 68's Joint Mobility Screenings were different from the joint mobility limitation categories included in the facility's P&P. The DOR stated Resident 68's Joint Mobility Screenings did not include an assessment category for moderate/severe loss. 3. During a review of Resident 68's Joint Mobility Screen - Quarterly, dated 4/19/2023, the Joint Mobility Screen - Quarterly indicated Resident 68 maintained the assessed mobility (unspecified) and tolerated the RNA program for PROM to both arms, five times per week. The Joint Mobility Screen did not include an assessment of the ROM of each major joint in both arms and legs. During a review of Resident 68's Joint Mobility Screen - Quarterly, dated 7/19/2023, the Joint Mobility Screen - Quarterly did not include an assessment of the ROM of each major joint in both arms and legs. During a review of the facility's undated P&P titled, Joint Mobility Assessment, the P&P indicated the facility determined a resident's ROM for all major joints to increase, maintain, or prevent decline in joint mobility. The P&P indicated all residents will be assessed for joint mobility limitations upon admission and at minimum every three months. During an interview on 7/25/2024 at 2:46 p.m. with the MDS Assistant (MDSA), Resident 68's Joint Mobility Screen - Quarterly, dated 4/19/2023 and 7/19/2023, and the facility's P&P titled, Joint Mobility Assessment, were reviewed. The MDSA stated she performed the quarterly Joint Mobility Screen. The MDSA stated the purpose of quarterly screens was to ensure the resident (in general) did not decline in ROM. The MDSA reviewed Resident 68's quarterly Joint Mobility Screens and stated they did not include Resident 68's joint mobility in each major joint. The MDSA stated the quarterly Joint Mobility Screens did not follow the facility's P&P to assess each major joint to prevent ROM loss. 4. During a review of Resident 68's physician orders, dated 3/14/2023, the physician orders indicated for the RNA to provide PROM to both legs. Another physician order, dated 4/24/2023, indicated for the RNA to provide resident 68 with PROM to both arms and apply a right resting hand splint and right elbow extension splint for one to two hours per day, five times per week. (continued on next page)

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Documentation Survey Report for RNA in 5/2023, the Documentation Survey Report indicated not applicable NA for RNA treatment on 5/1/2023, 5/4/2023, 5/5/2023, 5/6/2023, 5/7/2023, 5/10/2023, 5/11/2023, 5/12/2023, 5/13/2023, 5/17/2023, and 5/19/2023. During a review of Resident 68's Documentation Survey Report for RNA in 11/2023, the Documentation Survey Report was blank for RNA treatment on 11/3/2023, 11/10/2023, 11/16/2023, 11/17/2023, 11/24/2023, 11/27/2023, 11/28/2023, and 11/30/2023. During a review of Resident 68's Documentation Survey Report for RNA in 1/2024, the Documentation Survey Report was blank for RNA treatment on 1/2/2024, 1/3/2024 1/7/2024, 1/9/2024, 1/11/2024, 1/14/2024, 1/15/2024, 1/16/2024, and 1/18/2024. During an interview on 7/26/2024 at 8:32 a.m. with the DSD, the DSD stated a blank box in the Documentation Survey Report for RNA indicated the treatment was not completed. During an concurrent interview and record review on 7/26/2024 at 9:56 a.m. with the DSD, Resident 68's Documentation Survey Reports for RNA were reviewed, including 5/2023, 11/2023, and 1/2024. The DSD stated Resident 68's Documentation Survey Report for RNA indicated N/A in 5/2023 because a Certified Nursing Assistant (CNA) entered documentation for the RNA, which disabled the RNA from documenting the treatment session. The DSD stated the Documentation Survey Report for 5/2023, 11/2023, and 12/2023 did not indicate RNA provided treatment to Resident 68 in accordance with the physician orders. The DSD stated Resident 68 had the potential to decline in mobility without the provision of RNA treatment. During a review of the facility's undated P&P titled, Restorative Nursing Program, the P&P indicated the RNA program maintained the resident's functional ability and reduce further decline. c. During a review of Resident 21's Admission Record, the facility admitted Resident 21 on 5/4/2022 and readmitted on [DATE] with diagnoses including Alzheimer's disease (generalized brain deterioration that leads to progressive decline in mental ability severe enough to interfere with daily life), history of falling, fracture (break in bone) of the right femur (hip bone), and presence of a right artificial (made or produced by human being rather than naturally occurring) hip joint. During a review of Resident 21's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 6/30/2023, the PT Discharge Summary indicated a recommendation for Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) to perform passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises to both legs. During a review of Resident 21's physician orders, dated 6/5/2023, the physician orders indicated for the RNA to provide PROM to both legs as tolerate, five times per week. During a review of Resident 21's Documentation Survey Report (record of nursing assistant tasks) for RNA in 7/2023, the Documentation Survey Report was blank on 7/2/2023, 7/6/2023, 7/7/2023, 7/10/2023, 7/14/2023, 7/17/2023, 7/24/2023, 7/25/2023, 7/26/2023, and 7/31/2023. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Documentation Survey for RNA in 11/2023, the Documentation Survey Report was blank on 11/6/2023, 11/13/2023, 11/20/2023, 11/22/2023, 11/24/2023, 11/27/2023, 11/28/2023, 11/29/2023, and 11/30/2023. During a review of Resident 21's Documentation Survey Report for RNA in 1/2024, the Documentation Survey Report was blank on 1/17/24, 1/18/2024, 1/19/2024, and 1/20/2024. During a review of Resident 21's Documentation Survey Report for RNA in 3/2024, the Documentation Survey Report was blank on 3/13/2024, 3/14/2024, 3/15/2024, 3/19/2024, 3/20/2024, 3/21/2024, 3/22/2024, 3/23/2024, 3/28/2024, and 3/30/2024. During a review of Resident 21's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 6/14/2024, the MDS indicated Resident 21 had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 21 had ROM impairments in both arms and one leg and required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting, showering/bathing, dressing, rolling in bed to either side, sit to stand transfers, and chair/bed-to-chair transfers. During an interview on 7/23/2024 at 8:52 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA (in general) was to maintain a resident's level of mobility achieved during therapy and to prevent decline. During an observation on 7/23/2024 at 9:38 a.m., Resident 21 was sleeping while seated in a wheelchair. During an observation on 7/23/2024 at 9:44 a.m., Resident 21 woke up but was non-verbal. Resident 21 moved both arms and legs. During a concurrent interview and record review on 7/26/2024 at 8:32 a.m. with the Director of Staff Development (DSD), Resident 21's Documentation Survey Reports were reviewed, including 11/2023, 1/2024, and 3/2024. The DSD stated a blank box in the Documentation Survey Report for RNA indicated the treatment was not completed. The DSD stated Resident 21 was not seen for PROM to both legs, five times per week, in accordance with the physician orders during the months of 7/2023, 11/2023, 1/2024, and 3/2024. The DSD stated Resident 21 had the potential to decline in mobility without the provision of RNA treatment. During a review of the facility's undated policy and procedure(P&P) titled, Restorative Nursing Program, the P&P indicated the RNA program maintained the resident's functional ability and reduce further decline. d. During a review of Resident 69's Admission Record, the facility admitted Resident 69 on 2/13/2023 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), osteoporosis (medical condition in which the bones become brittle and fragile from loss of tissue), and repeated falls. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 5/10/2023, the PT Discharge Summary indicated Resident 69 walked 125 feet without an assistive device with minimal assistance (physical steadying assistance or requires less than 25 percent (%) physical assistance to perform the task). The PT Discharge Summary indicate to a recommendation for Resident 69 to ambulate with Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) using handheld assistance ([HHA] handheld physical assistance of another person). During a review of Resident 69's physician orders, dated 5/10/2023, the physician orders indicated for the RNA to provide ambulation (the act of walking) as tolerated using a front-wheeled walker (FWW, an assistive device with two front wheels used for stability when walking), three times per week. Resident 69's physician orders, revised on 8/1/2023, indicated for the RNA to provide ambulation with HHA, three times per week. During a review of Resident 69's Documentation Survey Report (record of nursing assistant tasks) for RNA in 11/2023, the Documentation Survey Report was blank on 11/2/2023, 11/22/2023, 11/24/2023, 11/30/2023. During a review of Resident 69's Documentation Survey Report for RNA in 1/2024, the Documentation Survey Report was blank on 1/9/2024, 1/16/2024, 1/17/2024, and 1/18/2024. During a review of Resident 69's Documentation Survey Report for RNA in 3/2024, the Documentation Survey Report was blank on 3/13/2024, 3/14/2024, 3/19/2024, 3/20/2024, 3/21/2024, and 3/28/2024. During a review of Resident 69's Documentation Survey Report for RNA in 4/2024, the Documentation Survey Report was blank on 4/14/2024, 4/23/2024, 4/24/2024, and 4/25/2024. During an interview on 7/23/2024 at 8:52 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA (in general) was to maintain a resident's level of mobility achieved during therapy and to prevent decline. During an observation on 7/25/2024 at 9:17 a.m. with Restorative Nursing Aide 3 (RNA 3) in the hallway, Resident 69 was awake and sitting up in a wheelchair. RNA 3 placed a gait belt (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) around Resident 69's waist. RNA 3 held onto Resident 69's hands to assist Resident 69 with transferring from sit to stand. Resident 69 walked down the facility's hallways with RNA 3's HHA. During an interview on 7/26/2024 at 8:32 a.m. with the Director of Staff Development (DSD), the DSD stated a blank box in the Documentation Survey Report for RNA indicated the treatment was not completed. During a concurrent interview and record review on 7/26/2024 at 9:27 a.m. with the DSD, Resident 69's Documentation Survey Reports for RNA were reviewed, including 11/2023, 1/2024, 3/2024, and 4/2024. The DSD stated Resident 69 was not seen for ambulation, three times per week, in accordance with Resident 69's physician orders. The DSD stated Resident 69 had the potential to decline in mobility without the provision of RNA treatment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated policy and procedure(P&P) titled, Restorative Nursing Program, the P&P indicated the RNA program maintained the resident's functional ability and reduce further decline.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43988 Based on observation, interview, and record review the facility failed to provide an environment free from accidents and hazards, ensure residents received adequate supervision, and implement interventions to prevent accidents for five out of five sampled residents (Residents 2, 22, 46, 62, and 68) investigated under the Accidents care area by: 1. Failing to ensure two tubes of hydrocortisone (a type of medicine used for treating dermatitis [inflammation of the skin with dry skin, redness, and itchiness] and other skin conditions that cause itching) 1 percent (% - a unit of measurement) cream were not left unattended and easily accessible on top of Resident 2's overbed table. This deficient practice placed other residents at risk for obtaining topical medication without staff knowledge resulting in accidental ingestion causing harm to residents. 2. Failing to ensure Residents 22, 46, and 62's wheelchair were not placed on top of floor mat while the residents were up on the wheelchair. This deficient practice had the potential to result in the wheelchair becoming unstable on a soft surface resulting in resident injury. 3. Failing to ensure Resident 46's bed pad alarm (a pressure-sensitive pad placed under the mattress or seat cushion that trigger an alarm or warning light when they detect a change in pressure) was functioning properly. This deficient practice had the potential to result in Resident 46 exiting the bed without staff knowledge and sustaining injuries from falls. 4. Failing to ensure one of five sampled residents (Resident 68) with limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility (ability to move) was transferred from the bed to the wheelchair in a manner to reduce the risk of injury to Resident 68, including the right arm which had pain and swelling. This failure placed Resident 68 at increased risk for physical injury. Cross reference to F580. Findings: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 2's Admission Record, it indicated the facility admitted the resident on 9/29/2022 and readmitted the resident on 1/25/2023 with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dermatitis (inflammation of the skin with dry skin, redness, and itchiness), and dermatophytosis (also known as ringworm, a fungal infection of the skin that may affect the skin, hair, and nails). During a review of Resident 2's History and Physical (H&P) dated 2/20/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/5/2024, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance from staff with mobility; substantial/maximal assistance with tub/shower transfers; and supervision or touching assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 2's Order Summary Report, there was no documented evidence of an active physician's order for hydrocortisone 1% cream. During an observation on 7/23/2024 at 11:18 a.m. inside Resident 2's room, observed CNA 4 explaining to the resident regarding application of the hydrocortisone cream as requested by the resident. During an interview on 7/23/2024 at 11:27 a.m., with CNA 4, CNA 4 stated he applied the hydrocortisone cream as requested by the resident on both lower legs, abdomen, and bilateral breast folds. CNA 4 stated a nurse left the cream at the bedside (unable to tell which nurse). CNA 4 stated the hydrocortisone cream is a medication. During a concurrent observation and interview on 7/23/2024 at 11:34 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated there was a tube half empty tube of hydrocortisone cream on top of resident's overbed table. TN 1 there should be no medication left at the resident's bedside at all times as they are prescribed medications for certain conditions and other residents can easily access the medication by accident and may result in injury. During an interview on 7/26/2024 at 11:17 a.m., with the Director of Nursing (DON), the DON stated the hydrocortisone cream should not have been left at the bedside as it placed other residents at risk of easy access to the medication and may result in injury. During a review of the facility's policy and procedure titled, Med Pass, last reviewed 1/10/2024, indicated do not leave medications at the bedside for resident unless ordered by physician. b. During a review of Resident 22's Admission Record, it indicated the facility admitted the resident on 2/2/2017 and readmitted on [DATE] with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's History and Physical (H&P) dated 4/15/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/2/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance with eating and mobility; supervision or touching assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 22's Order Summary Report, it indicated: -5/22/2024: [Non-RESTRAINT] Low bed with bilateral floor mat to decrease potential injury (Informed consent obtained from During a review of Resident 22's Fall Risk assessment dated [DATE], it indicated the resident was a high risk for falls. During a review of Resident 22's care plan (CP), the CP indicated the following: 1. Resident is on low bed with bilateral floor mat to prevent or reduce incident of injury or fall as well as for comfort of getting in and out of bed initiated 5/23/2024 last revised 6/16/2026 target date 8/31/2024 indicated to attempt to use less restrictive devices on an ongoing basis. 2. Resident 22 has self-car deficits needs assistance with ADLs; supervision touching assistance with transfers and ambulation in room and corridor initiated 5/29/2018 last revised 6/16/2024 target date 8/31/2024 indicated to provide a safe environment as one of the interventions. During a concurrent observation and interview on 7/23/2024 at 9:32 a.m., inside Resident 22's room, observed resident in the wheelchair and the wheelchair was on top of the floor mat. Certified Nursing Assistant 3 (CNA 3) stated the wheelchair is not supposed to be left on top of the floor mat while a resident is sitting on it. CNA 3 stated the resident 's wheelchair can get caught on the floor mat and the resident may fall from the wheelchair when the resident tries to move. During an interview on 7/26/2024 at 12:20 p.m., with the Director of Nursing (DON), the DON stated the wheelchair should not be left on top of the floor mat while the resident is sitting on it as it can get unstable and can cause accident and/or injury. During a review of the facility provided instruction manual, undated, on Medical Equipment 2 (ME 2), it indicated the following: -Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. -Failure to comply with instructions, warnings, and cautions may result in serious injury to the patient. -Keep sharp objects away from mat or damage may occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 46's Admission Record, it indicated the facility admitted the resident on 8/26/2019 and readmitted the resident on 7/29/2022 with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood, and history of falling. During a review of Resident 46's History and Physical (H&P) dated 3/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/16/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident was using a bed alarm. During a review of Resident 46's Order Summary Report, it indicated the following physician's order: -7/29/2022: [NON-RESTRAINT] Apply pad alarm in bed as nursing intervention to alert staff for unassisted transfer and attempting to walk. Nursing staff to check proper placement and function every shift. -8/10/2023: [Non-RESTRAINT] Low bed with bilateral floor mat to decrease potential injury (Informed consent obtained from resident/responsible party after explanation of risks and benefits and verified with MD) every shift. During a review of Resident 46's care plan (CP), the CP indicated the following: 1. Risk for falls or injury related but not limited to dementia, generalized weakness, history of falls, and impaired cognition initiated on 7/4/2023 and a goal to reduce falls and injury daily with a target date 8/14/2024. The care plan indicated the following interventions: - Apply bed pad alarm to alert staff for unassisted transfer and attempting to walk ad nursing staff to check proper placement and function every shift. - Low bed with bilateral pads. - provide resident with a safe and clutter- free environment. 2. Falling Star program: At risk for falls related to balance deficit, bladder/bowel dysfunction, cognitive impairment, history of falls, etc. initiated on 7/23/2024 and a goal to reduce risk for fall and /or injury thru appropriate interventions daily with a target date 8/14/2024. The care plan indicated the following interventions: - Low bed with bilateral pads in place - Quarterly review of the fall risk assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Bed pad alarm During a review of Resident 46's Fall Risk Assessments dated 5/16/2024, 2/12/2024, and 11/16/2023, it indicated the resident is a high risk for falls. During a concurrent observation and interview on 7/23/2024 at 10:17 a.m., inside Resident 46's room, observed resident in the wheelchair and with wheelchair was on top of the floor mat. Certified Nursing Assistant 1 (CNA 1) stated the wheelchair is not supposed to be left on top of the floor mat while the resident is sitting on it. CNA 1 stated the resident wheelchair can get caught on the floor mat and the resident may fall from the wheelchair when the resident tries to move. During a concurrent observation and interview on 7/25/2024 at 10:34 a.m. with Registered Nurse 2 (RN 2) and Certified Nursing Assistant 3 (CNA 3) inside Resident 46's room, observed Resident 46 constantly moving in bed from left to right. Observed Resident 46's bed alarm box hanging on the headboard with the cord connected to the pad alarm underneath the resident's sheets. RN 2 and CNA 3 turned resident towards the left side and the bed alarm did not trigger an alarm. RN 2 and CNA 3 verified the bed pad alarm did not function when the resident was turned to the side. CNA 3 stated she checks the alarm functionality by pressing on the sensor pad then release and the alarm will sound. RN 2 stated the box will emit beeping sounds and a flashing red light when the battery is low. RN 2 stated there was no flashing red light and beeping sound from the bed alarm box. RN 2 tested alarm functionality by pressing her hand and knee and release pressure on the sensor pad but the alarm did not sound. RN 2 stated the bed pad alarm should be in working order to alert staff because Resident 46 is at risk for rolling out of the bed accidentally and sustaining injury due to constant moving from left to right while in bed. During an interview on 7/26/2024 at 12:20 p.m., the Director of Nursing (DON), the DON stated bed pad alarm functionality should be checked every shift every shift. The DON stated monitoring of functionality is documented in the Medication Administration Record (MAR). The DON stated the bed pad alarm should be functioning well as the resident can accidentally roll out of the bed and sustain an injury. The DON stated the wheelchair should not be left on top of the floor mat while the resident is sitting on it as the wheelchair can get unstable and may cause accident and/or injury. During a review of the facility provided instruction manual, undated, on Medical Equipment 1 (ME 1) indicated the following: -It is the responsibility of the caregiver to ensure that the product is properly installed, tested , and functioning correctly before each use. -Low Battery indicator on the front of the alarm will flash or light up when the battery is low and needs to be replaced. Replace battery immediately if indicator flashes or lights. -Bench test monitor and sensor pad prior to use. Use the hand to apply pressure to the sensor pad. The monitor will automatically sense the pressure and provide an audible beep when activated. Remove the pressure and the alarm will sound. During a review of the facility provided instruction manual, undated, on Medical Equipment 2 (ME 2) indicated the following: (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. -Failure to comply with instructions, warnings, and cautions may result in serious injury to the patient. -Keep sharp objects away from mat or damage may occur. During a review of the facility's policy and procedure titled, Accident/Incident Prevention, last reviewed 1/10/2024, indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control. The policy indicated: -The facility will repair equipment to prevent defective equipment such as wheelchairs, geri-chairs with loose nuts/bolts, etc. -Identify and eliminate electrical appliances with frayed wires, lock up cleaning supplies not in use, and identify wet floors. d. During a review of Resident 62's Admission Record, it indicated the facility admitted the resident on 2/2/2017 and readmitted the resident on 2/27/2018 with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), mood disorder (a mental health condition that primarily affects emotional state experiencing long periods of extreme happiness, extreme sadness, or both), and dermatophytosis (also known as ringworm, a fungal infection of the skin that may affect the skin, hair, and nails). During a review of Resident 62's History and Physical (H&P), dated 2/3/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/11/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with toileting; partial/moderate assistance with mobility and ambulation; dependent with eating and showers; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 62's Order Summary Report, it indicated: -10/20/2023: [Non-RESTRAINT] Low bed with bilateral floor mat to decrease potential injury (Informed consent obtained from resident/responsible party after explanation of risks and benefits and verified with MD) every shift. During a review of Resident 62's Fall Risk assessment dated [DATE], 4/11/2024, and 1/11/2024, the assessments indicated the resident was a high risk for falls. During a review of Resident 62's care plan (CP), the CP indicated the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident is on low bed with bilateral floor mat to prevent or reduce incident of injury or fall as well as for comfort of getting in and out of bed initiated 1/22/2023 last revised 10/23/2023 target date 10/10/2024 indicated for the prevention/management of safety/injury from potential falls and attempt to use less restrictive devices on an ongoing basis as a few of the interventions. 2. Resident 62 has self-car deficits needs assistance with ADLs; partial to maximal assistance with bed mobility, supervision to substantial assistance with transfers and partial to moderate assistance with ambulation in room and corridor initiated 10/1/2021 last revised 6/16/2024 target date 8/31/2024 indicated to provide a safe environment as one of the interventions. 3.Resident 62 is at risk for falls/injury related to dementia and abnormalities of gait/mobility initiated 7/1/2023 last revised 10/23/2023 target date 10/10/2024 indicated to provide resident with a safe and clutter free environment and keep frequently used personal items within easy reach. During a concurrent observation and interview on 7/23/2024 at 10:17 a.m., inside Resident 62's room, observed the resident in the wheelchair and the wheelchair was on top of the floor mat. Certified Nursing Assistant 3 (CNA 3) stated the wheelchair is not supposed to be left on top of the floor mat while a resident is sitting on it. CNA 3 stated the resident 's wheelchair can get caught on the floor mat and the resident may fall from the wheelchair when the resident tries to move. During a concurrent observation and interview on 7/23/2024 at 10:18 a.m., inside resident 62's room, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated wheelchairs with residents sitting on it should not be left on top of the floor mat as the floor mat can get unstable and could result into accidents or injury. During an interview on 7/26/2024 at 12:20 p.m., with the Director of Nursing (DON), the DON stated the wheelchair should not be left on top of the floor mat while the resident is sitting on it as the wheelchair can get unstable and cause accident and/or injury. During a review of the facility provided instruction manual, undated, on Medical Equipment 2 (ME 2), it indicated the following: -Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. -Failure to comply with instructions, warnings, and cautions may result in serious injury to the patient. -Keep sharp objects away from mat or damage may occur. During a review of the facility's policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed 1/10/2024, thr P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control. The policy indicated: -The facility will repair equipment to prevent defective equipment such as wheelchairs, geri-chairs with loose nuts/bolts, etc. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Identify and eliminate electrical appliances with frayed wires, lock up cleaning supplies not in use, and identify wet floors. 36943 e. During a review of Resident 68's Admission Record, the facility admitted Resident 68 on 6/30/2022 and readmitted the resident on 1/13/2023 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), type 2 diabetes mellitus (high blood sugar), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), Vitamin D deficiency (not enough Vitamin D needed for strong bones and teeth), and contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to the right hand, both elbows, and both knees. The Admission Record indicated Resident 68 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/26/2024 with diagnosis of cerebral atherosclerosis (blood vessels in the brain have become blocked by fatty substances). During a review of Resident 68's care plan for spontaneous (sudden), pathological (caused by disease), stress (tiny breaks in bone) fracture (break in bone), initiated on 6/30/2022 and revised on 3/20/2024, the care plan interventions included to observe Resident 68 for sudden pain, swelling, and guarded movement (cautious with resistance, protecting against pain) of the extremity (arm or leg), handle gently and carefully during care, encourage mild exercises as tolerated and within joint limitation, and to notify the physician, responsible party, and the Hospice (specialized care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, quality of life rather than cure, and free of pain to live each day as fully as possible) Registered Nurse (Hospice RN) of changes in condition. During a review of Resident 68's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 6/10/2024, the MDS indicated Resident 68 was severely impaired for daily decision making, had ROM limitations in both arms and legs, and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, toileting, upper and lower body dressing, rolling to both sides in bed, and chair/bed-to-chair transfers. During a concurrent observation and interview on 7/23/2024 at 3:30 p.m. with Certified Nursing Assistant (CNA) 8 in the bedroom, Resident 68 was sitting up in a reclining wheelchair. Resident 68 was using the left arm to hold onto the right arm. CNA 8 stated Resident 68 had pain and swelling in the right elbow but had not fallen or had any injury. CNA 8 attempted to lift Resident 68's right arm but Resident 68 immediately used the left arm to grab and guard the right arm, had a facial wince (gesture in the face of pain), and had tears in the left eye. CNA 8 stated Resident 68 appeared to be in 10 out of 10 pain (pain scale from zero [0], indicating no pain, to 10, indicating the worst pain possible) in the right arm because Resident 68's eye was tearing up. CNA 8 stated Resident 68 complained of right elbow pain for one to two weeks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2024 at 7:47 a.m. with Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility)) 3 (RNA 3), RNA 3 stated the nurse (unknown) was giving Resident 68 pain medication prior to the RNA session this morning. RNA 3 stated Resident 68 was seen yesterday evening (7/23/2024) for RNA. RNA 3 stated Resident 68 did not tolerate the exercises to the right arm yesterday and did not apply the right arm splints due to Resident 68's right elbow pain and swelling. RNA 3 stated Resident 68 used the left arm to guard and hold onto the right arm. RNA 3 stated Resident 68 did not want anyone touching her right arm due to the pain for the past month. During an observation on 7/24/2024 at 8:24 a.m. with RNA 3 in the bedroom, Resident 68 was lying in bed with swelling throughout the right arm compared to the left arm. RNA 3 stood on the left side of the bed and performed exercises to Resident 68's left shoulder, elbow, and hand. RNA 3 stood on the right side of the bed, lifted the right arm at the shoulder joint, and attempted to extend the elbow. Resident 68 immediately held onto the right arm using the left hand and flexed (bent) the body as a pain response. RNA 3 stated Resident 68 was in pain. RNA 3 called CNA 8 to assist with transferring Resident 68 from the bed to the wheelchair. During a concurrent observation and interview on 7/24/2024 at 8:48 a.m., Resident 68 was already seated in the reclining wheelchair. RNA 3 described and demonstrated how RNA 3 and CNA 8 transferred Resident 68 from the bed to the wheelchair. RNA 3 stated the reclining wheelchair was positioned directly next to the bed. RNA 3 stated both RNA 3 and CNA 8 stood on the left side of Resident 68's bed. RNA 3 stated CNA 8 held onto Resident 68's trunk while RNA 3 lowered both legs to sit Resident 68 at the edge of the bed. RNA 3 stated Resident 68 sat at the edge of the bed while RNA 3 stood on Resident 68's right side and CNA 8 stood on Resident 68's left side. RNA 3 stated she cradled Resident 68's upper body by placing one arm underneath Resident 68's right axilla (armpit) and the RNA 3's other arm held onto the right leg. CNA 8 stated she similarly cradled Resident 68's upper body by placing one arm underneath Resident 68's left axilla and CNA 8's other arm held onto the left leg. RNA 3 stated both RNA 3 and CNA 8 physically lifted Resident 68 from the edge of the bed and into the reclining wheelchair. During an interview on 7/24/2024 at 11:38 a.m. with the Director of Nursing (DON), the DON stated Resident 68's contractures increased Resident 68's risk for injury. During a concurrent interview and record review on 7/24/2024 at 12:25 p.m. with the DON, Resident 68's MDS was reviewed. The DON stated Resident 68 was dependent for all activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) including bed/chair-to-bed transfers. The DON stated Resident 68 should be transferred with two persons - one person carrying the resident's upper body and the second person carrying the lower body. During an interview on 7/25/2024 at 5:29 p.m. with the DON, the DON stated the facility usually used two persons to physically transfer each resident to different surfaces and did not routinely use a mechanical lift. The DON stated physically transferring Resident 68, who already had right arm swelling and pain, could potentially increase Resident 68's pain and risk for injury. During a review of the facility's undated policy and procedure (P&P) titled, Accident/Incident Prevention, the P&P indicated the facility strived to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, identify each resident at risk for accidents/incidents, and provide care plans with procedures to prevent accidents.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49947 Based on interview and record review, the facility failed to complete a performance evaluation (PE - a formal and productive procedure to measure an employee's work and results based on their job responsibilities) every twelve months for three Restorative Nursing Aides (RNA - Certified Nursing Assistants [CNA] with specialized training to help residents regain their physical function and quality of life after illness or injury) reviewed under the sufficient and competent nurse staffing task. This deficient practice prevented the identified RNA's from receiving individualized training and education based on the outcome of their PE that could impact resident safety and satisfaction. Findings: During a review of the facility's RNA job description, last reviewed on 1/10/2024, it indicated the RNA performs restorative nursing approaches on residents to assist the resident in reaching their maximum potential mobility. The RNA duties and responsibilities included range of motion, daily and weekly documentation for residents in the program, assistance with walking and transfers, activities of daily living (ADL - basic tasks that must be accomplished every day for an individual to thrive), placement of restorative devices and equipment such as wheelchairs and walkers, positioning, and restorative feeding program (individualized assistance to residents during mealtimes). During a concurrent interview and record review on 7/25/2024 at 3:30 p.m. with the Director of Staff Development (DSD), reviewed RNA 1, 2, and 3's employee files: 1. RNA 1 was hired on 4/9/2019 and did not have a PE for 2019, 2022 and 2023. The DSD stated she was responsible for conducting the PE on all RNAs and CNAs and she does not know why the PE's were not done. 2. RNA 2 was hired on 4/18/2022 and did not have a PE for 2022 and 2023. The DSD stated, she must have overlooked it, when asked why the PEs were not completed. 3. RNA 3 was hired on 7/4/2015 and did not have a PE for 2015, 2016, 2017, 2019, 2022, and 2023. The DSD stated that she must have overlooked it and did not get a chance to complete them. The DSD stated it is important to complete a PE every 12 months to ensure staff knows how to complete their job functions as well as provide the best care for the residents. During an interview on 7/25/2024 at 6:40 p.m. with the Director Of Nursing (DON), the DON stated PEs must be completed annually to reevaluate staff; if they are still performing the same, as this can possibly lead to mistakes, errors, and failure to provide the correct care. During a review of the facility's policy and procedure (P&P) titled, Employee Evaluation Policy, last reviewed 1/10/2024, the P&P indicated employees are evaluated annually and as needed based on performance. Employees who need immediate improvement may be evaluated more frequently.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 43988 Based on observation, interview and record review, the facility failed to post daily staffing information that included the total number of Registered Nurses (RN), Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs) and their actual hours worked for three of three sampled dates (7/21/2024, 7/22/2024, and 7/23/2024) during a review of sufficient and competent staff facility task. This deficient practice resulted in residents, visitors, and facility staff not knowing how many staff were available to provide care to the residents. Findings: During a concurrent observation and interview on 7/23/2024 at 2:25 p.m., with the Director of Staff Development (DSD), reviewed the daily staffing posting for 7/23/2024. The DSD stated the wall next to Station 1 is the only place where they post the nurse staffing information. The DSD stated the posting did not show how many staff were working for the day, but it showed the projected hours and the actual hours. The DSD stated the nursing staffing information posted dated 7/23/2024, should have been updated to reflect the number of direct patient care of RNs, LVNs, and CNAs so the staff, residents and visitors would be aware how many licensed and unlicensed staff were working. The DSD stated she is responsible for posting the nurse staffing data at the beginning of the shift. During an interview on 7/23/2024 at 2:52 p.m., with the Administrator (Adm), the Adm stated the facility was not aware that the nursing staffing posting should include the number of licensed and unlicensed staff working and the number of hours. The Adm stated the posting should indicate the number of RNs, LVNs, and CNAs working for the day and the actual hours worked per regulation to ensure that all visitors and staff would be aware how many staff are working. During a review of the facility's policy and procedure titled, Post Nursing Staffing information, last reviewed 1/10/2024 indicated, the facility will post nurse staffing information in a prominent place to ensure that the nurse staffing information is accessible to all residents and visitors on a daily basis. The policy indicated the posted nurse staffing information will include: Facility name Current date Resident census Total number of staff and actual hours worked per shift for - Registered Nurses - Licensed Nurses (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	- Certified Nurse Aides

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 49947 Based on observation, interview and record review, the facility failed to provide individualized care approaches to meet the emotional and psychosocial needs of residents with mental disorder diagnosis for one of three sampled residents (Resident 70) residents investigated during review of behavioral-emotional care area by failing to address Resident 70's behavior of disrobing. This deficient practice had the potential to prevent Resident 70 from receiving appropriate treatment, approaches, and the ability to attain the highest practicable mental and psychosocial well-being. Cross reference F550 and F656 Findings: During a review of Resident 70's Admission Record, it indicated the facility admitted Resident 70 on 9/8/2023 with diagnoses including, but not limited to, dementia (loss of memory, language, and other thinking abilities that interfere with daily life and gets worse over time), Alzheimer's Disease (a common type of dementia), major depressive disorder (a persistent feeling of sadness and loss of interest), and anxiety disorder (excessive worry and feelings of fear and uneasiness). During a review of Resident 70's History and Physical (H&P), dated 11/8/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 70's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/13/2024, the MDS indicated Resident 70 had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and needed maximum assistance with upper body dressing, lower body dressing, toileting, hygiene, and bathing. During an observation on 7/23/2024 at 11:10 a.m., outside of Resident 70's room, Resident 70 could be viewed from the hallway disrobed from the waist up; the privacy curtain was partially drawn. Upon entering Resident 70's room, Resident 70 was up in her wheelchair with her shirt off, breast exposed while other residents were passing by the room. Resident 70 yelled out nonsensically (not making sense) when interview was attempted. During a concurrent observation and interview on 7/23/2024, at 11:15 a.m., inside Resident 70's room, with Restorative Nursing Assistant (RNA) 1, RNA 1 assisted Resident 70 back into her shirt and confirmed that Resident 70 had the behavior of disrobing in the past. RNA 1 further explained the behaviors are to be reported to the charge nurse. RNA 1 further stated he will report the behavior to the charge nurse. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 7/23/2024, at 12:30 p.m., with the Director of Medical Records (DMR), reviewed the Clinical Chart of Resident 70. The DMR stated there were no care plans or interventions addressing Resident 70's behavior of disrobing. During an interview on 7/25/24 at 8:30 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she cared for Resident 70 approximately 4 times in the last month and Resident 70 disrobed once or twice. CNA 7 stated she reported to the charge nurse each time the resident had the behavior of disrobing but does not remember which date or charge nurse she reported it to. CAN 7 further explained she was unaware of specific approaches to assist Resident 70 when she disrobes. During a concurrent interview and record review on 7/25/24 at 9:15am with the Director of Staff Development (DSD), reviewed the MAR and care plan of Resident 70. The DSD stated on 7/23/2024 she was covering as the charge nurse for the first shift (7:00 a.m.- 3:30 p.m.) in station two (the station that covers the area of Resident 70) and did not remember if the behavior of disrobing was reported to her that day. The DSD stated she remembers Resident 70 disrobing her shirt since she was admitted to the facility and any new identified behaviors are to be reported to the supervising registered nurse. The DSD further stated the behaviors are tallied in the MAR, but disrobing is not listed as a behavior to monitor in the MAR nor was there a care plan or interventions to address the behavior of disrobing. During a concurrent interview and record review on 7/25/2024 at 9:55 a.m. with Registered Nurse (RN) 2, reviewed the MAR, care plan and notes of Resident 70. RN 2 stated the disrobing behavior was not reported to her and if the behavior is not in the MAR, it is not care planned. RN 2 confirmed disrobing is not mentioned in any notes, care plans or the MAR in Resident 70's chart. RN 2 further stated the resident could miss out on measurable goals and approaches that staff could use during care without the care plan. During a review of the facility's policy and procedure (P&P) titled, Policy: The Resident Care Plan, last reviewed 1/10/2024, the P&P indicated the resident care plan shall be implemented for each resident on admission and developed throughout the assessment process. The P&P further indicated, the care plan should include measurable goals and approaches to meet the goals. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, last reviewed 1/10/2024, indicated residents have the right to be informed of, and participate in, his or her care planning and treatment.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43455 Based on interview and record review, the facility failed to ensure control and accountability of Controlled Substance (CS- medications which have a potential for abuse and may also lead to physical or psychological dependence, also known an Controlled Medication [Drug]) awaiting final disposition (process of returning and/or destroying unused medications) when the facility's Antibiotic or Controlled Drug Record accountability logs did not include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with the Licensed Vocational Nurse (LVN) for seven of seven sampled logs. This deficient practice increased the opportunity for CS diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and accidental exposure of residents to harmful medications, potentially negatively impacting their health and wellbeing. Findings: During a review of Antibiotic or Controlled Drug Record accountability logs on 7/24/2024 at 1:13 PM, with the DON, 7 Antibiotic or Controlled Drug Record accountability logs indicated the CSs awaiting final disposition did not contain any verifying signatures. During a concurrent interview on 7/24/2024 at 1:13 p.m., with the DON, the DON stated she was unable to locate the verifying signatures of LVNs and the RN/DON on the seven accountability logs. The DON stated the DON failed to sign the seven Antibiotic or Controlled Drug Record accountability logs upon receipt of the CS's. The DON stated the DON counts the CSs with the LVNs upon receipt of the accountability logs, however there was no consistent process of signing the logs. The DON stated the DON needed to immediately implement a process for including verifying signatures on the accountability logs to ensure each CS dose was accounted for until disposed. The DON stated it was also important to verify and sign the logs to prevent diversions and accidental exposure of harmful substances to residents. During a review of the facility's policy and procedures (P&P) titled, Controlled Medications, dated April 2008, the P&P indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the consultant pharmacist (CP) in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. A review of the facility's P&P titled, Controlled Medication Disposal, dated April 2008, indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. The DON, in collaboration with the CP, is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. B. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal documented on the accountability record/book on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of CS wasted for any reason. Review of the facility's P&P titled, Controlled Substances, dated March 2023, the P&P indicated that The facility complies with all laws, regulations, and other requirements related to administration, handling, storage, disposal, and documentation of controlled medications. 9b. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.

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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. 43455 Based on interview and record review, the facility failed to ensure the consultant pharmacist's (CP) recommendation for June 2024 Medication Regimen Review (MRR) (a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) note was carried out as per facility policy and procedure for one of four sampled residents (Resident 70). The deficient practice increased the risk of receiving medication that was not optimal for Resident 70's medical condition, that would not maintain the resident's highest level of physical, mental, and psychosocial well-being and/or increase the risk of adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) from the medication therapy. Cross reference to F758. Findings: During a review of Resident 70's Admission Record (a document containing demographic and diagnostic information,) dated 7/26/2024, the Admission Record indicated the facility originally admitted Resident 70 on 9/8/2023 and readmitted the resident on 11/7/2023 with a diagnosis of anxiety. During a review of Resident 70's Order Summary Report, dated 7/26/2024, the report indicated Resident 70 was prescribed Ativan (a medication used for anxiety) 0.5 milligram ([mg] - a unit of measure of mass) tablet to give 1 tablet by mouth twice a day for anxiety manifested by constant movement/rolling out of bed to exhaustion, starting 2/21/2024. During a review of the MRR note for Resident 70 by the CP on 7/25/2024 at 2:43 PM, titled Note to Attending Physician/Prescriber and dated 6/13/2024, stated Resident has been taking Ativan 0.5 mg BID (abbreviated for twice a day), since 2/2024. Please consider a dose reduction if appropriate. If therapy is to continue, please document risk versus benefit assessment. The document did not contain a response from a physician and was not signed or dated by a physician. During a review of Resident 70's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record,) on 7/25/2024 at 2:48 PM, the MAR indicated Resident 70 was prescribed Ativan 0.5 mg to give 1 tablet by mouth twice a day for anxiety manifested by constant movement/rolling out of bed to exhaustion, since 2/21/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/24 at 9:35 AM, with the Director of Nursing (DON,) the DON stated per facility policy the MRR irregularity notes by the CP needed to be reviewed and documented within 30 days of the written report. The DON stated it was important to review the irregularities timely to ensure residents were receiving treatment that was optimal for their condition and to maintain their highest level of well-being. The DON stated the facility and physician failed to timely review and address the CP MRR note written on 6/13/2024 for the Ativan 0.5 mg BID identified irregularity and failed to document a rationale for continuing the Ativan order for anxiety manifested by constant movement/rolling out of bed to exhaustion, for Resident 70. Review of facility policy and procedure (P&P) titled Medication Regimen Review (Monthly Report), dated July 2024, the policy indicated The consultant pharmacist performs a comprehensive MRR at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. C. Recommendations are acted upon and documented by the facility staff and or the prescriber. 1) If irregularities are found the DON and/or designated licensed nurse will follow up with the prescriber within 30 working days of receipt of the MRR report. 3) The prescriber, the DON or the designated licensed nurse will document the rational if the recommendation is declined. Review of the facility's P&P titled Policy for Unnecessary Medication, dated July 2024, the P&P indicated: Facility will follow state and federal regulation to ensure that all residents will be free from unnecessary psychotropic medication and unnecessary drugs. Licensed nurse will review resident's drug regimen based on the following criteria: 1. Excessive dose 2. Excessive duration 3. Adequate indication Licensed nurse will communicate with the primary physician and adjusting the medication dosage, duration, frequency and/or discontinue the medication if indicated. Licensed nurse will communicate with the primary physician regarding the pharmacist recommendation on a monthly basis to ensure all residents' medications are appropriate.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 70) drug regimen was free from the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure by failing to identify specific, measurable target behaviors related to the use of Ativan (a psychotropic medication used to treat anxiety) for Resident 70. These deficient practices had the potential to place Resident 70 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic medications, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Cross reference to F756 Findings: During a review of Resident 70's Admission Record (a document containing demographic and diagnostic information,) dated 7/26/2024, the Admission Record indicated Resident 70 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis anxiety. During a review of Resident 70's Order Summary Report, dated 7/26/2024, the report indicated Resident 70 was prescribed Ativan 0.5 milligram ([mg] - a unit of measure of mass) tablet to give 1 tablet by mouth twice a day for anxiety manifested by constant movement/rolling out of bed to exhaustion, starting 2/21/2024. During a review of Resident 70's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 5/13/2024, the MDS indicated Resident 70 did not have potential indicators of psychosis, no hallucinations (perceptual experiences in the absence of real external sensory stimuli), and no delusions (misconceptions or beliefs that are firmly held, contrary to reality). Resident 70's MDS indicated there were no physical, verbal, or other behavioral symptoms exhibited or directed toward others, including no pacing, wandering, or disrobing. Resident 70's MDS indicated Resident 70 received antianxiety medication on a routine basis. During a review of the Medication Regimen Review (MRR) note for Resident 70 by the Consultant Pharmacist (CP) on 7/25/2024 at 2:43 PM, titled Note to Attending Physician/Prescriber and dated 6/13/2024, stated Resident has been taking Ativan 0.5 mg BID (abbreviated for twice a day), since 2/2024. Please consider a dose reduction if appropriate. If therapy is to continue, please document risk versus benefit assessment. The document did not contain a response from a physician and was not signed or dated by a physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 70's Medication Administration Record ([MAR] - a record of mediations administered to residents) between 5/1/2024 through 7/26/2024, on 7/25/2024 at 2:48 PM, the MAR indicated Resident 70 had zero documented episodes for anxiety manifested by constant movement/rolling out of bed to exhaustion for 85 out of 87 days. The MAR also indicated Resident 70 continued to be prescribed Ativan 0.5 mg 1 tablet by mouth twice a day for anxiety manifested by constant movement/rolling out of bed to exhaustion, since 2/21/2024. During a review of Resident 70's Psychiatric FU Note on 7/25/2024 at 3 PM, dated 5/4/2024, the note indicated Last seen in February 2024. Ativan started for agitation and verbally aggressive as Thyroid Stimulating Hormone ([TSH] - hormone that control how the body uses energy) was elevated (depicted by arrow up symbol) which may contribute. The note indicated to continue current medications, behavior not well controlled, and no dose reduction indicated. During a review of Resident 70's Psychiatric FU Note on 7/25/2024 at 3:05 PM, dated 7/4/2024, the note indicated Patient remains restless and anxious. The note indicated to continue current medications, behavior not well controlled, and no dose reduction indicated. During a review of progress note by Registered Nurse (RN) 2, dated 7/25/2024 at 6:36 PM, the note indicated Nurse Practitioner (NP,) . made aware of pharmacy recommendation to reduce Ativan 0.5 mg PO (by mouth) BID but NP stated no Gradual Dose Reduction (GDR) d/t (due to) worsening symptoms. During a concurrent record review of Resident 70's clinical record, MAR, MRR, MDS and an interview on 7/26/2024 at 9:35 AM, with the Director of Nursing (DON,) the DON stated after identifying that the facility failed to review and document the MRR note by the CP written on 6/13/2024, the DON contacted the NP on 7/25/2024 and the NP made an addendum (addition) to the Psychiatric FU Note originally dated 7/4/2024 that Resident 70 was disrobing per staff report on 7/25/24 and no GDR indicated. The DON stated that Resident 70 did not have documented behaviors of anxiety manifested by constant movement/rolling out of bed to exhaustion since May 2024. The DON stated the DON was unable to find a clinical rationale to continue the Ativan 0.5 mg BID indicated for constant movement/rolling out of bed to exhaustion, as those behaviors have resolved. The DON stated there was no new Ativan order prescribed for the specific targeted behavior of disrobing therefore that behavior was not monitored. The DON stated the decision for not completing a GDR of the Ativan for Resident 70 was based on a behavior of disrobing for which the Ativan order was not indicated for. The DON stated continuing Ativan 0.5 mg BID for disrobing behavior that was different than constant movement/rolling out of bed to exhaustion originally indicated for, was inappropriate for Resident 70. The DON stated without specific targeted behavior monitoring, assessments, and evaluations for medication orders such as lowering the dose or discontinuing the medication will be inaccurate leading to unnecessary use of medications which may result in adverse consequences for the residents. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 11:23 PM, with Licensed Vocational Nurse (3), LVN 3 stated LVN 3 takes care of Resident 70 four times a week and was very familiar with the resident. LVN 3 stated Ativan 0.5 mg BID was prescribed for anxiety manifested by constant movement/rolling out of bed to exhaustion since 2/21/2024 for Resident 70. LVN 3 stated that Resident 70 was not exhibiting anxiety manifested by constant movement/rolling out of bed to exhaustion since May 2024. LVN 3 stated that according to psychiatric note addendum on 7/25/2024 no GDR was indicated for Ativan 0.5 mg BID due Resident 70 disrobing. LVN 3 stated that there was no Ativan prescribed for disrobing, and as a result disrobing behaviors were not being monitored for Resident 70. LVN 3 stated if there was a new behavior concern of disrobing then a medication for that specific behavior should be prescribed to ensure behaviors and medication effectiveness were being monitored for Resident 70. LVN 3 stated that medications should have indications for specific target behaviors to ensure specific behavior monitoring, evaluation of medication effectiveness for that behavior, and to prevent adverse consequences by continuing use of unnecessary medications for resolved behaviors. Review of the facility's Policy and Procedures (P&P,) titled Behavioral Health Services, dated May 2023, the P&P indicated: The Facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Review of the facility's P&P titled Policy for Unnecessary Medication, dated July 2024, the P&P indicated: Facility will follow state and federal regulation to ensure that all residents will be free from unnecessary psychotropic medication and unnecessary drugs. Licensed nurse will review resident's drug regimen based on the following criteria: 1. Excessive dose 2. Excessive duration 3. Adequate indication Licensed nurse will communicate with the primary physician and adjusting the medication dosage, duration, frequency and/or discontinue the medication if indicated. Licensed nurse will communicate with the primary physician regarding the pharmacist recommendation on a monthly basis to ensure all residents' medications are appropriate. Review of the facility's P&P titled Psychotherapeutic Medications, dated July 2024, the P&P indicated to Evaluate the resident's response to psychotropic medication therapy to determine that the medications are appropriate, and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The licensed nurse will assess resident to ensure: D. Actual behavior with goals and approaches on care plan K. Attempt Gradual Dose Reduction unless clinically contraindicated, at least twice in first year and yearly thereafter. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L. System I pace to document explanation of repeated behavior on MAR with notification of physician and reevaluation for intervention. M. The pharmacist will complete monthly drug regimen review and give recommendations as indicated and the facility will follow up with the recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Two medication errors out of twenty-five (25) total opportunities contributed to an overall medication error rate of eight % affecting one of seven residents observed for medication administration (Resident 14.) The medication errors were as follows: 1. Resident 14 did not receive a dose of Tylenol (a medication used for pain) as ordered by Resident 14's physician, and 2. Resident 14 received Keflex (a medication used to treat an infection) in a form that was not ordered by Resident 14's physician. These failures had the potential to result in Resident 14 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 14's health and well-being to be negatively impacted. Findings: During an observation on 7/23/2024 at 12:15 PM, in Medication Cart Station 1, Licensed Vocational Nurse (LVN) 1 was observed opening Keflex 500 milligram ([mg]-a unit of measure of mass) capsule and pouring the contents into a small plastic cup (a process similar to when crushing [pressing the medication very hard so that the shape is destroyed and forms a soft powder] medications) containing applesauce for Resident 14. During an observation on 7/23/2024 at 12:22 PM with LVN 1, Resident 14 was observed swallowing spoonsful of the applesauce containing the contents of the Keflex 500 mg capsule followed by a glass of juice. During an interview on 7/23/2024 at 3:11 PM, with Registered Nurse (RN) 1, RN 1 stated that Resident 14's clinical chart did not contain physician orders instructing to open Keflex capsules and mix with applesauce. RN 1 stated if there was no order indicating to do so then it should not have been done. During an observation on 7/24/2024 at 9:13 AM, in Medication Cart Station 1, in the presence of RN1, LVN 2 was observed administering one (1) tablet of Tylenol 500 mg to Resident 14. Resident 14 was observed swallowing the tablet whole with a glass of juice. During an interview on 7/24/2024 at 11:27 PM, with RN 1 and LVN 2, LVN 2 stated that LVN 2 administered one (1) tablet of Tylenol 500 mg to Resident 14 during the morning medication administration on 7/24/2024 at 9:13 AM. LVN 2 acknowledged the physician's order specified to give two (2) tablets (1000 mg). LVN 2 stated LVN 2 failed to administer two (2) tablets as ordered by the physician and underdosed (gave an insufficient amount) Resident 14. LVN 2 stated there was a risk Resident 14 would not see the therapeutic (expected response from a treatment) effect of the Tylenol and continue to be in pain. RN 1 and LVN 2 stated an additional tablet of Tylenol 500 mg will be administered immediately to Resident 14. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 12:43 PM, with the Director of Nursing (DON,), the DON stated that Resident 14 did not have a physician order stating to open the Keflex 500 mg capsule and mix with applesauce for administration. The DON stated that certain medications should not be opened or crushed as they can cause adverse effects such as stomach irritation. The DON stated that Resident 14 had an order of Tylenol 1000 mg for Osteoarthritis pain, and not receiving the prescribed amount can lead to uncontrolled pain for the resident. The DON stated that LVN 1 and LVN 2 failed to follow the 5 rights of medication administration to ensure physician orders were followed and the right doses and forms of medications were administered to Resident 14. The DON stated these were considered medication errors. During an interview on 7/26/2024 at 11:11 AM, with LVN 1, LVN 1 stated that LVN 1 administered opened Keflex 500 mg capsule mixed with applesauce on 7/23/2024 at 12:22 PM to Resident 14, and that there was no physician order instructing LVN 1 to do so. LVN 1 stated this is considered a medication error. LVN 1 stated not all medications could be opened (similar to not all medications can be crushed) and if the wrong medication was opened it may not have the desired effect and could cause adverse effects to the resident. LVN 1 stated LVN 1 failed to follow the facility's medication administration policy and failed to follow physician orders. During a review of Resident 14's Admission Record (a document containing demographic and diagnostic information,) dated 7/23/2024, the Admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteoarthritis (breakdown of bone causing pain and stiffness,) and dermatophytosis (infection of the skin and nails.) During a review of Resident 14's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], dated 7/23/2024, the MAR indicated Resident 14 was prescribed the following: 1) Tylenol 500 mg tablet to give 2 tablets by mouth two times a day at 8 AM and 4 PM for pain management related to osteoarthritis, starting 5/20/2024. The order indicated the medication should be given as two tablets for a dose of 1000 mg twice a day. 2) Keflex 500 mg capsule to give 1 capsule by mouth three times a day at 8 AM, 12 PM, 4 PM for right second finger infection for 7 days, starting 7/17/2024. The physician order did not specify to open the Keflex capsule and mix the contents with applesauce. During a review of Resident 14's clinical record, the record contained no documentation that Resident 14 should be given one (1) Tylenol 500 mg tablet and no documentation to mix the contents of Keflex 500 mg capsule with applesauce. During a review of the facility's policy and procedures (P&P), titled Medication Administration - General Guidelines, dated October 2017, the P&P indicated that Medications are administered as prescribed . A. Preparation 3) Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Administration 2) Medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P, titled Procedures for all Medications, dated April 2008, the P&P indicated: To administer medications in a safe and effective manner. F. Read medication label before administering. During a review of the facility's P&P, titled Med Pass, [undated], the P&P indicated: I.A.2. The 5 Rights Make sure that meds are administered according to: b. Right medications c. Right dose III.A. Med errors A med error is a violation in the 5 rights, or in medication regulations; or in approved medication policy or current standard of practice. C.Survey deficiencies A survey deficiency is a combination of significant and insignificant med errors that amount to 5% or [NAME] of the total opportunities for error. VIII.G. Crushed Meds Meds may be crushed and mixed with applesauce or pudding, per physician order . During a review of the facility's P&P, titled Crushing Medications, dated March 2023, the P&P indicated that Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for three of ten sampled residents (Resident 10, 38, and 76) by: 1. Failing to ensure nurses were rotating (a method to ensure repeated injections are not administered in the same area) the insulin (a medication that regulates sugar in the blood) injection sites for Resident 10 during review of insulin care area. 2. Administering insulin to Resident 38 when the blood sugar (BS - the amount of sugar measured in the blood stream) was below the physician ordered parameters (a set of limits determining if a medication can be given) during review of insulin care area. 3. Failing to ensure Treatment Nurse 1 (TN 1) administered the first dose of Keflex (an antibiotic [medication that fights infections caused by bacteria delivered directly into the bloodstream]) immediately or within four hours of receiving a verbal order from the Wound Care Consultant (WCC) for Resident 76 with an active skin infection reviewed during the Infection Control task. This deficient practice had the potential to result in bruising, pain, and/or lipohypertrophy (lump or accumulation of fatty tissue under skin) to Resident 10, placed Resident 38 at risk for hypoglycemia (a condition when the blood sugar is dangerously low), and had the potential to jeopardize the therapeutic effectiveness of the antibiotic resulting in further complications of Resident 76's infection. Cross refence to F658 and F880. Findings: 1. During a review of Resident 10's Admission Record, it indicated the facility admitted the resident on 3/10/2023, with diagnoses including, but not limited to, type 2 diabetes mellitus (DM - a disease that occurs when the glucose, also called blood sugar, is too high) with unspecified complications, and long-term use of insulin. During a review of Resident 10's History and Physical (H&P), dated 3/4/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/13/2024, the MDS indicated the resident had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect the everyday life) and required moderate assistance with eating, oral hygiene, and upper body dressing. (continued on next page)

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's Order Summary Report, printed on 7/25/2025, the report indicated Resident 10 had an order increase on 7/4/2024 for Lantus (long-acting insulin) SoloStar Subcutaneous (SQ - into the fatty layer under the skin) Solution Pen-injector (a device used to administer medication into the body through a needle) 100 unit per milliliters (unit/ml, a unit of fluid volume) from 12 to 14 units: inject 14 unit SQ at bedtime (HS). Hold if BS is less than 110. May give orange juice for BS less than 60. Rotate site. During a review of Resident 10's Medication Administration Record (MAR, a record of all medications taken by a resident on a day-to-day basis) for 5/2024-7/2024, indicated Lantus SoloStar SQ Solution Pen-injector; inject 14 units SQ at HS was administered on: 5/7/2024 at 8:00 p.m. on the left lower quadrant 5/8/2024 at 8:00 p.m. on the left lower quadrant 5/12/2024 at 8:00 p.m. on the abdomen 5/13/2024 at 8:00 p.m. on the abdomen 5/14/2024 at 8:00 p.m. on the abdomen 5/17/2024 at 8:00 p.m. on the right lower quadrant 5/18/2024 at 8:00 p.m. on the right lower quadrant 5/24/2024 at 8:00 p.m. on the left lower quadrant 5/25/2024 at 8:00 p.m. on the left lower quadrant 6/2/2024 at 8:00 p.m. on the abdomen 6/3/2024 at 8:00 p.m. on the abdomen 6/8/2024 at 8:00 p.m. on the abdomen 6/9/2024 at 8:00 p.m. on the abdomen 6/10/2024 at 8:00 p.m. on the abdomen 6/11/2024 at 8:00 p.m. on the abdomen 6/19/2024 at 8:00 p.m. on the left lower quadrant 6/20/2024 at 8:00 p.m. on the left lower quadrant 7/3/2024 at 8:00 p.m. on the left arm 7/4/2024 at 8:00 p.m. on the left arm (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/5/2024 at 8:00 p.m. on the left lower quadrant 7/6/2024 at 8:00 p.m. on the left lower quadrant 7/12/2024 at 8:00 p.m. on the left lower quadrant 7/13/2024 at 8:00 p.m. on the left lower quadrant 7/18/2024 at 8:00 p.m. on the left lower quadrant 7/19/2024 at 8:00 p.m. on the left lower quadrant 7/21/2024 at 8:00 p.m. on the left arm 7/22/2024 at 8:00 p.m. on the left arm During a concurrent interview and record review on 7/24/2024, at 3:00 p.m., with Registered Nurse (RN) 3, reviewed the Order Summary Report and the MAR of Resident 10 with RN 3. RN 3 stated there were multiple instances where the injection sites of the insulin were not rotated from 5/2024 to 7/2024. RN 3 stated the sites of insulin administration should be rotated to prevent bruising, hardening of the skin injection sites, and lipodystrophy (abnormal distribution of fat). RN 3 also stated the failure to follow the physician's order to rotate the insulin administration site is considered a medication error. During a review of the facility's Policy and Procedure (P&P) titled, Medication Error, last reviewed on 1/10/2024, the P&P indicated the facility will follow the medication administration P&P to avoid any medication errors including wrong route of administration. During a review of the facility's P&P titled, Insulin Administration, last reviewed on 1/10/2024, the P&P indicated to select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior and lateral areas of the thighs and abdomen. Avoid the are approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area. During a review of the facility provided FDA Label for Lantus SoloStar, undated, it indicated to rotate injection sites within the same area you choose each time form one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis (skin with lumps). Do not use the same spot for injection. 2. During a review of Resident 38's Admission Record, it indicated the facility admitted the resident on 2/20/2019, with diagnoses including, but not limited to, type 2 diabetes mellitus without complications. During a review of Resident 38's H&P, dated 2/13/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident was severely cognitively impaired. The MDS indicated Resident 38 is dependent on eating, toileting, showers, dressing, personal hygiene, and mobility. During a review of Resident 38's Order Summary Report, printed on 7/25/2024, the Order Summary Report indicated an order for Basaglar (long-acting insulin) KwikPen Solution Pen-Injector 100 u/ml.: inject 4 units SQ one time a day. Rotate site; hold for BS less than 90. During a review of Resident 38's Care Plan (CP) focused on hypoglycemia related to DM, revised on 1/28/2024, the CP indicated to administer the medications as ordered. During a review of Resident 38's MAR for 4/2024 to 7/2024, the MAR indicated: Basaglar KwikPen Solution Pen-Injector 100 u/ml.: inject 4 units SQ one time a day. Rotate site; hold for BS less than 90, was administered on: a. 4/1/2024 at 8:00 a.m. on the right arm with a BS of 89. b. 7/2/2024 at 8:00 a.m. on the right lower quadrant with a BS of 80. During a concurrent interview and record review on 7/24/2024, at 2:30 p.m. with Licensed Vocational Nurse (LVN) 3, reviewed the Order Summary Report and the MAR of Resident 38 with LVN 3. LVN 3 stated, she gave the resident insulin with BS below 90, when it should have been held to prevent the BS from going down even lower. During an interview on 7/25/2024, at 6:25 p.m., with the Director of Nursing (DON), the DON stated the orders must be double checked; the parameters the physician ordered must always be followed to prevent hypoglycemia. The DON further stated not following the physician ordered parameters during administration of insulin constitutes a medication error. During a review of the facility's P&P titled, Medication Error, last reviewed on 1/10/2024, indicated the facility will follow the medication administration P&P to avoid any medication errors including failure to follow parameters for specific medications. During a review of the facility's P&P titled, Insulin Administration, last reviewed on 1/10/2024, the P&P indicated to check the order for the amount of insulin and the blood sugar parameter per physician order. 44244 3. During a review of Resident 76's Admission Record, it indicated the facility admitted the resident on 4/4/2023 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hypertension (a condition in which the force of the blood against the artery walls is too high), and malignant neoplasm (commonly referred to as cancer, term for a disease in which abnormal cells divide without control and can invade nearby tissues) of the skin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's MDS 6/10/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident requires substantial/maximal assistance from staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 76's CP titled, (Resident 76) has unspecified dermatitis. Location: generalized body rash (bilateral upper extremities, chest, back) ., initiated 6/13/2024, the CP indicated goals to promote healing without complications and will show no signs and development of infection. The CP indicated to monitor for signs and symptoms of infection (redness, presence of drainage, odor, pain), to report change in resident's kin condition to physician and resident's family, and to provide treatment as ordered. During a review of Resident 76's Skilled Nursing Facility Wound Care Consultant notes, dated 7/24/2024, the Wound Care Consultant Notes indicated Resident 76 had an infected wound with scant serous drainage. The notes indicated to start the resident on Keflex 500 mg, four times a day for seven days. During a review of Resident 76's physician orders, the orders indicated the following orders: -Keflex oral capsule 500 milligrams (mg, a unit of measurement), give one capsule by mouth one time only for bacterial folliculitis (the hair follicle becomes infected/inflamed and forms a pustule), first dose from the emergency kit (e-kit, emergency drug supplies), dated 7/24/2024. -Monitor for symptoms and signs of Group A Streptococcus (IGAS, a severe and sometimes life threatening infection in which the bacteria have invaded parts of the body where bacteria are not usually found, such as the blood, deep muscle and fat tissue): cough; sore throat; fever; skin infection - tenderness or pain, heat, swelling, serous drainage at affected site and document yes/no, (if yes, indicate in the nurse's note and call physician), every shift until 8/17/2024, dated 7/17/2024. During a review of Resident 76's MAR, the MAR indicated the following: -On 7/24/2024 at 3:15 p.m., TN 1 documented the administration of Keflex Oral Capsule 500 mg capsule. During an observation on 7/23/2024 at 11:40 a.m., observed Resident 76 sitting in a wheelchair in the hallway outside the resident's room. Observed the resident with multiple open wounds on the left arm and a clear dry crusted substance on the left wrist. During an observation and interview on 7/24/2024 at 11 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she was caring for Resident 76. LVN 3 assessed Resident 76 and stated the resident had open wounds with discharge that she was not aware of. LVN 3 called TN 1. LVN 3 stated TN 1 stated the resident was seen by the wound care consultant that morning and would be started on antibiotics for an infection. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2024 at 1:32 p.m., TN 1 stated the facility currently has an Outbreak (OB, the occurrence of disease cases in excess of normal expectancy) of IGAS. TN 1 stated Resident 76's left wrist was crustier today when she made rounds with the WCC at 6:30 a.m. and the WCC verbally ordered antibiotics for a skin infection on Resident 76's left wrist. TN 1 stated she was not given a start date for the antibiotics, so she was going to enter the verbal order to give the first dose on 7/25/2024, the next day. TN 1 then stated antibiotics should be given immediately or within two hours of an order. TN 1 stated the antibiotics should have been given by 8:30 a.m. TN 1 stated it was now 1:45 p.m. and the antibiotics had not been administered to Resident 76. TN 1 stated when antibiotics are delayed a wound can worsen. During an interview on 7/24/2024 at 2:09 p.m., with the Infection Preventionist (IP), the IP stated the facility currently has an OB for IGAS. The IP stated the guidance given to the facility by the Department of Public Health was to monitor all residents for signs and symptoms of IGAS including open wounds with signs of infection. The IP stated a resident identified with an open wound with signs of infection should be tested to confirm or rule out as IGAS, the primary physician should be notified, and treatment should be started. The IP stated TN 1 did not notify her there are any newly identified residents with open wounds that have signs and symptoms of infection. The IP stated TN 1 should have notified her in the morning regarding Resident 76's wound and started the antibiotic treatment because the facility has an OB. The IP stated when the WCC gave a verbal order for antibiotics, the antibiotics should have been started within four hours because the resident has an infection, they want to stop the infection from worsening, and to prevent the OB from spreading to other residents. During an interview and record review on 7/25/2024 at 5 p.m., with the DON reviewed the facility policies regarding antibiotic medication administration and antibiotic stewardship. The DON stated for a new order of antibiotics, the first dose should be given within four hours of receiving the order. The DON stated TN 1 should have asked someone for help when she was making rounds with the WCC and was given a verbal order to start Resident 76 on antibiotics. The DON stated the facility policies do not specifically indicate antibiotics must be started within four hours, but it is a standard of practice. The DON stated the antibiotic was available in the facility e-kit and should have been given to Resident 76 as soon as possible and not the following day. The DON stated it was a medication error to delay the initial dose of antibiotics. During a review of the facility P&P titled, Physician Orders and Telephone Orders, last reviewed 1/10/2024, the P&P indicated all orders must be specific and complete with all necessary details to carry out the prescribed order without any questions. Methods of obtaining orders may be verbal. All orders must indicate the date and time received and must be noted by the professional staff taking the order. During a review of the facility P&P titled, Organizational Aspects, last reviewed 1/10/2024, the P&P indicated the pharmacy provides routine and timely pharmacy services seven days a week and emergency pharmacy service 24 hours per day, seven days a week. Medications which should be promptly available, such as anti-infectives are available within four hours. During a review of the facility P&P titled, Medication Ordering and Receiving from Pharmacy, last reviewed 1/10/2024, the P&P indicated medications and related products are received from the dispensing pharmacy on a timely basis. Stat and emergency medications, the initial dose is obtained from the emergency kit and administered immediately. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Medication Orders, last reviewed 1/10/2024, the P&P indicated medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Each medication is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The nurse on duty at the time the order is received enters it on the physician order sheet/telephone sheet. If the order is from a prescriber other than the attending physician, the order is verified with the current attending physician. Emergency/STAT medicine order is scheduled to be given within the legally specified time. During a review of the facility P&P titled, Antibiotic Stewardship - Orders for Antibiotics, last reviewed 1/10/2024, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facilities antibiotic stewardship program in conjunction with the facilities general policy for medication utilization and prescribing. If an antibiotic is indicated, providers will provide complete antibiotic orders. Before a nurse removes an antibiotic from the emergency supply of medication, he or she will report the use to the infection preventionist.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and appearance when the broccoli was mushy, overcooked and did not have a garlic flavor. This deficient practice placed 21 of 78 facility residents on regular consistency texture (texture with no restriction) at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: A review of the facility's summer menu spreadsheets (a list containing types and amount of foods of what each diet type would receive) dated 7/23/2024, indicated regular texture diet included the following food items on the tray: -Roast Turkey 3 ounces (oz, unit of measurement) -Gravy 1 oz -Bread stuffing 2.7 oz -Broccoli with garlic 1/2 cup (c, household measurement) -Wheat roll 1 piece -Glazed apple square 1 pc, except for the following diets: consistent carbohydrate diet (CCHO, diet that had the same amount of carbohydrates per meal). During a trayline (an area where food was assembled) observation on 7/23/2024 at 12:20 p.m., the broccoli in the steam table looked overcooked and mushy. During a test tray conducted with the Dietary Supervisor (DS) and Registered Dietitian (RD) on 7/23/2024 at 12:51 p.m. for regular diet (diet with no restrictions), broccoli was mushy, overcooked and no garlic flavor. DS stated the broccoli was mushy, overcooked, soft and it was served to everybody including soft diet textures. The DS stated the broccoli had no garlic flavor after tasting it. RD stated overcooked vegetables could lose its nutrients and flavor and as a potential outcome, residents would not get the proper nutrients they were supposed to get. During a review of the facility's diet manual titled Regular diet dated 2020, it indicated The regular diet is designed to meet the nutritional needs of residents who do not need dietary modification or restrictions. A review of the facility's recipe titled Recipe: Broccoli with Garlic dated week 4, Tuesday, 2024 indicated the recipe contained the following ingredients: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Broccoli, fresh 12 pounds (lbs., unit of measurement) or frozen 15 lbs. -Margarine, melted 1 1/8 c. -Garlic powder 1 1/2 - 3 tablespoon (tbsp, household measurement). During a review of the facility's policies and procedures (P&P) titled Food Preparation dated 1/10/2024, the P&P indicated POLICY. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure: (1) All food will be prepared by methods that preserve nutritive value, flavor, and appearance and will be attractively served at the proper temperature and in a form that meet the individual needs of the resident. (6) Prepare foods as close as possible to serving time in order to preserve the nutritive value, freshness, and to prevent overcooking.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview and record review, the facility failed to prepare foods in a form designed to meet individual needs when: 1. Resident (Resident 33) on vegan (a diet containing plant and plant products only), lactose free diet (diet that consist of food with no lactose, a type of sugar in milk, found in milk, cheese and dairy products) received grilled cheese and bread stuffing containing eggs, poultry seasoning, low sodium chicken stock and lactose on her lunch tray. 2. Fifteen (15) of 78 residents on puree diet (food with smooth, pudding like consistency) had parsley flakes on top of puree foods as garnish. These deficient practices had the potential to cause weight loss and frustrations (Resident 33), coughing, choking (to keep from breathing the normal way) and death for residents on puree diets. Findings: 1. During a review of Resident 33's Admission Record, it indicated the facility admitted the resident on 2/23/2020 with diagnoses including unspecified dementia (a form of mild or mixed dementia characterized with a mild cognitive impairment), iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells) and chronic kidney disease stage 3 (a reduced in kidney function associated loss of kidney function overtime). During a review of Resident 33's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated Resident 33 had severe cognitive impairment (unable to reason and make their own decision) and able to eat with set-up or clean-up assistance. During a review of Resident 33's diet order by physician, dated 6/17/2024, the physician order indicated Mechanical soft diet (foods that are soft and chopped), vegetarian diet, nectar/mildly thick (a fluid which flows off a spoon but slower than thin liquids) Additional directions: vegetarian diet, inner lip plate for all meals. During a review of Resident 33's care plan (CP) initiated 5/30/2024, the CP indicated Resident is at risk for alteration in nutritional status and interventions included mechanically altered diet, lactose free milk. Adhere to food preferences. Resident requests grilled cheese sandwich. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent trayline observation (an area where resident's foods were assembled) and interview with Registered Dietitian (RD) and DS on 7/23/2024 at 12:40 p.m., Resident 33's meal ticket indicated a diet of order of mechanical soft, regular diet, fluids-nectar mildly thick. Adaptive Equipment: lip late. Notes: VEGAN, lactose free. Resident 33's tray contained grilled cheese, bread stuffing, broccoli, nectar thickened milk, juice, and water. The RD stated the tray was wrong because Resident 33 was not supposed to get grilled cheese due to resident was on vegan diet per diet ticket. The DS stated Resident 33 requested grilled cheese all the time and the diet needed to be changed to a vegetarian diet. The DS stated the meal ticket needed to reflect vegetarian diet instead of Vegan diet, however, she was not sure and needed to double check. The DS stated vegan diet should not receive dairy, milk, and cheese. The DS stated the resident was on a lactose free diet hence cheese should not be served on to the resident. The DS stated the potential outcome of not updating resident's diet ticket would be residents might not eat and could cause weight loss, frustrations, and complaints. During a review of the facility's recipe titled Bread Dressing dated week 4, Tuesday 2024, the recipe indicated ingredients included poultry seasoning and low sodium chicken stock. During a review of the facility's diet manual titled Vegetarian and Vegan Diet dated 2020, the diet manual indicated There are four general categories of adequate vegetarian diets: (1) Vegans use vegetables, salads, legumes, tofu, fruits, whole grains, nuts, and seeds. Excluded all animal products. (2) Lacto-ovo-vegetarians use the above plus dairy products (milk, butter, cheese, yogurt, and eggs (3) lacto-vegetarians use dairy items but not eggs. During a review of the facility's diet manual titled Lactose Restricted Diet dated 2020, the diet manual indicated Description: This diet provides a restricted intake of lactose in the dietetic management of patients exhibiting lactose intolerance. Words that may indicate lactose in food: milk, lactose, margarine, butter, milk solids, curds, sweet cream, whey, cheese flavors and sour cream. Read labels carefully. Food to be avoided included cheese. During a review of facility's policies and procedure (P&P) titled Resident Food Preferences revised 1/10/2024, the P&P indicated Procedure: Dietary Service Supervisor (DSS) will meet with resident or representative to go over food preferences, allergies, likes and dislikes upon admission and as needed. The DSS will update meal ticket according to resident food preferences, diet order and nourishments. During a review of facility's P&P titled Menu, dated 1/10/2024, the P&P indicated (7) Individual resident trays will have a meal ticket which identifies the residents name, room number, diet order. Also sated on the card: -Portion size. -Food preferences -Beverage preferences -Allergies -Nourishment order if applicable (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meal tickets are periodically checked by the Dietary Services Supervisor and/or Consultant Dietitian for accuracy. 2. During a review of the facility's summer menu spreadsheets (a list containing types and amount of foods of what each diet type would receive) dated 7/23/2024, the menu spreadsheets indicated puree diet included the following food items on the tray: -Puree Roast Turkey 1/2 cup (c, household measurement) -Gravy 1 oz (if needed) -Puree Bread stuffing 2.7 ounces with gravy (oz, a unit of measurement) -Puree Broccoli with garlic 2.7 oz -Puree Wheat roll 2.7 oz -Puree Glazed apple square 2.7 oz, except for the following diets: consistent carbohydrate diet (CCHO, diet that had the same amount of carbohydrates per meal). During a trayline observation on 7/23/2024 at 12:20 p.m., staff used parsley flakes for puree diet garnishing. During a test tray for puree diet tray conducted with the DS and the RD on 7/23/2024 at 12:51 p.m., the puree turkey, puree stuffing had parsley flakes garnish. The RD stated there was a lot of parsley flakes as a garnish that would produce lumps that would have a potential outcome of aspiration-to-aspiration risk residents. The RD stated puree diets were allowed to use parsley flakes per the facility policy. During a review of the facility's diet manual titled Regular Pureed Diet dated 2020, the diet manual indicated Description: The Pureed Diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. All foods are prepared in a food processor or blender, with the exception of foods which are normally in soft and smooth state such as pudding, ice cream, applesauce, mashed potatoes, etc. Food allowed included: raw vegetable- pureed, cooked vegetables-pureed. During a review of facility's P&P titled Food Preparation dated 1/10/2024, the P&P indicated Foods will be cut, chopped, ground, or pureed to meet individual needs of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. Walk-in refrigerator shelves were chipped and cracked. b. Freezer one (1) and two (2) bottom shelves had dried up pink liquid, and dust buildup. c. One (1) dented can was stored with non-dented cans. d. Knife container had dust and sticky residue. e. One scoop had sticky and dirt debris was stored with the clean scoops. f. Scoop handles storage was not in one direction. g. Clean storage area for pots and pans had dust, crumbs, food residues and dried up food. h. Mixer had dirt and food buildup. i. Food carts used for lunch service had dried up milk spill and tape residues. j. Resident's food from home in the resident's refrigerator had no label and no received date. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 78 of 78 medically compromised residents who received food and ice from the kitchen. Findings: a. During an initial kitchen tour observation on 7/23/2024 at 8:13 a.m. in the walk-in refrigerator, shelves was chipped and cracked. During a concurrent observation of the walk-in refrigerator shelves and interview with Dietary Supervisor (DS) on 7/23/2024 at 8:41 a.m., the DS stated it was not okay that the paint of the shelves were coming off. The DS stated it did not look good and bacteria could live there and grow because it's a place to store food. DS stated the shelves surface should be smooth to prevent cross-contamination. During a review of facility's Policies and Procedures (P&P) titled Sanitizing Equipment and Surfaces dated 1/10/2024, the P&P indicated (6) Dietary staff should ensure that all the equipment, shelves, utensils, and surface area are clean and in good condition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Food Code 2017 , the P&P indicated 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. b. During an initial kitchen tour observation of the reach-in freezer one (1) on 7/23/2024 at 8:22 a.m., the bottom shelves had dried up pink liquid and dirt debris. During an initial kitchen tour observation of the reach-in freezer two (2) on 7/23/2024 at 8:25 a.m., the bottom shelves had dirt and tape debris. During a concurrent observation of the reach-in freezer 1 and 2 and interview with DS on 7/23/2024 at 8:36 a.m., DS stated the freezers had dirt and it was not supposed to be there. DS stated they cleaned the refrigerator daily when its dirty and deep clean it every Wednesdays. DS stated the spills, dust build up, sticker and label residues were not acceptable as it could attract germs. DS stated residents could get sick with diarrhea, vomiting, upset stomach and food poisoning as potential outcome. During a review of facility's P&P titled Sanitation and Infection Control dated 1/10/2024 indicated Food service employees will follow infection control policies to ensure the department operates under sanitary condition at all times. During a review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. c. During a concurrent observation of the dry storage area and interview with the DS on 7/23/2024 at 8:49 a.m., the DS stated there was one dented can along with undented cans. The DS stated there was a separate area for dented cans because they could not sure the dented cans as it was dangerous due to metal inside the can that could cause botulism (a serious illness caused by toxin that attacks the body's nerves). The DS stated when the can metal part was broken it would start to create or grow bacteria. The DS stated residents could die from it if they eat the food from dented cans as a potential outcome. The DS stated it was important to separate dented cans from non-dented cans to avoid using the product accidentally. The DS stated they needed to return cans that were dented even if it only had a little dent. During a review of facility's P&P titled Storage of Canned and Dry Goods dated 1/10/2024, the P&P indicated 10. Canned items should be inspected for damage such as dented, leaking or bulging cans. These items will be stored separately in the designated area-DENTED CANS for return to the vendor or disposed of properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Food Code 2017, it indicated 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101. 11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. d. During a concurrent observation of the knife container and interview with the DS on 7/23/2024 at 10:38 a. m., the DS stated the knife container had a sticky and dirt residue. DS stated staff cleaned the knife container every Wednesday and it was important to maintain the cleanliness for infection control. e. During a concurrent observation of the scoop drawer and interview with the Registered Dietitian (RD) on 7/23/2024 at 10:49 a.m., a scoop with purple handle had sticky residue. RD stated the scoop had grease build up and it was stored along with the clean ones that could contaminate the rest. The RD stated it needed to be cleaned to prevent cross-contamination. During a review of Food Code 2017, it indicated 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306. f. During a concurrent observation of the scoop drawer and interview with the RD and the DS on 7/23/2024 at 10:49 a.m., the scoops used for trayline were stored in a cabinet with the handles in different direction. The RD stated the scoop storage as not organized but the storage was sanitary. The RD stated they follow the Retail Food Code but needed to check why the practice of storing the scoop handle in different direction was not a good practice. During a review of Food Code 2017, it indicated 4-904.11 Kitchenware and Tableware (A) Single-service and Single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food-and lip-contact surfaces is prevented. g. During a concurrent observation of the clean pots and pans storage area by the trayline and interview with the RD and the DS on 7/23/2024 at 11:04 a.m., the clean area had dust, crumbs, and other food debris. The RD stated there were crumbs in the pots and pans storage and needed to be cleaned to prevent cross-contamination. DS stated they would clean it today. h. During a concurrent observation of the mixer and interview with the RD and the DS on 7/23/2024 at 11:08 a.m., the RD stated the mixer had dried up dirt. The DS stated they did not use the mixer always however it needed to be cleaned after each use. The DS sated they also needed to cover the mixer when not in sue as there was dust and dried up food residue. The DS stated it was important to clean the mixer as dirt could get into the food and residents could get sick when they ate the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Food Code 2017, it indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. 4-701.10 Food Contact Surfaces and Utensils shall be sanitized. 4-702.11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. i. During concurrent observation of the food carts and interview with DS on 7/23/2024 at 11:18 a.m., the food carts had white dirt spill and tape residues. DS stated four (4) of 4 carts had dried up milk spill and needed to be cleaned to prevent cross-contamination. DS stated residents could get sick if the carts were not cleaned after each meal. During a review of facility's P&P titled Cleaning Schedule dated 1/10/2024, the P&P indicated All areas and equipment should be cleaned daily. The assigned dietary personnel will deep clean the area equipment assigned for them that day using the dietary cleaning schedule. Daily cleaning schedule weekly checklist: refrigerators, freezers, tray carts and mixer. j. During concurrent observation of the resident's refrigerator and interview with the Director of Nursing (DON) and the RD on 7/24/2024 at 9:10 a.m., a bottle of yogurt had no name and received date. The DON sated this was clearly their mistake that there was no name and label on the yogurt. The DS stated it was important to label food from the outside so that they would know who it belongs to and ensure diet correctness and meal restrictions of the residents. The DON stated they label outside food with name, received date and three (3) days self-life. The DS stated they follow labeling and dating policies from dietary. The RD stated it was important to label outside food to ensure correctness of diet texture and allergies of the residents. The RD stated allergic reactions and chocking as a potential outcome of not labeling outside food. During a review of facility's P&P titled Resident's Refrigerator/Freezer Storage dated 1/10/2024, the P&P indicated (6) All items should be properly covered, dated, and labeled. Food items should have appropriate dates: delivery date-when received; open date-opened containers of PHF. During a review of Food Code 2017, it indicated 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review the facility failed to have a policy regarding the use and storage of food brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption when the policy did not include the facility's responsibility for storing food brought in by family and other visitors beyond one (1) mealtime. This deficient practice had the potential to cause a decrease food intake resulting to unintentional (without trying) weight loss, frustrations, and psychosocial harm to 78 of 78 facility residents. Findings: During a review of the facility's Policies and Procedures (P&P) titled Food from Outside Sources dated [DATE], the P&P indicated Policy: Food from outside sources is discouraged due to concerns with food safety and infection control and maintaining control of therapeutic diet orders. Procedure: 1. While it is preferred that families and/or friends do not bring foods or beverages into the facility, it is within resident's rights to allow the resident to eat outside food, especially if an individual is eating poorly. If outside food is brought in, the facility is not liable for any food safety and infection control concerns. 2. If a resident, family member, or friend wants to bring the resident an outside food or beverage, the resident, family member, or friend should talk with the charge nurse and or Dietary Services Supervisor and or food service manager to determine if the outside food or beverage is within the resident's prescribed diet. 3. The charge nurse must be notified if any outside food or beverage is brought in. It is recommended that only enough food/beverage be brought for the visit/meal with the resident. The staff will discard any leftovers. During concurrent interview with the Registered Dietitian (RD) and facility document review of the food from the outside sources policy on [DATE] at 8:55 a.m., the RD stated they tell the residents that they could bring food from the outside though it was not recommended for them due to food safety. The RD stated they label, date, and put the food from the outside in the resident's refrigerator. The RD stated they only keep the food for 72 hours and discard the rest of the food. The RD stated the residents might not comply with the policy if food that were not expired were thrown away and it could cause them to get upset. The RD stated the policy did not indicate safe food storage guidelines. During concurrent interview with the Director of Nursing (DON) and facility food from the outside sources policy review on [DATE] at 9:10 a.m., the DON stated their policy regarding food from home were as follows: 1. Staff checked what was type of food families/friends are bringing in the facility. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. They encourage the family to bring food just enough for the day. However, it was important to have food from home because the residents miss their home cooked foods. The DON stated the food from outside sources policy was very general, had no guidance for food storage and needed to be revised as it indicated staff will discard any leftovers. The DON stated she learned from dietary that they could only keep food from outside for 72 hours and the rest would be discarded. The DON stated family and residents would find the foods and could cause emotional change in behavior and weight loss as a potential outcome. During a review of facility's P&P titled Resident's Refrigerator/Freezer Storage dated [DATE], the P&P indicated 5. Leftover food or unused portions of packaged foods should be discarded. No food will be stored beyond 72 hours from received.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not maintaining the trash area free from trash, plastic utensils, other dirt debris and liquid drippings from the garbage bin. This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to 78 of 78 facility residents. Findings: During a concurrent observation of the dumpster (a large metal trash container designed to be emptied into a truck) area outside of the facility and interview with the Dietary Supervisor (DS) on 7/24/2024 at 8:20 a.m., the bottom of the blue dumpster had soiled plastic spoon and fork, trash, and liquid drippings from dumpster. The DS stated the trash surroundings was not clean. During a concurrent observation of the trash area and interview with the Maintenance Supervisor (MS) on 7/24/2024 at 8:22 a.m., the MS stated he was the one cleaning the trash area and brought the blower last Saturday to blow away the leaves. The MS stated they do not use water pressure to clean. The MS stated it was important to maintain the cleanliness of the trash's surroundings to prevent the spread of infection. The MS stated he did not know if the garbage area was clean or not clean. During a concurrent observation of the trash area and interview with the Housekeeping Supervisor (HKS) on 7/24/2024 at 8:30 a.m., the HKS stated he cleaned the trash surroundings this morning but did not get to the bottom of the trash bin. The HKS stated the trash area had trash and liquid drippings. HKS stated they needed to keep the trash surroundings clean for the prevention of spread of infection. During a record review of the facility's policies and procedures (P&P) titled Waste Control and Disposal dated 1/10/2024, the P&P indicated (6) Outside garbage bin should be kept closed at all times and surrounding area must be kept clean. During a review of Food Code 2017, it indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. During a review of Food Code 2017, it indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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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. 36943 Based on interview and record review, the facility failed to provide appropriate hospice services (specialized care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, quality of life rather than cure, and free of pain to live each day as fully as possible) to one of three sampled residents (Resident 68) receiving hospice care by failing to officially designate the facility's staff member responsible for coordinating hospice services in the facility's policy and ensure the facility's licensed staff were aware of the facility's designated coordinator for hospice care. These failures that the potential to prevent Resident 68 from receiving well-coordinated and comprehensive hospice services. Cross reference to F580. Findings: During a review of the facility's policy and procedure (P&P) titled, Hospice Program, revised 7/2017, the P&P did not indicate the name and title of the staff to coordinate care provided to the resident by the facility staff and hospice staff. During an interview on 7/25/2024 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 did not know who the facility's hospice coordinator was. LVN 3 stated the licensed nurses directly coordinated care with the hospice nurse and physician. During an interview on 7/25/2024 at 9:11 a.m. with the Administrator (ADM), the ADM stated the Director of Nursing (DON) or the Registered Nurse (RN) supervisor coordinated care with the hospice. During an interview on 7/25/2024 at 11:02 a.m. with the Treatment Nurse (TN 1), TN 1 did not know who the facility's hospice coordinator was. During an interview on 7/25/2024 at 1:00 p.m. with Registered Nurse 2 (RN 2), RN 2 stated the DON communicated information from the hospice to the nursing staff. During an interview on 7/25/2024 at 2:09 p.m. with the Director of Staff Development (DSD), the DSD did not know who the facility's hospice coordinator was. During an interview on 7/25/2024 at 2:26 p.m. with the DON, the DON stated the Social Services Designee (SSD) and the DON are the facility's hospice coordinators. The DON stated the SSD is the facility's main hospice coordinator and the DON fills in when SSD is not available. The DON stated the SSD involved the interdisciplinary team (group of healthcare professionals working together to treat a person) and ensured the resident was appropriate for hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 7:59 a.m. with the Minimum Data Set ([MDS] a comprehensive assessment and care planning tool) Nurse (MDSN), the MDSN did not know who the facility's coordinator was. During an interview on 7/26/2024 at 11:30 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the hospice nurse came to the facility but did not know who the facility's hospice coordinator was. During a concurrent interview and record review on 7/26/2024 at 12:12 p.m. with the ADM, the facility's P&P titled, Hospice Program, was reviewed. The ADM stated the facility's hospice coordinator was SSD with the DON and the ADM as back-up coordinators. The ADM stated the staff knew to communicate with SSD for any hospice related issues. The ADM reviewed the facility's P&P and stated the policy had blank lines that did not indicate the name and title of the staff to coordinate care provided to the resident by the facility staff and hospice staff. The ADM stated there could be gaps in communication and provision of care if the facility's staff did not know who the facility's hospice coordinator was.

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	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 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** 44244 Based on observation, interview, and record review the facility failed to implement and maintain an infection control program for two of six sampled residents (Resident 76 and Resident 2) reviewed under the Infection Control task by failing to: 1. Ensure Licensed Vocational Nurse 3 (LVN 3) monitored, identified, and reported Resident 76's open wounds (a break in the skin) with signs and symptoms (s/s) of invasive group A streptococcus (IGAS - a severe and sometimes life-threatening infection that is spread from person to person through respiratory droplets or touching other surfaces contaminated with bacteria that may invade parts of the body where bacteria are not usually found) on the left wrist. 2. Ensure Treatment Nurse 1 (TN 1) identified and reported Resident 76's open wounds with s/s of IGAS on the left wrist. 3. Ensure Resident 76's open wound was immediately tested for IGAS and the resident was placed in contact /droplet isolation (used to help prevent the spread of infectious agents that spread by direct or indirect contact with a resident or a resident's environment) for suspected IGAS or colonization of IGAS. 4. Ensure TN 1 administered the first dose of Keflex (an antibiotic [medication that fights infections caused by bacteria delivered directly into the bloodstream]) immediately or within four hours of receiving a verbal order from the Wound Care Consultant (WCC) for a resident with an active skin infection. 5. Ensure Certified Nursing Assistant 4 (CNA 4) wore a gown while providing care to Resident 2 who was placed on enhanced barrier precautions (EBP - a type of precaution that involves utilizing gown and gloves during high contact activities for residents with known infection or at risk for acquiring infections). These deficient practices had the potential to spread microorganisms including IGAS to facility residents, visitors, and staff. Cross reference to F580 and F760. Findings: a. During a review of Resident 76's Admission Record, it indicated the facility admitted the resident on 4/4/2023 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities), hypertension (a condition in which the force of the blood against the artery walls is too high), and malignant neoplasm (commonly referred to as cancer [term for a disease in which abnormal cells divide without control and can invade nearby tissues]) of the skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/10/2024, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident requires substantial/maximal assistance from staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 76's Care Plan (CP) titled, (Resident 76) has unspecified dermatitis. Location: generalized body rash (bilateral upper extremities, chest, back) ., initiated 6/13/2024, the CP indicated goals to promote healing without complications and will show no signs and development of infection. The CP indicated to monitor for signs and symptoms of infection (redness, presence of drainage, odor, pain), to report change in resident's kin condition to physician and resident's family, and to provide treatment as ordered. During a review of Resident 76's physician orders, the physician orders indicated the following orders: -Monitor for symptoms and signs of IGAS: cough; sore throat; fever; skin infection (tenderness or pain, heat, swelling, serous drainage [a clear to yellow fluid that leaks out of a wound and may be a sign of infection] at affected site) and document yes/no, (if yes, indicate in the nurse's note and call physician), every shift until 8/17/2024, dated 7/17/2024. -Keflex oral capsule 500 milligrams (mg, a unit of measurement), give one capsule by mouth one time only for bacterial folliculitis (the hair follicle becomes infected/inflamed and forms a pustule), first dose from the emergency kit (e-kit, emergency drug supplies), dated 7/24/2024. During an observation and interview on 7/23/2024 at 9:58 a.m., observed Resident 76 in a wheelchair (WC) outside the resident's room. Observed the resident with multiple open skin wounds on the left upper extremity and a clear dried substance crusted on the left dorsal wrist. Certified Nursing Assistant 9 (CNA 9) stated the resident had multiple open wounds on the left arm and he did not know when it started. a.1. During a review of Resident 76's Medication Administration Record (MAR, a record of all medications taken by a resident on a day-to-day basis), the MAR indicated on 7/23/2024 for the evening shift (3 p.m. to 7 p.m.), LVN 3 documented the resident did not have any signs or symptoms of IGAS. During an observation, interview, and record review on 7/24/2024 at 11 a.m., with LVN 3 reviewed Resident 76's progress notes for July 2024. LVN 3 stated she was caring for Resident 76 on 7/23/2024 and 7/24/2024 and was not aware of any issues on the resident's skin. Observed LVN 3 assess Resident 76's left wrist while the resident sat in the WC in the hallway. LVN 3 stated the resident had open wounds with discharge on the L wrist that she was not aware of. LVN 3 stated she would do skin assessment daily of the resident, but on 7/23/2024 and 7/24/2024 she only scanned the resident while administering his medications. LVN 3 stated she relies on the CNAs to report any skin changes. LVN 3 reviewed the resident progress notes and stated there was no documentation that the resident had a change of condition (COC, decline in a resident's status) on the skin of the left wrist. LVN 3 called TN 1. LVN 3 stated TN 1 stated the resident was seen by the wound care consultant that morning and would be started on antibiotics for an 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 7/24/2024 at 11:30 a.m., CNA 9 stated Resident 76 had an issue on his left wrist that was progressively getting worse. CNA 9 stated he did not know for how long the resident had the issue, but the charge nurses were aware. During an interview on 7/24/2024 at 2:09 p.m., with the Infection Preventionist (IP), the IP stated the facility currently has an outbreak (OB, the occurrence of disease cases in excess of normal expectancy) for IGAS. The IP stated the guidance given to the facility by the Department of Public Health was to monitor all residents for signs and symptoms of IGAS including open wounds with signs of infection. The IP stated a resident identified with an open wound with signs of infection should immediately be placed in contact/droplet isolation, the wound should be tested to confirm or rule out IGAS, the primary physician should be notified, and treatment should be started. During an interview and record review on 7/24/2024 at 5:26 p.m., with the IP reviewed Resident 76's Medication Administration Record (MAR) for 7/2024. The IP stated on 7/23/2024 evening shift LVN 3 documented that she monitored Resident 76 for s/s of IGAS and there were no s/s of skin infection present. The IP stated monitoring a resident's skin includes removing the clothing and completing a head-to-toe skin assessment. The IP stated when LVN 3 did not do a thorough skin assessment on Resident 76, LVN 3 did not identify the new skin issue and it resulted in a delay of the necessary care and treatment for the resident. During an interview on 7/24/2024 at 8:25 a.m., with LVN 3, LVN 3 stated she did not remove Resident 76's sleeves or clothing to monitor the resident's skin. LVN 3 stated if she would have done a thorough skin assessment on 7/23/2024, she would have identified the change of condition. LVN 3 stated because she did not do a skin assessment and it resulted in a delay in care to the resident and a delay in placing the resident in isolation. LVN 3 stated things should have been done with more urgency. During an interview on 7/25/2025 at 9:42 a.m., the IP stated anything new on a resident is a change of condition and should be reported. The IP stated LVN 3 did not follow the facility policy for monitoring for, identifying, and reporting a change of condition. During a review of the facility policy and procedure (P&P) titled, Outbreak of Communicable Diseases, last reviewed 1/10/2024, the P&P indicated outbreaks of communicable diseases within the facility are promptly identified and managed. The infection preventionist and director of nursing are responsible for monitoring ill residents and staff and initiating transmission-based precautions as appropriate. The nursing staff are responsible for notifying the director of nursing services of newly symptomatic residents, providing infection surveillance data in a timely manner. a.2. During an observation and interview on 7/24/2024 at 11 a.m., Licensed Vocational Nurse 3 (LVN 3) stated she was caring for Resident 76. Observed LVN 3 assessed Resident 76 sitting in a WC in the hallway and stated the resident had open wounds with discharge that she was not aware of. LVN 3 called TN 1. LVN 3 stated TN 1 stated the resident was seen by the WCC that morning and would be started on antibiotics for an 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 7/24/2024 at 1:32 p.m., TN 1 stated she provides daily skin treatments to Resident 76's generalized body rash that includes the bilateral upper extremities (both arms). TN 1 stated the facility currently has an OB of IGAS and the public health nurse thinks resident rashes may be related to the OB. TN 1 stated she noticed on 7/23/2024 that Resident 76's left wrist was irritated and moist. TN 1 stated she did not report to anyone that on 7/23/2024 the resident's wrist was irritated and moist. TN 1 stated Resident 76's left wrist was crustier today when she made rounds with the WCC at 6:30 a.m. and the WCC verbally ordered antibiotics for an infection of Resident 76's left wrist wound. TN 1 stated she was not given a start date for the antibiotics, so she was going to enter the verbal order to give the first dose on 7/25/2024, the next day. TN 1 then stated antibiotics should be given immediately or within two hours of an order. TN 1 stated the antibiotics should have been given by 8:30 a.m. TN 1 stated it was now 1:45 p.m. and the antibiotics had not been administered to Resident 76. TN 1 stated when antibiotics are delayed a wound can get worse. TN 1 further stated any residents with open wounds that have signs and symptoms of infection are considered possibly contagious and should be placed in contact/droplet isolation. TN 1 stated Resident 76 was not placed in contact/droplet isolation. TN 1 stated the facility is currently swabbing all open wounds to test for IGAS, but resident 76 was not swabbed. TN 1 stated she did not notify the IP or Director of Nursing (DON) that Resident 76 had an open skin wound with an infection, place the resident on contact/droplet isolation, or swab the resident's open wound because she was very busy that morning. During a review of Resident 76's Skilled Nursing Facility Wound Care Consultant notes, dated 7/24/2024, the notes indicated Resident 76 had an infected wound with scant serous drainage. The notes indicated to start the resident on Keflex 500 mg, four times a day for seven days. During an interview on 7/24/2024 at 2:09 p.m., with the IP, the IP stated the facility currently has an OB of IGAS. The IP stated the guidance given to the facility by the Department of Public Health was to monitor all residents for signs and symptoms of IGAS including open wounds with signs of infection. The IP stated a resident identified with an open wound with signs of infection should immediately be placed in contact/droplet isolation, the wound should be tested to confirm or rule out IGAS, the primary physician should be notified, and treatment should be started. The IP stated TN 1 did not notify her there were any newly identified residents with open wounds that had signs and symptoms of infection. The IP stated TN 1 should have notified her in the morning regarding Resident 76's wound so she could have assessed the wound, placed the resident in isolation, swabbed the wound for IGAS, and started the antibiotic treatment because the facility has an OB. The IP stated they want to prevent the OB from spreading to other residents. During a review of Resident 76's Medication Administration Record (MAR, a record of all medications taken by a resident on a day-to-day basis), the MAR indicated the following: -On 7/24/2024 at 3:15 p.m., TN 1 documented the administration of Keflex 500 mg capsule. (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 7/24/2024 at 3:17 p.m., with the IP, the IP stated she just assessed Resident 76's left wrist and there is an open wound with serous drainage. The IP stated TN 1 should have identified Resident 76's change of condition on 7/23/2024 and again on 7/24/2024 when TN 1 was with the WCC. The IP stated TN 1 should have notified the IP immediately because there is an OB. The IP stated she spoke with TN 1 and TN 1 stated she did not notify the IP because she was overwhelmed. During an interview on 7/25/2025 at 9:42 a.m., with the IP, the IP stated anything new on a resident is a change of condition and should be reported. The IP stated TN 1 did not follow the facility policy for monitoring for, identifying, and reporting a change of condition. During an interview and record review on 7/25/2024 at 5 p.m., with the DON, reviewed the facility policies regarding antibiotic medication administration. The DON stated for a new order of antibiotics, the first dose should be given within four hours of receiving the order. The DON stated TN 1 should have asked someone for help when she was making rounds with the WCC and was given a verbal order to start Resident 76 on antibiotics. The DON stated the facility policies do not specifically indicate antibiotics must be started within four hours, but it is a standard of practice. During a review of the facility policy and procedure (P&P) titled, Outbreak of Communicable Diseases, last reviewed 1/10/2024, the P&P indicated outbreaks of communicable diseases within the facility are promptly identified and managed. The infection preventionist and director of nursing are responsible for monitoring ill residents and staff and initiating transmission-based precautions as appropriate. The nursing staff are responsible for notifying the director of nursing services of newly symptomatic residents and providing infection surveillance data in a timely manner. During a review of the facility provided Group A Streptococcal (GAS) Infections form, undated, the form indicated Group A streptococci are bacteria commonly found in the throat and on the skin. Usually, these bacteria cause strep throat but can cause life threatening skin rashes or other infections. These bacteria are spread by direct contact with nose and throat secretions of someone who has an active infection. The risk of spread is greatest when an individual is ill, such as when people have strep throat or an infected wound. During a review of the facility provided Centers for Disease Control and Prevention, Decision Tool for investigating Group A Streptococcus Infections in Long-Term Care Facilities (LTCF), undated, it indicated one invasive case of GAS should prompt an epidemiological investigation by the LTCF infection control personnel. Identify additional symptomatic cases by surveying all residents for symptoms of GAS infection. Culture throat or skin lesions of residents as clinically indicated. Residents with suspected or confirmed GAS infection or colonization should be placed on appropriate Transmission-Based Precautions pending culture results: wound- residents with GAS cultured from a wound should remain on contact and droplet precautions until 24 hours after the initiation of effective antibiotic therapy and any wound drainage stops or can be contained by a dressing. During a review of the facility policy and procedure titled, Infection control 'Isolation Precautions', last reviewed 1/10/2024, the P&P indicated it is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure titled, Organizational Aspects, last reviewed 1/10/2024, indicated the pharmacy provides routine and timely pharmacy services seven days a week and emergency pharmacy service 24 hours per day, seven days a week. Medications which should be promptly available, such as anti-infectives are available within four hours. During a review of the facility policy and procedure titled, Medication Ordering and Receiving from Pharmacy, last reviewed 1/10/2024, indicated medications and related products are received from the dispensing pharmacy on a timely basis. Stat and emergency medications, the initial dose is obtained from the emergency kit and administered immediately. 43988 b. During a review of Resident 2's Admission Record, it indicated the facility admitted the resident on 9/29/2022 and readmitted the resident on 1/25/2023 with diagnoses including dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dermatitis (inflammation of the skin with dry skin, redness, and itchiness), and dermatophytosis (also known as ringworm, a fungal infection of the skin that may affect the skin, hair, and nails). During a review of Resident 2s History and Physical (H&P) dated 2/20/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 2s MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance from staff with mobility; substantial/maximal assistance with tub/shower transfers; and supervision or touching assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 2s care plan (CP), the CP indicated: -Group A Streptococcus Infection, Resident is at risk for sore throat, cough, fever more than 99.6, skin infection; tenderness or pain, heat, swelling, serous drainage at affected site related to exposure initiated 7/12/2024 indicated to utilize appropriate PPE if indicated as one of the interventions. During an observation on 7/23/2024 at 11:18 a.m. outside Resident 2's room by the door, observed a sign for EBP with instructions on the type of PPE to use during high contact activities with the resident. Observed inside the resident's room CNA 4 without a gown on while applying cream on Resident 2's skin. During an interview on 7/23/2024 at 11:27 a.m. with CNA 4, CNA 4 stated the sign by the door indicated Resident 2 was placed on EBP and he should be wearing a gown while providing care to the resident as the facility currently has an outbreak for IGAS. CNA 4 stated not wearing a gown can spread the infection among residents and staff. (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 7/25/2024 at 9:53 a.m., with the IP, the IP stated that all residents were placed on EBP following an outbreak of IGAS in the facility and staff were in-serviced multiple times on hand hygiene, proper donning (put on) and donning (take off) of PPEs, types of isolations, and EBP. The IP stated staff should wear an isolation gown and gloves after proper hand hygiene during direct patient care or high contact activities for residents on EBP. The IP stated CNA 4 was present during the in-services and CNA 4 should have donned an isolation gown while applying a cream to Resident 2 to prevent spread of infection among other residents and staff. During an interview on 7/26/2024 at 11:31 p.m., with the DON, the DON stated that all residents were placed on EBP due to exposure to IGAS infection. The DON stated CNA 4 should have donned an isolation prior to application of cream to Resident 2's skin. The DON stated all staff should wear an isolation gown and gloves after hand hygiene during close or direct patient care to prevent spread of infection among other residents and staff. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, last reviewed 1/10/2024, the P&P indicated EBP are utilized to prevent the spread of multi-drug resistant organisms (MDROs). The policy indicated: 1. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. o Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and patient care equipment in safe operating condition for one of one sampled resident (Resident 46) investigated during a random observation when Resident 46's bed controller (device used to change the height and angle of the bed) cable was observed with exposed wires. This deficient practice had the potential to place Resident 46 at risk for injury. Findings: During a review of Resident 46's Admission Record, it indicated the facility admitted the resident on 8/26/2019 and readmitted on [DATE] with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood, and history of falling. During a review of Resident 46's History and Physical (H&P) dated 3/15/2024, the HP indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/16/2024, the MDS indicated the resident had severe cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 7/23/2024 at 10:17 a.m., inside Resident 46's room, Resident 46 was observed in the wheelchair with the bed controller placed on top of the resident's bed and within reach. Observed the base of the bed controller cable with the white, red, green, and yellow wires exposed. During a concurrent observation and interview on 7/23/2024 at 10:17 a.m. inside Resident 46's room, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the base of resident's bed controller had exposed wires and further stated it is not safe for the resident to have exposed wires within their reach as it placed the resident at risk for injury from being electrocuted. CNA 1 stated she will notify the Maintenance Supervisor (MS) to change the bed controller. During an interview on 7/26/2024 at 10:49 a.m., with the Director of Nursing (DON), the DON stated the maintenance department makes rounds every month to check for any malfunctioning equipment in the building. The DON stated the staff are supposed to report any equipment issues to the MS such as a bed control with exposed wires. The DON stated a bed control with exposed wires placed the resident's safety at risk. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, last reviewed 1/10/2024, the P&P indicated the following: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Maintenance service shall be provided to all areas of the building, grounds, and equipment. - The maintenance department is responsible for maintaining the buildings grounds, and equipment in a safe and operable manner at all times. - Maintaining the building in good repair and free from hazards - Maintaining the heat/cooling system, plumbing fixtures, wiring, etc. in good working order.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 43988 Based on observation, interview, and record review, the facility failed ensure resident rooms meet the requirement of 80 square feet (sq feet - a unit of measurement) per resident in multiple resident bedrooms (Rooms 1, 2, 3, 4, 5, 6, 8, 10, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25, and 34). This deficient practice had the potential to result in inadequate usable living space and privacy for the residents and working space for the health caregivers. Findings: During a review of the Request for Room Size Waiver letter dated 7/23/2024 submitted by the Administrator, the letter indicated 19 rooms did not meet the 80 square feet requirement per federal regulation. The letter indicated the resident beds are in accordance with the special needs of the residents and will not adversely affect resident's health and safety and do not impede the ability of the residents in the room to obtain their highest practicable well-being. The following rooms provided less than 80 square; feet per resident: , Rooms # Beds Floor Area Sq. Ft. 1 3 238 2 3 232 4 3 212 5 3 212 6 3 212 8 3 212 10 3 213 12 3 212 14 3 212 16 3 212 17 3 212 18 3 212 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	19 3 212 20 3 212 21 3 212 22 3 212 23 3 212 23 3 212 34 3 212 The minimum square footage for a 3-bed resident room should be 240 sq ft. During a review of the Resident Council meeting minutes dated 5/21/2024, 6/18/2024, 7/9/2024, and 7/22/2024, the meeting minutes did not indicate there were no concerns brought up by the residents regarding the size of the rooms. During a concurrent observation and interview with Resident 40 on 7/24/2024 at 6:26 p.m. inside the resident's room, observed Resident 40 moving freely inside the room. Resident 40 stated she can move freely in the room, and she had ample space for her personal belongings. During interviews with staff on 7/24/2024 and 7/25/2024, there were no concerns regarding the size of the aforementioned rooms. During a general observation of the mentioned resident rooms on 7/23/2024 to 7/25/2024, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There were also sufficient space for beds, side tables and resident care equipment. The facility submitted a written request for continued waiver dated 7/23/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47441 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when one (1) fly (a type of insect) was observed flying in the kitchen and landing on surfaces and yellow cake. This deficient practice had a potential to result in 78 of 78 residents, who received food from the kitchen, to acquire food borne illnesses (illness caused by consuming contaminated foods or beverages) by consuming potentially contaminated food. Findings: During a concurrent observation of the kitchen and interview with the Registered Dietitian (RD) and the Dietary Supervisor (DS) on 7/23/2024 at 10:53 a.m., an insect landed on the can opener. The RD stated the insect was a fly. The DS stated the fly could be coming from the breakroom or office when staff opened the door. The DS stated they did not want the fly on the food because it could transmit germs and residents could get sick and an infection. During concurrent observation in the trayline (area where food was assembled) area and interview with the RD and the DS on 7/23/2024 at 12:34 p.m., a fly landed on a baked good placed on top of the trayline area. The DS stated the food on top of the trayline area was a yellow cake. The RD stated they would not use the yellow cake and would throw it away instead. During a review of facility's Policy and Procedure (P&P), titled, Pest Control Policy, dated 1/10/2024, the P&P indicated, The facility shall maintain an effective pest control program. (1) This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.