STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47883 Based on interview and record review, the facility failed to ensure an advance directive acknowledgement form (a 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) was complete and in the resident's medical chart for one of seven sampled resident (Resident 133). This deficient practice had the potential to result in the facility not honoring the resident's medical decisions regarding end-of-life treatment. Findings: A review of Resident 133's Admission Record indicated the facility admitted Resident 133 on 6/5/2024 with diagnoses including cerebrovascular disease (a condition that affect blood flow to your brain), myocardial infraction (a condition that happens when one or more areas of the heart muscle don't get enough oxygen), and diabetes Type II (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). A review of Resident 133's Minimum Data Set (MDS- standardized assessment and care planning tool) dated 6/9/2024, indicated the resident had moderately impaired cognition (ability to remember, learn and make decisions) and required substantial / maximal assistance for oral hygiene, upper body dressing, and personal hygiene. A review of Resident 133's History and Physical, dated 6/7/2024, indicated Resident 133 could make needs known but could not make medical decisions. During a concurrent interview and record review, on 4/17/2024 at 1:05 PM, Resident 133's medical chart was reviewed with the Social Services Designee 1 (SSD 1) who stated there was no Advance Directive Acknowledgment Form in Resident 133's medical chart. During an interview on 7/18/2024 at 12:36 PM, the Director of Nursing (DON) stated the Advance Directive Acknowledgment Form had to be filled out upon admission and that if the Advance Directive Acknowledgment Form was not filled out there was a potential the resident's end of life wishes may not be honored. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Advance Directives, revised January 2024, indicated upon admission the facility will provide the resident or the resident's representative with written information regarding to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment , and the right to formulate advance directives.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to provide a bed hold notification (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) in writing, at the time of transfer to the hospital for one of three sampled residents (Resident 61). This deficient practice denied Resident 61 or the Responsible Party (RP) of being informed of the resident's right to have the facility hold and reserve his bed while absent from the facility. Findings: A review of Resident 61's Admission Record (Face Sheet) indicated the facility originally admitted the resident on 5/29/2024, and readmitted on [DATE], with diagnoses including anemia, urinary tract infection (UTI) and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). A review of Resident 61's Bedhold Notification form, dated 5/29/2024 indicated the form had two sections, the first was To be Completed upon Admission and the second was To be Completed upon Transfer. Under the section To be Completed upon Admission, Resident 61's admitted was 5/29/2024 and the form was signed by Resident 61's family member on 5/30/2024. This section of the form also indicated, It is the policy of this facility to provide residents the right to secure a bed-hold during hospitalization on therapeutic leave from the facility. If you must be transferred to an acute hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you. A review of the To be Completed upon Transfer, section of the form indicated staff were to fill out where the resident was transferred to, the date, the resident or resident representative (RP) informed, who notified the resident/RP, how they were notified and if the copy was mailed. A review of the To be Completed upon Transfer section of Resident 61's form indicated the form was blank. A review of Resident 61's Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 7/4/2024, indicated the resident's cognitive skills (ability to think, remember and make decisions) for daily decision making was moderately impaired. The MDS indicated Resident 61 required partial to substantial assistance (helper does less than half to more than half the effort) from staff for oral hygiene, toileting hygiene, showering/bathing and upper and lower body dressing. A review of the Physician's Orders dated 7/11/2024, indicated to transfer Resident 61 to the General Acute Care Hospital (GACH) for further evaluation and management of bloody stool, bed hold for seven days. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 61's Progress Note dated 7/11/2024 indicated the charge nurse reported to the writer that the patient has an episode of bloody stool. The physician was made aware and ordered the resident to transfer out via 911 (a telephone number used to reach emergency medical, fire, and police services). The paramedics arrived and at 4:55 PM, the resident was transferred to hospital via 911. A review of Resident 61's Change in Condition (CIC) Evaluation, dated 7/11/2024, indicated the resident had an episode of bloody stool. The CIC form indicated the primary physician was notified and the primary physician ordered the facility to transfer Resident 61 to the hospital via 911 A review of Resident 61's Notice of Proposed Transfer/Discharge form, dated 7/11/2024, indicated the transfer or discharge was necessary for the resident, the date of the discharge was 7/11/2024 and the resident was sent to a general acute care hospital. During a interview and concurrent record review on 7/18/2024 at 8:46 AM, Resident 61's electronic health record was reviewed. Registered Nurse Supervisor 2 (RN 2) stated per the CIC, Resident 61 was transferred to the hospital for blood in the stool. The resident was transferred on 7/11/2024. Upon review of Resident 61's CIC and progress notes, RN 2 stated there was no documentation that the family or resident was notified of the 7-day bed-hold. RN 2 stated generally the family was informed about the 7-day bed-hold upon notification of the family of the resident's transfer. RN 2 further stated neither Resident 61 nor the family was not provided with a written bed hold notification upon Resident 61's transfer to the hospital on 7/11/2024 and the facility policy was just for the physician to order a 7-day bed-hold. During an interview on 7/18/2024 at 9:02 AM, the Medical Records Director (MRD) stated there was no bed hold form given to the resident or RP. The MRD stated there was a bed hold order by the physician and the resident and/or family were advised of the bed-hold policy as part of the admission agreement. During an interview on 7/18/2024 at 3:49 PM, the Administrator (ADM) stated when the resident was admitted , the resident/family gets a packet informing them of the bed-hold policy. The ADM also stated we do not mail a written notice of bed-hold. A review of the federal guidelines indicated for bed-hold notice upon transfer; at the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy. A review of facility's policy and procedure titled, Bed-Holds and Returns, revised 3/2023, indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed of the bed-hold and return policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to develop a person-centered care plan timely for three of 29 sampled residents (Residents 117, Resident 51, and Resident 136). Resident 117, who was receiving occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) services, did not have a care plan for OT treatment. Resident 51 did not have a care plan for the Hoyer Lift during transfer and Resident 136 did not have an Out On Pass care plan. These deficient practices caused an increased risk in accidents leading to harm and there was a lack of individualized care effecting the services provided to the residents. Findings: a. A review of Resident 117's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including brachial plexus (network of nerves in the shoulder) disorders, muscle weakness, and difficulty walking. A review of Resident 117's physician's History and Physical Examination dated 12/25/23 indicated Resident 117 had the capacity to understand and make decisions. A review of Resident 117's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/21/24 indicated Resident 117 had moderate cognitive impairments, functional limitation impairment in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity and no functional limitation impairment in ROM on both sides of the lower extremity (hip, knee, ankle, foot). The MDS also indicated Resident 117 required partial or moderate assistance for lying to sitting on side of the bed, bed to chair transfers, and walking 10 feet. A review of Occupational Therapy treatment encounter notes indicated Resident 117 received OT treatments on 6/26, 6/27/24, 7/2, 7/7, 7/9, 7/14, and 7/15/24. A review of Resident 117's care plans did not indicate a care plan for OT treatment. During an observation and interview on 7/15/24 at 10:04 AM, in Resident 117's room, Resident 117 was standing with a front-wheeled walker and looking out the window. Resident 117 was able to walk short distances inside the room with the front-wheeled walker, stated she was receiving therapy, and that therapy was helping her get better. During a concurrent interview and record review on 7/16/24 at 10:47 AM, the Director of Rehabilitation (DOR) reviewed Resident 117's therapy records and stated Resident 117 was currently receiving OT treatment three times a week. The DOR reviewed Resident 117's care plan and stated there was no OT care plan for Resident 117 and that there should be a care plan for any resident that was receiving OT services. The DOR stated therapy care plans were important so staff could see what the general plan in therapy was for the resident. (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 7/17/24 at 9:54 AM, the Director of Nursing (DON) stated all residents on therapy services required a care plan and the purpose of care plans was to individualize the care provided to the resident and for all staff to know what type of specific care was needed for the resident. The DON stated care plans were discussed and reviewed to determine the effectiveness of the current care provided to the resident. A review of the facility's policy and procedure revised 1/2024, titled, Care Plans - Comprehensive, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, mental and psychological needs is developed for each resident. b. A review of Resident 51's Admission Record indicated Resident 51 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left dominant side. A review of Resident 51's physician's History and Physical dated 6/3/24 indicated Resident 51 lacked capacity to make medical decisions and was non-verbal. A review of Resident 51's MDS dated [DATE] indicated Resident 51 was moderately impaired in cognitive skills for decision making and required dependent assistance (helper does all of the effort, resident does none of the effort, or the assistance of two or more helpers was required) with oral hygiene, bed to chair transfers, rolling left and right. The MDS also indicated walking was not attempted. A review of Resident 51's Nursing Fall Risk assessment dated [DATE] indicated a score of 18. The Fall Risk Assessment indicated a score of 18 was a high risk for falls. A review of Resident 51's care plan did not indicate a care plan for type and level of assistance from staff Resident 51 required for ADLs and transfers. During an observation and interview on 7/15/24 at 12:50 PM in Resident 51's room, two staff members assisted Resident 51 behind the privacy curtain around the resident's bed. The privacy curtain was removed, and Resident 51 was observed laying on a geriatric chair (a large, padded chair designed to help persons with limited mobility) with eyes closed and neck flexed. There was no Hoyer lift machine (a mechanical lift that allows a person to be transferred from one surface to another) or sling (flexible material used to support a person during a mechanical lift transfer) observed in the room. Certified Nursing Assistant (CNA) 1 stated she was Resident 51's assigned CNA today and just completed a transfer with another CNA from the bed to the geriatric chair. CNA 1 stated they used a bed sheet underneath the resident to slide the resident onto the chair instead of using a Hoyer lift. (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 and record review on 7/16/24 at 2:28 PM, the Registered Nurse Supervisor (RN 1) stated Resident 51 was very dependent with all care, not alert, and did not talk. RN 1 stated Resident 51 was dependent with all transfers. RN 1 stated Resident 51 needed a Hoyer lift for transfers because Resident 51 was very dependent and could not help with the transfer. RN 1 stated the facility should care plan how much assistance Resident 51 needed with all ADLs including transfers so that staff would know how much assistance to provide the resident. After a review of Resident 51's records at the nursing station, RN 1 stated there was no care plan for how much assistance Resident 51 needed for ADLs and transfers. RN 1 stated it was important to have a care plan because the care plan indicated the intervention for the residents and communicated to staff how to care for the resident. RN 1 stated if staff used the wrong transfer method with Resident 51, then Resident 51 could have a fall incident. A review of the facility's policy and procedure revised 1/2024, titled, Care Plans - Comprehensive, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, mental and psychological needs is developed for each resident. A review of the facility's policy and procedure revised 1/2024, titled, Activities of Daily Living (ADLs), Supporting, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene, mobility, elimination, dining, and communication. 47883 c. A review of Resident 136's Admission Record indicated the facility admitted the resident on 6/21/24, with diagnoses including acute embolism (obstruction of an artery from blood clot or air bubble) and thrombosis of right perineal vein (a clinical conditions affecting the veins and arteries in the right lower extremity), unspecified mental disorder (a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior), muscle weakness and depressive episode (a person experiences a depressed mood [feeling sad, irritable, empty]). A review of Resident 136's History and Physical, dated 6/21/24, indicated the resident had the capacity to make needs known, but not to make medical decisions. A review of Resident 136's MDS dated [DATE], indicated the resident had mildly impaired cognition, needed partial assistance for eating, dressing, oral and toileting hygiene, and maximal assistance with walking 10 feet. A review of the Physician's Order, dated 6/28/2024 indicated Resident 136 may go out of pass. During concurrent interview and record review on 7/16/2024 at 1 PM, the Social Service Director (SSD) stated Resident 136 went out on pass with her family member on 7/8/2024. The SSD stated that during the outing, around 2:30 PM, the family member left the resident unattended and was not able to locate Resident 136 until 10:15 PM. The SSD stated that after this accident, Resident 136's family member was removed from the list who can take the resident out on pass for further instance, but the SSD did not initiate a care plan reflecting the accident occurrence. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/18/2024 at 4:25 PM, Resident 136's chart was reviewed with Director of Nursing (DON). The DON stated no accident care plan was initiated for Resident 136 and that it was important to initiate a care plan after the accident occurred, with measurable objectives to meet the residents' needs and desired outcomes. A review of the facility's policy and procedure revised 1/2024, titled, Care Plans - Comprehensive, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, mental and psychological needs is developed for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to update one of 29 sampled residents (Resident 56) physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person ' s capability to participate in everyday life activities) care plans to reflect changes in the PT and OT services. This deficient practice had the potential for Resident 56 to receive incorrect services and minimize the facility's ability to review the effectiveness of PT and OT services. Findings: A review of the Admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including cerebral edema (swelling in the brain), muscle weakness, difficulty walking. A review of the Physician's History and Physical Examination dated 12/11/23 indicated Resident 56 did not have the capacity to understand and make decisions. A review of Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/7/24 indicated Resident 56 had severe cognitive impairment, had functional limitation in range of motion impairment on one side of the upper extremity (shoulder, elbow, wrist, hand) and both sides of the lower extremity (hip, knee, ankle, foot). The MDS also indicated the resident required substantial or maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting hygiene, upper and lower body dressing, and bed to chair transfers, and walking was not attempted. A review of Physician's Order Summary Report dated 7/10/24 indicated for Resident 56 an OT clarification order: skilled OT two times a week for four weeks and for PT re-clarification order: skilled PT four times a week for four weeks. A review of the OT care plan dated 12/11/23 indicated Resident 56 had a decline in grooming / personal hygiene, dressing, activity tolerance and required OT treatment five times a week for four weeks. A review of the PT care plan dated 12/11/23 indicated Resident 56 required skilled PT due to muscle weakness for six times a week for four weeks. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/16/24 at 10:47 AM, the Director of Rehabilitation (DOR) reviewed Resident 56's medical records and stated Resident 56 was currently on skilled OT services for two times a week for four weeks, and on skilled PT services for four times a week for four weeks. The DOR reviewed Resident 56's OT care plans and stated the OT care plan did not reflect the current services and frequency Resident 56 was receiving in OT. The DOR reviewed Resident 56's PT care plan and stated the PT care plan did not reflect the current services and frequency Resident 56 was receiving in PT. The DOR stated the OT and PT care plans should be updated when the therapists changed the frequency and services provided to the residents, to reflect what the resident was currently receiving from therapy. The DOR stated therapists were supposed to develop an initial care plan after the initial evaluation to include basic impairments, goals, frequency and duration of treatment, and that when any of these were changed, the care plans should also be updated. The DOR stated it was important to update care plans because care plans outlined the general plan for the resident on therapy. During an interview on 7/17/24 at 9:54 AM, the Director of Nursing (DON) stated all residents on therapy services required a care plan and the purpose of care plan was to individualize the care provided to the resident and for all staff to know what type of specific care was needed for the resident. The DON stated care plans should be updated based on the current care provided to the resident. A review of the facility's policy and procedure revised 1/2024, titled, Care Plans - Comprehensive, indicated the comprehensive care plan is based on a thorough assessment and care plans are revised as information about the resident and the resident's condition change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47883 Based on observation, interview, and record review, the facility failed to ensure that residents were provided a communication device or board with the language that the resident was able to understand for one of one sampled resident (Resident 133). This deficient practice prevented the resident from communicating with the staff and had the potential to delay receiving the care/treatment the resident needed. Findings: A review of Resident 133's Admission Record indicated the facility admitted Resident 133 on 6/5/2024 with diagnoses including cerebrovascular disease (a condition that affect blood flow to your brain), myocardial infraction (a condition that happens when one or more areas of the heart muscle don't get enough oxygen), and diabetes type two (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). A review of Resident 133's Minimum Data Set (MDS- standardized assessment and care planning tool) dated 6/9/2024, indicated that the resident had moderately impaired cognition (a moderate damaged mental abilities, including remembering things, making decisions, concentrating, or learning) and required substantial/maximal assistance for oral hygiene, upper body dressing, and personal hygiene. A review of Resident 133's History and Physical , dated 6/7/2024, indicated that Resident 133 can make needs known but cannot make medical decisions. A review of Resident 133's Activity Assessment, initiated on 6/5/2024, indicated that the resident's primary language is Spanish. During a concurrent observation and interview on 7/15/2024 at 11:00 AM, with Resident 133's Family Member 1 (FM 1), the resident was observed in her room with notes on the wall stating, Spanish speaking only. FM 1 stated that the resident speaks Spanish only and there were not always Spanish speaking nurses around to communicate with the resident. FM 1 stated Resident 133 is alert and oriented and understands but does not speak English. She stated that there is no communication device or board in Resident 133's room. FM 1 stated that a communication device would make it clearer what the resident wanted. She stated that she was not aware that there was any type of communication device for the resident to use to communicate. During a concurrent interview and record review on 7/18/2024 at 10:11 AM, the Activity Director (AD) stated Resident 133 speaks only Spanish. She stated that Resident 133's relatives were coming every day and helping to communicate with the resident. The AD stated that the facility should provide a communication board for Resident 133 to make communication easier when her relatives are not around. She stated that the communication board is for residents who have difficulty communicating to help residents communicate better with staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2024 at 12:36 PM, the Director of Nursing (DON) stated that Resident 133 was unable to speak English and a care plan with interventions to provide a communication board for Resident 133 should have been developed after the activity assessment was done. He stated that if Resident 133 was not provided a communication device or board, there was the potential that the resident would have difficulty communicating accurately with staff. A review of the facility's policy and procedure title Communication Language Barrier, revised 1/2024, indicated : Residents with visual, hearing, or language barrier will be provided an equal opportunity to participate in and to benefit from these services. Residents with a Communication Language Barrier: . utilize visual aide(i.e. communication board, white board, tablets) and /or gesture for basic care needs.

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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. 47883 Based on observation, interview, and record review the facility failed to obtain a physician's order for a low air loss mattress (LALM) and to maintain the correct setting of a LALM for one of three sampled residents (Resident 128). This deficient practice had the potential to result in the failure of delivery of necessary care to maintain the skin integrity (the health of skin) of Resident 128. Findings: A review of Resident 128's Admission Record indicated that the facility admitted Resident 128 on 4/26/2024 and readmitted her on 5/3/2024 with diagnoses including polyneuropathies (a condition when multiple peripheral nerves became damaged), type 2 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and pressure ulcer of right hip unspecified stage (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the right hip). A review of Resident 128's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/9/2024, indicated that Resident 128 had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks) and required maximal assistance for dressing, personal hygiene, and all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated that Resident 128 had one unstageable pressure ulcer which was present upon admission. A review of Resident 128's History and Physical dated 5/7/2024, indicated that Resident 128 had the capacity to understand and make decisions. A review of Resident 128's Order Summary Report, dated 7/17/2024, indicated that there was no order for a LALM. During a concurrent observation and interview with Licensed Vocational Nurse 5 (LVN 5) on 7/15/2024 at 10:20 AM, Resident 128 was observed in bed on a LALM with a setting of 180. LVN 5 stated that an LALM has to be set according to the resident's weight and that it was the responsibility of the treatment nurse to make sure it was on the correct setting. LVN 5 stated that having the correct setting on the LALM was important to prevent pressure injuries. During a concurrent observation and interview on 7/18/2024 at 9:36 AM, the surveyor observed Treatment Nurse 1 (TN 1) providing skin treatment to Resident 128. TN 1 stated that Resident 128's weight was 108 pounds (lb. - unit of weight measurement) and the 180 was the incorrect setting for her LALM. TN 1 stated that it was important to obtain and follow the physician's order for the correct setting of LALM for each resident. During an interview on 7/18/2024 at 12:36 PM, the Director of Nursing (DON) stated that licensed nurses had to obtain a physician's order for the LALM. The DON further stated that the LALM had to be set according to the resident's weight to maintain the resident's skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's recent policy and procedure titled Prevention of Pressure Ulcers/Injuries, last reviewed on 1/21/2024, indicated: Select appropriate support surfaces based on resident's mobility .body size, weight, and overall risk factors. Utilize pressure relieving devices(. low air loss mattresses .) as per manufacturer's guidelines and in accordance with physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observations, interviews, and record reviews, the facility failed ensure environment was free of accident hazards for two of ten sampled residents (Resident 51 and Resident 19). For Resident 51. the facility did not use the hoyer lift (a mechanical lift that allows a person to be transferred from one surface to another) to transfer the resident and for Resident 19, the facility failed to place foot rests on the resident's wheelchair during transport. These deficient practices caused an increased risk in hazards with the potential to cause a fall with injury to the residents. Findings: A review of Resident 51's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left dominant side. A review of the Physician's History and Physical dated 6/3/24, indicated Resident 51 lacked capacity to make medical decisions and was non-verbal. A review of Resident 51's Nursing Fall Risk assessment dated [DATE], indicated the resident was a high risk for fall with a score of 18. A review of Resident 51's Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 6/25/24, indicated Resident 51 was moderately impaired in cognitive skills for decision making and required dependent assistance (helper did all of the effort, resident did none of the effort, or the assistance of two or more helpers was required) with bed to chair transfers, rolling left and right. The MDS indicated walking was not attempted. During an observation on 7/15/24 at 12:50 PM in Resident 51's room, two staff members assisted Resident 51 behind the privacy curtain around the resident's bed. The privacy curtain was removed, and Resident 51 was observed laying on a geriatric chair (a large, padded chair designed to help persons with limited mobility) with eyes closed and neck flexed. There was no hoyer lift machine or sling (flexible material used to support a person during a mechanical lift transfer) observed in the room. During a concurrent interview, Certified Nursing Assistant (CNA) 1 stated she was Resident 51's assigned CNA today and just completed a transfer with another CNA from the bed to the geriatric chair. CNA 1 stated they used a bed sheet underneath the resident instead of using a hoyer lift. CNA 1 stated using the bed sheets to transfer the resident instead of the hoyer lift was not the best option and could be a fall risk. CNA 1 stated Resident 51 was 100 percent dependent with all care. During an observation and interview on 7/16/24 at 9:21 AM in Resident 51's room, the privacy curtain was drawn. Upon entering the room with permission, CNA 1 and CNA 2 stood around Resident 51 who was sitting up in a shower chair with neck flexed. There was no hoyer lift machine or sling observed in the resident's room. CNA 2 stated CNA 1 and CNA 2 both lifted Resident 51 under the shoulder and transferred Resident 51 from the bed to the shower chair and did not use a hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 10:47 AM, the Director of Rehabilitation (DOR) stated if a resident required two staff to transfer and if a resident was completely dependent and a high fall risk, the recommendation indicated that nursing staff use a hoyer lift to transfer a resident. The DOR stated a hoyer lift transfer was recommended for safety for the resident and for the staff completing the transfer to protect them from injuries. During an interview on 7/16/24 at 2:28 PM, the Registered Nurse Supervisor (RN 1) stated Resident 51 was very dependent with all transfers, not alert, and did not talk. When asked how staff should have transferred the resident, RN 1 walked into Resident 51's room and showed a laminated white sign posted on the wall across Resident 51's bed. The laminated with sign had Resident 51's name and room number. The sign had one two and hoyer lift and a black circle around the words hoyer lift. RN 1 stated this sign was completed by the therapy staff and the sign communicated to all staff how they should have transferred the resident. RN 1 stated staff should have used a hoyer lift to transfer Resident 51 safely. RN 1 stated Resident 51 needed a hoyer lift for transfers because Resident 51 was very dependent and could not help with the transfer. RN 1 stated if staff used the wrong transfer method with Resident 51, then Resident 51 could have a fall incident. During an interview and record review of Resident 51's medical records, on 7/17/24 at 9:54 AM, the DON stated Resident 51 was assessed as a high fall risk and the rehab staff could use the sign in the room and mark how much assistance to use such as 1 person, 2 person or hoyer lift. The DON stated if the hoyer lift was circled on the sign, then staff should have used the hoyer lift to transfer the resident. The DON stated if a resident was dependent and did not help at all with transfers, then a hoyer lift should have been used for transfers. The DON stated if staff did not use a hoyer lift to transfers a resident, then not using one was a safety risk and risk for falls because the hoyer lift was what was determined to be a safe transfer for Resident 51 and staff did not follow the recommendation. A review of the facility's policy and procedures revised January 2024, titled, Activities of Daily Living (ADLs), Supporting, indicated appropriate care and services would be provided for residents who were unable to carry out ADLs independently, including appropriate support and assistance with transfer. 48661 b. A review of Resident 19's Admission Record indicated the facility admitted the resident on 6/5/24 with diagnoses including muscle weakness (decrease in muscle strength), difficulty in walking, and osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time). A review of Resident 19's Physical Therapy Care Plan dated 6/6/2024, indicated a goal for the resident for wheelchair mobility to be improved. The Care Plan indicated interventions for wheelchair mobility training but did not include ensuring foot rests must be applied during wheelchair use. A review of Resident 19's Decreased Functional Mobility Care Plan dated 6/6/2024, indicated a goal for the resident to improve activities of daily living (ADL) skills. The Care Plan indicated interventions for wheelchair mobility but did not include ensuring foot rests must be applied during wheelchair use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 19's MDS dated [DATE], indicated the resident had severe cognitive impairment (ability to think, remember, and make decisions) and required partial / moderate assistance on facility staff for showering and transfers. A review of Resident 19's Nursing Progress Note dated 6/24/2024, indicated the resident was up in the wheelchair, but the progress note did not indicate if the leg rests were placed on the wheelchair. A review of Resident 19's Change in Condition (COC) dated 7/8/2024 at 4:35 PM, indicated the resident was sitting in the wheelchair without leg rests and an in-service was done with all facility staff to ensure leg rests were placed when the resident was sitting in the wheelchair. The COC indicated the resident was calm, did not have signs or symptoms or distress, and no psychological or social trauma was noted. The COC indicated the resident's representative, and the physician were notified, and no new orders were obtained. During an observation on 7/15/2024 at 11:46 AM, Resident 19 was observed sitting in the wheelchair outside on the patio with both foot rests on the wheelchair. During an observation on 7/16/2024 at 10:01 AM, Physical Therapy (PT) was observed putting Resident 19 in the wheelchair. The PT placed both leg rests on the wheelchair once the resident was in the sitting position. During an interview on 7/16/2024 at 10:48 AM, the Resident's Representative (RR) stated Resident 19 was going to an appointment and the facility sent Resident 19 in a wheelchair without leg rests or shoes during the transfer. The RR showed a picture of the resident at the appointment sitting in a wheelchair with no leg rests or shoes. Resident 19 had gray non-skid socks on. During an interview on 7/18/2024 at 12:15 PM, the Occupational Therapist (OT) stated the resident was able to lift both legs up but for appointments, Resident 19 should have had the leg rests on. The OT stated if the leg rests were not on, the resident's feet could drag, and he could have an injury. During an interview on 7/18/2024 at 1:00 PM, the Director of Nursing (DON) stated the foot rest should have been on for the resident's appointment. The DON stated if the foot rests were not on, the resident could be traumatized if the resident tried to step and could potentially hurt both legs. A review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated January 2024, indicated resident safety and supervision and assistance to prevent accidents were facility-wide priorities. Implementing interventions to reduce accident risks and hazards shall include the following: assigning responsibility for carrying out interventions and ensuring that interventions were implemented. The P&P indicated the facility-oriented and resident-oriented approaches to safety were used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Assistive Devices and Equipment, dated January 2024, indicated recommendations for the use of devices and equipment were based on the comprehensive assessment and documented in the resident's plan of care. Resident's, family, and visitors would be trained, as indicated, on the safe use of equipment and devices.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49604 Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Resident 144, Resident 39 and Resident 294), who received dialysis (process of removing waste products and excess fluid from the body) treatment received care and services in accordance with the professional standards of practice, by failing to: -Document Resident 294's assessment in the dialysis communication record. -Communicate with the resident's dialysis center about Epogen (a medication to treat anemia caused by chronic kidney disease) being administered during dialysis treatment for Resident 39 and Resident 294. Findings: a. A review of Resident 144's admission record indicated the facility admitted the resident on 7/9/2024 with diagnoses including end stage renal disease (ESRD - loss of kidney function in which the kidneys no long work to meet the body's needs) and dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) and diabetes (high blood sugar). A review of the Physician's History and Physical dated, 7/9/2024, indicated Resident 144 could make her needs known but could not make medical decisions. It also indicated Resident 144 was diagnosed with ESRD and was on hemodialysis (HD - a process of filtering the blood of a person whose kidneys are not working). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 7/9/2024 indicated Resident 144's cognition was moderately impaired, required extensive assistance with one-person assist in locomotion on and off unit, dressing and personal hygiene. The MDS indicated the resident was totally dependent upon staff for toileting hygiene and was receiving dialysis treatment. A review of Resident 144's Order Summary Report indicated the physician ordered the following: - On 7/9/2024, to monitor the resident's permacath (a flexible tube placed into the blood vessel in your neck or upper chest, used for dialysis treatment) site: right upper chest wall for bleeding and signs and symptoms of infection every shift. - On 7/12/2024, for the resident to receive dialysis every Tuesday, Thursday and Saturday via a right upper chest permacath. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 144's dialysis care plan, initiated 7/11/2024, indicated the resident was at risk for fluid overload related to the kidney's inability to regulate fluid balance and the resident was at risk for hemodialysis (HD) access site infections and bleeding. The goal was to have no episodes of shortness of breath, chest pain, pruritis, nausea or vomiting and swelling. The care plan interventions included to coordinate the HD schedule with the dialysis center and transportation, assess for dependent edema if present or if there was an increase in edema, notify MD. Labs as ordered and coordinate with HD center. A review of Resident 144's Licensed Personnel Progress Notes, dated 7/13/2024, indicated the resident returned from HD via gurney with no acute distress, no shortness of breath or signs and symptoms of infection noted. It did not indicate the Dialysis Unit Progress form and Post Dialysis Checklist was reviewed or that the dialysis center was contacted in order for them to complete the dialysis unit progress section of the communication form. During a concurrent interview and record review on 7/16/2024 at 10 AM, Resident 144's medical chart was reviewed. Registered Nurse (RN) 2 stated the dialysis center's section was not completed on the dialysis communication form, dated 7/13/2024. RN 2 stated the Dialysis Unit Progress form and Post Dialysis Checklist should be completely filled out and it was important to know what occurred during the dialysis treatment because the resident could experience hypotension, hypovolemia or edema. RN 2 stated when the dialysis section was not filled out, the nurse or medical records contacts the dialysis center to have them complete the form. RN 1 stated there was no documentation in the chart indicating the dialysis center was contacted regarding the 7/13/2024 form. During an interview on 7/16/2024 at 12:29 PM, the Medical Records Assistant (MRA) stated they have not contacted the dialysis center regarding Resident 144's dialysis communication form. During a concurrent interview and record review on 7/16/2024 at 5:13 PM, the Dialysis Unit Progress form and Post Dialysis Checklist was reviewed. The Administrator (ADM) stated the Dialysis Unit Progress form and Post Dialysis Checklist, dated 7/13/2024, should have been reviewed by the facility staff when the resident returned from dialysis and the dialysis center should have been contacted in order to complete the form. The ADM stated a possible outcome of not having the form completed was the resident could experience low blood pressure, also risk of not knowing how much fluid was removed and any complication that occurred during dialysis. A review of the facility's policy and procedure titled, Dialysis Services, revised 1/2024, under the section Dialysis Unit Progress and Post Dialysis Checklist indicated: This form will accompany the resident to dialysis and requests that the dialysis unit complete with the following information: -The facility will take vitals signs before and after dialysis. -The Dialysis center will communicate with the facility dialysis treatment adverse reaction complication during dialysis. -Pre-and post-dialysis weight and vital signs. -Any labs performed and results. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Any medications administered or Epogen given 47883 b. A review of Resident 39's Admission Record indicated the facility admitted the resident on 6/15/2024 with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), end stage of renal disease (final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidney stop working properly). A review of Resident 39's History and Physical, dated 6/15/2024, indicated the resident can make needs known but cannot make medical decisions. A review of Resident 39's MDS dated [DATE], indicated the resident had mildly impaired cognition, required partial assistance for eating, and was dependent on two or more helpers for toileting hygiene, and lower body dressing. A review of Resident 39's Order Summary Report, dated 7/17/2024 indicated the order for dialysis every Monday, Wednesday, and Friday at Dialysis Center 1 (DC 1) and an order for Epogen to be given at the dialysis center. During a concurrent interview and record review on 7/17/2024 at 3:16 PM, Resident 39's Order Summary Report dated 7/17/2025 and dialysis communication record dated 7/1, 7/3, 7/5, 7/8, 7/10 and 7/12, 7/18/2024 were reviewed by RN 2 who stated that there was no evidence in communication notes that Epogen was administered at the DC 1. RN 2 stated it was important to provide this information in Communication Dialysis Record. During a phone interview on 7/17/2024 at 2:10 PM, the Registered Nurse (RN) from DC 1 stated Epogen was given to Resident 39 all the time she was receiving treatment at the dialysis center 1 but was not recorded in the Communication Dialysis Record. During an interview on 7/18/2024 at 12:36 PM the DON stated it was important to provide information about the medication given to Resident 39 during the dialysis treatment in the ongoing Communication Dialysis Record with DC 1 to ensure Resident 39 received care and services needed. 44253 c. A review of Resident 294's admission record indicated the facility readmitted the resident on 7/3/2024 with diagnoses including ESRD, dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) and diabetes (high blood sugar). A review of Resident 294's Physician's Order, dated 7/3/2024 indicated for the resident to receive dialysis every Tuesday, Thursday and Saturday at Dialysis Center (DC) 2. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 294's dialysis care plan, initiated 7/3/2024, indicated the resident required hemodialysis (HD) due to ESRD. The goal was for the resident to have immediate intervention should any sign or symptom of complication from dialysis occurred. The care plan interventions included to monitor / document / report signs of bleeding, hemorrhage, bacteremia and septic shock and for Epogen to be given at dialysis center on dialysis days. A review of the MDS, dated [DATE], indicated Resident 294's cognition was intact, required substantial assistance with personal hygiene, and was receiving dialysis treatment. A review of Resident 294's Physician's Order, dated 7/15/2024, indicated Epogen to be administered at dialysis center. A review of the facility's Dialysis Communication Record indicated the front page consisted of three sections, the pre- hemodialysis assessment section, a section to be filled out by the dialysis center, and a post dialysis assessment section. A review of Resident 294's Dialysis Communication Record, dated 7/16/2024 indicated in the section for the dialysis unit to complete under special instructions / recommendation the resident was given Vancomycin 500 mg at the dialysis center. A review of the form indicated there was no evidence Epogen was given. During an interview on 7/17/2024 at 10 AM, Resident 294 stated she did not receive an Epogen injection during dialysis the day prior. During a concurrent interview and record review on 7/17/2024 at 12:38 PM, Resident 294's Dialysis Communication Record, dated 7/16/2024 was reviewed. Licensed Vocational Nurse (LVN) 3 stated the physician ordered Resident 294 to receive Epogen at the dialysis center. LVN 3 stated the form did not indicate the resident received dialysis and the form should have been followed up on. During a phone interview on 7/17/2024 at 2:09 PM, Dialysis Center 2 Registered Nurse (DRN) stated that Resident 294 did not receive Epogen on 7/16/2024 and based on the resident's low hemoglobin (protein contained in red blood cells that is responsible for delivery of oxygen to the tissues) level of 9.7 (normal range of 12 to 16 grams per deciliter for females), Resident 294 should have received the Epogen. The DRN stated, We write on the facility communication form any medications given during dialysis. When notified Resident 294's, Dialysis Communication Form did not indicate Epogen was given, the DRN stated if the Epogen was not documented on the form, that meant Resident 294 did not receive the Epogen. That just confirms it. During an interview on 7/18/2024 at 3:56 PM, the ADM stated the dialysis communication form was a communication between the facility and the dialysis center. The ADM stated if anything on the form was incomplete, we should follow up with the dialysis center. The ADM stated it was important to follow-up to make sure the resident received the care needed. A review of the facility's policy and procedure titled Dialysis Services, revised 1/2024, indicated the facility will communicate regarding care, services and the physician medication and treatment orders with the dialysis center.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28851 Based on interview and record review, the facility failed to ensure there was an emergency drug supply (E-Kit) usage or administration log. The facility also failed to ensure there was wastage documentation of a controlled drug removed from the E-Kit. These deficient practices had the potential of drug diversion and / or medication errors. Findings: On 7/16/2024 at 2:04 PM during an observation and a concurrent interview in the medication room at the nursing station on the first floor, Licensed Vocational Nurse (LVN) 1 did not know of an administration log or binder for the E-kit. LVN 1 stated nurses fill out the emergency drug kit slip and place it in the E-kit after removing a medication from the kit. During an interview on 7/16/2024 at 2:12 PM, Registered Nurse Supervisor (RN) 1 stated nurses would turn in the yellow slip to Assistant Director of Nursing (ADON). On 7/16/2024 at 2:15 PM during an interview, the ADON presented a Ziploc bag containing a stack of yellow emergency drug kit slips (the yellow carbon copy indicated it was facility record), stacked, approximately about three inches high. The ADON stated those slips were dated since the beginning of the year and the facility did not have a binder or log book recording E-Kit usage. During an interview and concurrent record review of a randomly selected yellow E-Kit slips, on 7/16/2024 at 2:20 PM, the ADON stated the E-Kit slip dated 4/17/2024 for Oxycodone (a potent narcotic to treat pain), under the strength, it was written 10 mg / (illegible). After reviewing an electronic health record, the ADON called the pharmacist who stated the nurse probably took out two tablets of Oxycodone 10 mg from the E-Kit and wasted half a tablet. The ADON stated the nurse should have documented the wastage of the Oxycodone. When asked where nurses would document wastage of medication retrieved from E-Kit, the ADON stated she did not know; the controlled substances stored in the E-Kit did not have the accountability record that were regularly dispensed from the pharmacy. A review of the facility policy and procedures titled, Emergency Medications, dated January 2024, indicated required documentation after dispensing an emergency medication is the same as for any other medication. Any medication that was removed from the emergency kit must be documented on the emergency medication administration log. A review of the facility policy and procedures titled, Discarding and Destroying Medications, dated January 2024, indicated for emergency kit controlled substances disposal, complete the appropriate portions of the controlled medication accountability form.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48661 Based on observation, interview, and record review, the facility failed to maintain proper storage of medications for one of 10 sampled residents (Resident 76), when a bottle of Vitamin C (a nutrient that is vital to the body's healing process) was at the bedside. This deficient practice had the potential for Resident 76 to take medications without the supervision of staff. Findings: A review of Resident 76's Admission Record indicated the facility admitted the resident on 5/17/2024 with diagnoses including anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), muscle weakness (decrease in muscle strength), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of Resident 76's Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 7/3/2024, indicated the resident's cognition was intact with an active diagnoses of anxiety disorder, depression, and muscle weakness. A review of Resident 76's Nursing Progress Note dated 7/15/2024, indicated the resident was found to have vitamins at the resident's bedside. The Nursing Progress Note indicated the Director of Nursing (DON) was made aware and a family meeting would be initiated regarding the bedside medication. During a concurrent observation and interview with Resident 76 in the resident's room, on 7/15/2024 at 9:58 AM, a bottle of Vitamin C 500 mg / Dietary Supplement, 200 tablets was on the bedside table. Resident 76 stated the medication helped to have a bowel movement (the last stop in the movement of food through your digestive tract) and the resident would take the medication when a bowel movement was needed. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 in Resident 76's room, on 7/15/2024 at 10:13 AM, LVN 1 stated medications should not have been with the resident. LVN 1 stated a family meeting was necessary to ensure resident safety. LVN 1 stated if the medications were left at the bedside, the facility would not know how much medication the resident was consuming, and the resident could potentially have an overdose depending on the type of medication. During an interview on 7/16/2024 at 10:25 AM, the DON stated medications should not have been at the bedside. The DON stated a family meeting must be done to re-educate the family to give medications to the nurses and to count and place inside the medication cart for safety. The DON stated if a medication was left at the resident's bedside, the resident could have an overdose or overuse the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated January 2024, indicated the nursing staff shall be responsible for maintaining medication storage. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding were to prevent the possibility of mixing medications of several residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48661 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards of practice by not labeling several food items with received date or use by date and failed to ensure safe and clean sanitary coffee cups were served to residents in accordance with professional standards for food service safety. These deficient practices had the potential for residents in the facility to be at risk for food borne illness (illness caused by food contamination with bacteria, viruses, parasites, or toxins). Findings: a. During a concurrent observation and interview on 7/15/24 at 8:15 AM, the Dietary Director (DD) observed one bag of mozzarella cheese, one block of white cheese, and one block of cheddar cheese without a received date. The DD observed one bag of shredded cheese without a use by date. The DD observed one container of tomatoes, one container of green and red bell peppers, one container of lemons, and one container of oranges without a received or use by date. The DD stated there should have been a label with a received date and a use by date, and if there was not, that could affect the residents and the residents could get sick. During an interview on 7/18/24 at 12:35 PM, the Registered Dietician (RD) stated food should have been labeled and should have always had a delivery date. The RD stated if the food was not labeled, the food could go bad, and the facility would want to prevent that. A review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated January 2024, indicated all foods stored in the refrigerator or freezer would be covered, labeled, and dated use by date. 49604 b. During a concurrent observation and interview, on 7/16/2024 at 11 AM in the activity room, 12 of 20 plastic cups for coffee were found to have a white residue inside the cups. The coffee cups were served to the residents. The Activity Director (AD) stated there was a white residue in these cups. During a concurrent observation and interview on 7/16/2024 at 11:10 AM in the activity room, the DD observed the 12 cups and stated the white residue looked like salt from the water softening machine. The DD stated the cups were not supposed to have any residue and removed all the cups from the activity room and took the cups to the kitchen. The DD stated maintenance service would be arranged for the water softening machine as soon as possible. During an interview on 7/16/2024 at 1 PM, the DD stated the white residue was from the water softener and that was the first time a white residue was found in the cups. The DD stated the knob to the water softener had to be on rinse but was on backwash. The DS stated in order to change the settings of the water softener, a screwdriver was required and did not know how the settings moved. The DD stated service for the water softener was done monthly and the last service was done a month ago. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/2024 at 11:45 AM, the Director of Nursing (DON) stated the staff should have been checking the utensils for cleanliness before offering the utensils to residents. The DON stated that the kitchen staff should have made sure only clean utensils were served to the residents as dirty utensils could cause harm to the residents. A review of facility's undated policy and procedure (P&P) titled, Sanitization, indicated The food service area was maintained in a clean and sanitary manner .All equipment, food contact surfaces and utensils were cleaned and sanitized using heat or chemical sanitizing solution.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48661 Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster areas were maintained in a sanitary manner. a. Two of four garbage dumpsters were overfilled with plastic bags and a cardboard box. b. One of four garbage dumpsters had the lid open. c. One of four garbage dumpsters lid was broken and cut in half. These deficient practices had the potential for harborage and feeding of pests. Findings: During a concurrent observation and interview with the Housekeeping Director (HD) on 7/17/2024 at 12:07 PM, there were two dumpsters outside of the kitchen back exit that were over filled with trash bags. One dumpster had the lid propped open with trash overflowing and another dumpsters lid could not close because the dumpster was overflowing with trash bags. There was a foul odor with flies flying around the dumpster. The HD stated the dumpsters should have been closed and not overflowing with trash. The HD stated if the dumpsters were not closed, the smell would attract flies and there could be an infection control issue because the flies could get inside the facility and go into the resident's food. During an interview on 7/17/2024 at 12:15 PM, the Maintenance Supervisor (MS) stated the dumpster lids should have been closed. The MS stated if the dumpster lids were not closed, that could attract insects or rodents and become an infection control problem if the insects or rodents enter the facility. A review of the facility's policy and procedure (P&P) titled, Sanitation, dated January 2024, indicated garbage and refuse containers were in good condition, without leaks, and waste was properly contained in dumpsters/compactors with lids (or otherwise covered). A review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable, indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they were inaccessible to insects and rodents.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide rehabilitative therapy services for two of seven sampled residents (Residents 136 and 117). Resident 136 did not receive a speech therapy (ST, profession that identifies, assesses, and treats speech, language, cognitive communication, and swallowing disorders) evaluation timely and the Occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) services were provided to Resident 117 without renewing an active physician's order for continuation of OT services. These deficient practices had the potential for a delay of therapy services and provision of therapy services without physician's approval. Findings: a. During an observation and interview in Resident 136's room, on [DATE] at 1:22 PM, Resident 136 was sitting at the edge of the bed with bedside table in front. Resident 136 was able to eat lunch independently. A review of Resident 136's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including acute embolism (blood vessel blockage) and thrombosis (clotting of the blood) of right peroneal vein (blood vessel in the leg), muscle weakness, difficult walking. A review of the physician History and Physical dated [DATE] indicated Resident 136 could make needs known, but could not make medical decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated [DATE] indicated Resident 136 had moderate cognitive impairment (ability to think, remember, and problem-solving) and required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene, upper body dressing. The MDS indicated the resident required substantial/maximal assistance (helper does more than half the effort) with lower body dressing, bathing, sit to stand, bed to chair transfers, and walking 10 feet. A review of Resident 136's physician Order Summary Report indicated an order dated [DATE] for Speech Therapy Evaluation and Treatment as indicated. A review of Resident 136's physician Order Summary Report indicated an order dated [DATE] indicated an order for skilled ST three times a week for four weeks, treatment may include orientation, cognitive communication tasks, short term recall tasks, verbal reasoning exercises. A review of Resident 136's Speech Therapy Evaluation and Plan of Treatment indicated a start of care dated [DATE] and indicated Resident 136 was referred for skilled ST services for cognitive communication deficit and increased confusion after hospitalization . The ST evaluation recommended skilled ST treatment three times a week for four weeks. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 136's therapy records, on [DATE] at 10:47 AM, the Director of Rehabilitation (DOR) stated Resident 136 had a speech therapy evaluation order dated [DATE]. The DOR stated the speech therapy evaluation was not completed until [DATE] and there was a delay in providing speech therapy services. The DOR stated if a resident was admitted Friday ([DATE]), then the latest the speech therapy evaluation should have been completed was the following Monday ([DATE]). The DOR stated the speech therapy evaluation was not completed timely and there was potential for a delay in care and that Resident 136 received speech therapy for cognitive issues. A review of the facility's undated policy and procedure titled, Evaluation (Therapy Plan of Care), indicated to initiate an evaluation within the first business day following weekends and holidays. b. During an observation and interview on [DATE] at 10:04 AM, in Resident 117's room, Resident 117 was standing with a front-wheeled walker and looking out the window. Resident 117 was able to walk short distances inside the room with the front-wheeled walker. Resident 117 stated she was receiving therapy and that therapy was helping her get better. A review of the Admission Record indicated Resident 117 admitted to the facility on [DATE] with diagnoses including brachial plexus (network of nerves in the shoulder) disorders, muscle weakness, and difficulty walking. A review of the physician History and Physical Examination dated [DATE] indicated Resident 117 had the capacity to understand and make decisions. A review of the MDS dated [DATE] indicated Resident 117 had moderate cognitive impairments, functional limitation impairment in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (shoulder, elbow, wrist, hand) and no functional limitation impairment in ROM on both sides of the lower extremity (hip, knee, ankle, foot). The MDS also indicated Resident 117 required partial or moderate assistance (helper does less than half the effort) for lying to sitting on side of the bed, bed to chair transfers, and walking 10 feet. A review of Resident 117's physician Order Summary Report did not indicate an active order for occupational therapy treatment. A review of Occupational Therapy treatment encounter notes indicated Resident 117 received OT treatments on ,d+[DATE], [DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]. During a concurrent interview and record review on [DATE] at 10:47 AM, the Director of Rehabilitation (DOR) reviewed Resident 117's therapy records and stated Resident 117 was currently receiving OT treatment three times a week. The DOR reviewed Resident 117's active orders and confirmed there was no active orders for continuation of OT treatment and that it should have been renewed [DATE]. The DOR stated therapists should review therapy order if as soon as the current order expired. A review of the facility's undated policy and procedure titled, Rehabilitation Clarification and Reclarification Orders, indicated the reclarification order contains the same required elements as the clarification order and will fulfill the requirement of the continued Physician Certification. There should be no gaps in dates between the clarification and reclarification orders. Orders must cover the entire span of treatment delivery.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to ensure the hospice residents binder had a copy of the Certification of Terminal Illness (CTI) for one sampled resident (Resident 8). This deficient practice resulted in failure to comply and coordinate with Hospice services. Findings: A review of Resident 8's Admission Record indicated the resident was readmitted to the facility on [DATE], with diagnoses including multiple sclerosis (disabling disease of the brain and spinal cord that causes the nerves to deteriorate or become permanently damaged) and pressure ulcer (an injury that breaks down the skin and underlying tissue, also known as bedsore or pressure sore). A review of the Physician's Order, dated 6/3/2024, indicated to admit Resident 8 to a hospice agency on a routine level of care for Stage IV pressure injury (deep wound reaching the muscles, ligaments, or bones) and protein calorie malnutrition. A review of the hospice and facility contract, dated 6/6/2024, indicated hospice and facility will communicate pertinent information with each other either verbally or in the patient's medical record at each hospice patient visit or more frequently, whenever needed to ensure that the needs of each hospice patients are met 24 hours per day. Documentation of such communication shall be included in the resident's medical record. A review of Resident 8's Quarterly Minimum Data Set (MDS, a standardized comprehensive assessment and care screening tool) dated 6/20/2024, indicated the resident's cognitive skills for daily decision-making were severely impaired (never/rarely makes decisions). The MDS also indicated Resident 8 required substantial to total assistance with eating, oral hygiene, showering, dressing and personal hygiene. During a concurrent interview and record review with Licensed Vocational Nurse 3 (LVN 3) on 7/17/24 at 12:44 PM, Resident 8's hospice chart and electronic medical chart was reviewed. LVN 3 stated she could not find Resident 8's CTI in her hospice binder or electronic chart. LVN 3 stated she did not know Resident 8's hospice diagnosis and she did not know why the CTI was to not available in the chart. During an interview on 7/17/2024 at 12:48 PM, the Registered Nurse Supervisor 1 (RN 1) stated Resident 8's hospice diagnosis was Stage IV pressure injury unhealing and protein calorie malnutrition. RN 1 stated she could not find the CTI in the resident medical chart. During an interview on 7/17/24 at 12:53 PM, the Director of Nursing stated he would call Resident 8's hospice agency to get the CTI. During an interview on 7/18/2024 at 3:55 PM, the Administrator (ADM) stated the CTI documents indicated if the resident was appropriate for hospice and Resident 8's CTI should be maintained in the resident's hospice chart. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled, Hospice Program, revised 1/2024, indicated hospice services are available to residents at the end of life. The P&P also indicated in order for a resident to qualify for the hospice benefit under Medicare, he or she must be certified as being terminally ill. The P&P further indicated the facility has designated Case Manager or designee to coordinate care provided to the resident by our facility staff and the hospice staff. He or she is responsible for the following: c. Obtaining the following information from the hospice: (I) The most recent hospice plan of care specific to each resident; (2) Hospice election form; (3) Physician certification and recertification of the terminal illness specific to each resident; (4) Names and contact information for hospice personnel involved in hospice care of each resident; (5) Instructions on how to access the hospice's 24-hour on-call system; (6) Hospice medication information specific to each resident; and (7) Hospice physician and attending physician (if any) orders specific to each resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41379

Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program by not providing supplies for hand hygiene in the occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) gym for staff to perform hand hygiene before and after donning (putting on) and doffing (taking off) protective personal equipment (PPE, protective gloves, gowns, facemasks, and other equipment designed to protect the wearer from the spread of infection or illness) under enhanced barrier precautions (EBP, (intervention designed to reduce transmission of infectious organisms).

The facility also failed to label oxygen tubing with date when it was changed for Resident 12. These deficient practices had the potential to cause complications associated with oxygen therapy for the residents. These deficient practices had the potential to spread infections among facility staff, residents, and visitors.

Findings:

a. During an observation and interview on 7/15/24 at 10:51 AM, in the OT gym, two therapy staff were in the OT gym working with two different residents. Both therapy staff were wearing a disposable gown, gloves, and face mask. Certified Occupational Therapy Assistant (COTA 1) stated therapy staff put on the gown and gloves inside the gym when working with residents on EBP. COTA 1 stated staff were to take off the PPE before they exited the gym and perform hand hygiene before and after putting on and taking off the PPE. COTA 1 looked around the OT gym and stated there was no sink or hand sanitizer inside the OT gym for staff to perform hand hygiene. COTA 1 stated staff had to walk outside the gym into the hallway past a couple of rooms before there was a hand sanitizer for staff to perform hand hygiene. COTA 1 stated staff were supposed to perform hand hygiene right away after they removed the PPE.

During an interview on 7/15/24 at 3:09 PM, the Director of Rehabilitation (DOR) stated therapy staff were to follow EBP when working with residents in the therapy gyms. The DOR stated therapy staff had to sanitize their hands before they put on PPE, and immediately after they take off the PPE in the therapy gyms before they exit the gym.

During an interview on 7/16/24 at 9:35 AM, the Infection Preventionist Nurse (IP) stated therapy staff working directly with residents on EBP need to perform hand hygiene, put on a gown, gloves, and face mask. The IPN stated once staff completed their treatment with residents, they were to take off the gown, then gloves, and sanitize or wash their hands. The IPN stated it was important to perform hand hygiene before and after putting on and taking off PPE to prevent infection and spread of viruses among staff and residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policies and procedures revised 1/2024, titled, Handwashing/Hand Hygiene, indicated this facility considers hand hygiene the primary means to prevent the spread of infections. The policy and procedure also indicated hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Hand hygiene is the final step after removing and disposing of personal protective equipment. 47883 b. A review of Resident 12's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including traumatic subdural hemorrhage with loss of consciousness (a serious condition where blood collects between the skull and the surface of the brain), acute pulmonary edema (a condition caused by too much fluid in the lungs), and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). A review of the Minimum Data Set (MDS - a standardized assessment and screening tool), dated 6/28/2024, indicated that Resident 12 had mildly impaired cognition and the resident needed supervision or touching assistance with bed mobility, dressing, eating, toileting and personal hygiene. A review of Resident 12's care plan revised on 5/25/2024 indicated the resident was at risk for complications with respiratory system due to chronic respiratory failure. The goal of care plan was to minimize the risk for acute exacerbation of respiratory disease. A review of Resident 12's Order Summary Report dated 7/17/2024 indicated an order for Oxygen two- four liters per minute via nasal cannula to keep oxygen saturation more than 92%. During a concurrent observation and interview on 7/16/2024 at 10:34 AM with Licensed Vocational Nurse (LVN 1), Resident 12 was observed in the wheelchair receiving three liters per minute (LPM - unit of measurement for volume) of oxygen via a nasal canula (NC - a device used to deliver supplemental oxygen to a patient) from an oxygen concentrator with no label on the oxygen tubing to indicate the date it was last changed. LVN 1 confirmed that the oxygen tubing was not labeled with the date it was last changed. LVN 1 stated that the oxygen tubing needed to be labeled with the date it was changed. LVN 1 also stated he was not sure how often oxygen tubing should be changed. LVN 1 stated that this deficient practice could result in Resident 12 developing a respiratory infection. During an interview on 7/18/2024 at 11:05 AM, the Director of Nursing (DON) stated licensed staff were required to change the oxygen tubing every seven days according to the facility's policy. A review of the facility's policy and procedure titled, Oxygen Administration-Resident, reviewed in January 2023, indicated to connect the humidifier bottle to the flow meter that is attached to the oxygen. Replace cannula, mask disposal humidifier bottle every seven days or as needed. Date and label new equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Beverly Hills Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 580 S San Vicente Blvd. Los Angeles, CA 90048	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the licensed nursing staff failed to offer the influenza as required or appropriate to one of five sampled residents (Resident 12). This deficient practice placed Resident 12 at increased risk of acquiring and/or transmitting the flu and pneumonia to other residents in the facility. Findings: A review of Resident 12's Immunization History Report, dated 9/19/2023, indicated Resident 12 last received the flu vaccine on 9/1/2020. A review of Resident 12's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses including heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), end stage renal disease (loss of kidney function in which the kidneys no long work to meet the body's needs) and Stage IV pressure ulcer (deep wound reaching the muscles, ligaments, or bones). A review of Resident 12's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/27/2024, indicated the resident had moderately impaired cognition and required substantial to partial assistance with oral hygiene, toileting hygiene, shower/bathe, dressing and personal hygiene. During an interview on 7/18/2024 at 1:23 PM, the Infection Preventionist (IP) stated the facility did not offer Resident 12 the flu or pneumococcal vaccine since his admission. The IP stated Resident 12 should have been offered both vaccines and that the facility offers residents all vaccinations, that were required, or the resident was eligible for. The IP stated vaccinations were offered to prevent residents from getting sick, to build up their immune system and prevent infection. During an interview on 7/18/2024 at 4 PM, the Administrator (ADM) stated we offer the flu vaccine from September to April 30th every year, and the pneumococcal vaccination year-round. The ADM further stated vaccinations were offered to prevent residents from contracting diseases or viruses and spreading them within the facility. A review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, revised 1/2024, indicated all residents who have no medical contraindication to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The P&P also indicated between October 1st and March 31 each year, the influenza vaccine shall be offered to residents within five working days of the resident's admission to the facility. A review of the facility's P&P titled, Pneumococcal Vaccine, revised 1/2024, indicated all residents are offered pneumococcal vaccines to aid preventing pneumonia/pneumococcal infection. The P&P also indicated prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.

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NAME OF PROVIDER OR SUPPLIER: Beverly Hills Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE: 580 S San Vicente Blvd. Los Angeles, CA 90048	

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to offer the Coronavirus Disease (COVID-19) vaccination to two of five sampled residents (Resident 12 and 132). This deficient practice placed Resident 12 and Resident 132 at a higher risk of acquiring and transmitting the COVID-19 to other residents in the facility. Findings: a. A review of Resident 12's Admission Record indicated the resident was readmitted to the facility on [DATE], with diagnoses including acute respiratory failure, Schizophrenia (a serious mental disorder in which people interpret reality abnormally) and atrial fibrillation (a-fib - an irregular and often rapid heart rhythm). A review of Resident 12's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 9/8/2023, indicated the resident had severely impaired cognition (never/rarely made decisions) and the resident was totally dependent on staff for transfer, dressing, eating, toilet use and personal hygiene. A review of Resident 12's History and Physical, dated 11/21/2023, indicated the resident did not have the capacity to understand and make decisions. b. A review of Resident 132's admission record, indicated the facility admitted the resident on 6/5/2024 with diagnoses including diabetes (high blood sugar), heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and peripheral vascular disease (PVD -a slow and progressive circulation disorder). A review of Resident 132's Internal Medicine History and Physical dated 6/7/2024, indicated resident had the capacity to understand and make decisions and the resident had no known allergies. A review of Resident 132's MDS, dated [DATE], indicated the resident's cognition was intact, and the resident was dependent upon staff for lower body dressing, putting on footwear, showering or bathing and toileting hygiene. The MDS also indicated partial to substantial assistance with personal and oral hygiene. During a concurrent interview and record review on 7/18/2024 at 1:23 PM, Resident 12's and Resident 132's electronic health records were reviewed with the Infection Preventionist (IP). The infection preventionist stated Resident 12 and Resident 132 had not been offered the COVID vaccination by the facility and the IP stated the resident's had not been assessed if they should offer the vaccination. The IP further stated the facility offers residents all vaccinations, that were required, or the resident was eligible for. We offer COVID year round because you can always get it. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2024 at 4 PM, the Administrator stated we offer the COVID vaccinations year round to all residents. Vaccinations were offered to prevent residents from contracting diseases or viruses. A review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, revised 6/2022, indicated each resident if offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. The P&P also indicated the residence medical record includes documentation that indicates, at a minimum, the following. a. that the resident or residence representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine, including: 1. samples of educational materials used; 2. the date the education took place; and 3. the name of the individual who received the education. b. Signed consent; and c. dose of COVID-19 vaccine that was administered to the resident.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48661 Based on observation, interview, and record review, the facility failed to have an effective pest control program when a fly was observed in the kitchen area. This deficient practice had the potential for residents at the facility to be at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During a concurrent observation and interview with the Dietary Director (DD) in the kitchen on 7/17/2024 at 11:18 AM, a fly was observed flying around during tray line. The DD stated, How did that get in here? The DD stated if a fly was in the kitchen, the fly could bring bacteria and the residents could have an infection. During an interview on 7/18/2024 at 2:20 PM, the Maintenance Supervisor (MS) stated having insects or rodents in the facility could be an infection control problem. The MS stated the residents or staff could have an allergic reaction and if a fly was in the food or water, the food or water could become contaminated. A review of the facility's policy and procedure (P&P) titled, Pest Control, dated January 2024, indicated this facility maintains an on-going pest control program to ensure that the building was kept free of insects and rodents.