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	08/07/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide care in a manner that maintained or enhanced the dignity and respect for one of two sampled residents (Resident 168) as evidenced by failing to ensure Resident 168's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag (a bag designed to collect urine drained from the bladder via a catheter) was covered with a privacy bag (a cover that discreetly conceals a urine drainage bag from public view).This failure had the potential for Resident 168 to experience psychosocial distress (a state of emotional suffering characterized by feelings of sadness, anxiety (nervousness), and other negative emotions) and violated Resident 168's right to be treated with dignity (the state of being worthy, honored, or respected). Findings:During a review of Resident 168's admission Record, the admission Record indicated the facility admitted the resident on 7/26/2025 with diagnoses that included multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), urinary tract infection (an infection in the bladder/urinary tract), atherosclerosis of the renal artery (a condition where plaque buildup narrows or blocks the arteries that supply blood to the kidneys), and muscle weakness.During a review of Resident 168's Order Summary Report dated 7/26/2025, the Order Summary Report indicated the resident had a physician order for a foley catheter (a type of urinary catheter) for a neurogenic bladder (a condition where nerve damage disrupts the normal communication between the brain, spinal cord, and bladder, leading to bladder dysfunction).During a review of Resident 168's Care Plan Report dated 7/31/2025, the Care Plan Report indicated the resident was at risk for complications with the urinary system related to a neurogenic bladder. The Care Plan Report indicated a goal for Resident 168 to maintain comfort and dignity daily. The Care Plan Report indicated an intervention for a privacy cover to Resident 168's catheter bag as indicated to promote dignity.During a concurrent observation and interview on 8/4/2025 at 12:30 PM, with Resident 168's, in Resident 168's room, Resident 168 was observed without a privacy cover on her foley catheter drainage bag. Resident 168 stated she usually had a covering that goes over her foley catheter drainage bag to hide and cover the urine inside the bag, but she didn't know what happened to it. During a concurrent observation and interview on 8/4/2025 at 12:34 PM, Certified Nursing Assistant 5 (CNA 5), in Resident 168's room, Resident 168 was observed without a privacy cover on her foley catheter drainage bag. CNA 5 stated Resident 168 should have a privacy cover on her foley catheter drainage bag to maintain the resident's dignity.During an interview on 8/7/2025 at 1:31 PM with the Director of Nursing (DON), the DON stated a foley catheter urinary drainage bag should have a privacy cover in place for the resident's dignity. The DON stated there was potential for Resident 168 to experience psychosocial distress due to the resident's dignity not being upheld and respected.During a review of the facility's Policy and Procedure (P&P) titled Resident Rights dated 1/2025, the P&P indicated Employees shall treat all residents with kindness, respect, and dignity.Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure to provide a Physician Orders for Life-Sustaining Treatment (POLST - a document that outlines a seriously ill patient's preferences for medical treatment, particularly at the end of life) to one of one sampled resident (Resident 186).This failure had the potential not to follow Resident 186's wishes for end-of-life.Findings:During a review of Resident 186's admission Record, the admission Record indicated the facility admitted the resident on 7/28/2025 with diagnoses including heart failure (a condition where the heart muscle cannot pump enough blood and oxygen to meet the body's needs) and metabolic encephalopathy (is a condition where brain dysfunction occurs due to a chemical imbalance in the body).During a review of Resident 186's Minimum Data Set (MDS - a resident assessment tool), dated 8/3/2025, indicated the resident was not oriented to time and had poor recall. The MDS indicated Resident 186 had trouble concentrating on things, felt down, sad, or hopeless. During an observation on 8/4/2025 at 9:53 AM in Resident 186's room, Resident 186 was lying in bed, the bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed. Resident 186 was on oxygen by nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at a rate of 2 Liters/min (2 liters of oxygen should flow into the patient's nose in 1 minute) dated 8/4/2025. Resident 186 had a foley catheter (a flexible, sterile tube inserted into the bladder to drain urine) and a dignity bag (a fabric or vinyl pouch designed to conceal the urinary drainage bag attached to a catheter) in place.During a concurrent interview and record review on 8/5/2025 at 11:05 AM with the Registered Nurse Supervisor (RN 1), Resident 186's POLST document was reviewed. RN 1 stated Resident 186 was a full code (a medical term used to indicate that a patient wishes to receive all possible life-saving measures in the event of a medical emergency) from the General Acute Care Hospital (GACH). The POLST was blank, RN 1 stated that Social Services obtained the advance directive and POLST for residents (in general).During an interview on 8/5/2025 at 11:05 AM with Social Services Director (SSD), the SSD stated Resident 186's Advance Directive Acknowledgement was obtained on 7/28/2025 and signed by the resident representative. The SSD stated the POLST should be done by the nursing staff and to direct the question to the Director of Nursing (DON).During an interview on 8/5/2025 at 11:27 AM with RN 1, RN 1 was not able to answer if the licensed nurses (in general) were able to do the POLST for the residents. RN 1 stated she would have to ask the DON whether licensed nurses were able to do the POLST. RN 1 stated upon admission, she (RN1) had done a POLST for other residents in the past.During an interview on 8/5/2025 at 11:41 AM with the DON, the DON stated that Resident 186 was a full code and that if the facility obtained an advanced directive, then the POLST was not needed. The DON stated that the Advance Directive was not to be used instead of POLST. The DON stated that the POLST was voluntary according to the facility policy.During a concurrent interview and record review on 8/5/2025 at 2:50 PM with the DON, the facility policy and procedures (P&P) titled, Physician Orders for Life-Sustaining Treatment, dated 1/2024 and the California Department of Public Health All Facilities Letter (AFL) dated 1/3/2009 were reviewed. The DON stated the P&P, and the AFL indicated completing the POLST form was a voluntary option. During an interview on 8/6/2025 at 8:26 AM with the DON, the DON was informed that the AFL form was indicated for a state survey recertification and the facility was surveyed under a federal recertification. The DON stated that all residents (in general) should have a POLST. The DON stated that Resident 186 would be at risk for the facility not caring out the resident's end of life wishes in the event of an emergency.During a review of the facility's (P&P) titled, Physician Orders for Life-Sustaining Treatment (POLST), dated 01/2024, indicated the facility would use the POLST for cardiopulmonary resuscitation (medical procedure involving repeated compression of a patient's chest, performed to restore the blood circulation and breathing) and related emergency measures to maintain life functions. The P&P indicated the POLST was a legally valid physician order and complements an Advance Directive and is not intended to replace that document.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure to develop a care plan for one of one sampled resident (Resident 175) who had a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).This failure had the potential for Resident 175 not to receive the necessary care and services for the diagnosis of depression.Findings:During a review of Resident 175's admission Record, the admission Record indicated the facility admitted the resident on 3/14/2025 with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic bronchitis (persistent inflammation of the bronchial tubes, the air passages to the lungs, leading to excessive mucus production and breathing difficulties), and acute respiratory failure (a sudden and potentially life-threatening condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide).During a review of Resident 175's Physician Diagnosis Verification form, dated 3/17/2025, the Physician Diagnosis Verification form indicated no depression diagnosis identified. The Physician Diagnosis Verification form identified the resident's primary as the prescribing doctor.During a review of Resident 175's Care Plan Report dated 3/24/2025, the Care Plan Report indicated the resident had the potential for side effects, complications or adverse reactions an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof) related to the ordered use of drug, Escitalopram Oxalate (medication to treat depression). The Care Plan Report indicated there was no care plan for depression.During a review of Resident 175's Minimum Data Set (MDS - a resident assessment tool) dated 6/13/2025 indicated the resident was not oriented to time and had poor recall. The MDS indicated Resident 175 felt little interest or pleasure in doing things, felt down, sad, or hopeless, had trouble falling or staying asleep or sleeping too much nearly every day. The MDS indicated Resident 175 was not triggered for depression for active Diagnoses.During an observation on 8/4/2025 at 11:47 AM in Resident 175's room, Resident 175 was lying in bed, bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed, and the call light (a device used by a patient to signal his or her need for assistance) was within reach.During a review of Resident 175's Order Summary Report, dated 8/6/2025, the Order Summary Report indicated that Escitalopram was taken for depression manifested by withdrawn behavior.During an interview on 8/6/2025 at 1:55 PM with the Minimum Data Set Nurse (MDSN), the MDSN stated the diagnosis of depression could not be triggered without an order from the psychologist (is a person who specializes in the study of mind and behavior). The MDSN stated that any resident on psychotropic (any drug that affects the brain) medications were referred for a psychologist's evaluation. The MDSN stated the psychologist progress notes had not been updated to reflect Resident 175 was prescribed Escitalopram. The MDSN stated the psychologist nurse practitioner would give the progress note to the medical records staff to be updated and scanned, then the MDSN would be able to see the diagnosis and medication. The MDSN stated that a resident on psychotropic medications should have a diagnosis. The MDSN stated Resident 175's primary doctor ordered Escitalopram. During a review of the General Acute Care Hospital (GACH) history and physical dated 3/17/2025 and 7/22/2025 indicated no diagnosis of depression or taking Escitalopram in the hospital. The MDSN could not explain why there was no current psychologist note present. The MDSN stated that there was a break in the process because the medical diagnosis, MDS, and care plan had not been triggered for depression. The MDSN stated Resident 175 would be at risk for inappropriate use of the medication.During an interview on 8/6/2025 at 2:23 PM with the Director of Nursing (DON), the DON stated that there was no order from the psychologist which was the reason the diagnosis of depression, MDS, and the care plan were not triggered. The DON stated Resident 175 took Escitalopram or had a diagnosis of depression from the GACH when the resident was admitted . The DON stated that Resident 175's primary doctor ordered Escitalopram. The DON stated without a medical diagnosis/triggered MDS/ and depression care plan, Resident 175 would be at risk for missing side effects of the medication and progression of symptoms of the disease.During a concurrent interview and record review on 8/6/2025 at 3:10 PM with the DON and the MDSN, a Psychologist Nurse Practitioner's Progress Note dated 7/16/2025 was reviewed, the Progress Note indicated a diagnosis of depression and prescribed Lexapro (medication for depression) 5 milligrams (mg, a unit of measurement). The DON stated that the progress note did not get to the medical records for the note to be scanned and the MDSN to therefore be able to trigger the depression in the MDS and care plan. A voice message was left for the psychologist nurse practitioner on 8/7/2025 at 8:20 AM, no call back was received.During a review of the facility's policy and procedures (P&P) titled, Care

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the appropriate Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) settings for two of five sampled residents (Resident 146 and Resident 205). These failures had the potential to cause harm to Resident 146 and Resident 205 by increasing the residents' risk of skin breakdown and development of pressure ulcers/injuries (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). Findings: During a review of Resident 146’s admission Record, the admission Record indicated the facility initially admitted the resident on 7/16/2022, with diagnoses that included Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the right heel , dementia (a progressive state of decline in mental abilities), malignant neoplasm of the bone (bone cancer, uncontrolled cell growth that originates in the bone), difficulty in walking, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 146’s Minimum Data Set (MDS, a resident assessment tool) dated 7/19/2025, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated Resident 146 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 146 had one Stage 4 pressure ulcer that was present on the resident’s admission to the facility. The MDS indicated Resident 146 utilized a pressure reducing device for bed. During a review of Resident 146’s Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident weighed 127 pounds (lbs., a unit of weight) on 8/4/2025. During a concurrent observation and interview on 8/4/2025 at 12:08 PM, with Licensed Vocational Nurse 4 (LVN 4), in Resident 146’s room, Resident 146 was observed on a “Domus 4” LALM with settings at 450 lbs. LVN 4 stated that Resident 146’s LALM settings were set at 450 lbs. LVN 4 stated the LALM settings should be based on Resident 146’s weight. LVN 4 stated Resident 146’s LALM settings at 450 lbs., were incorrect. During a review of Resident 146’s Order Summary Report dated 8/5/2025, the Order Summary Report indicated the resident was to use a LALM for skin management. The Order Summary Report indicated to set the LALM according to Resident 146’s weight. During a review of Resident 146’s Care Plan Report dated 8/5/2025, the Care Plan Report indicated the resident had a LALM for skin management. The Care Plan Report indicated to set the LALM according to Resident 146’s weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/2025 at 1:31 PM with the Director of Nursing (DON), the DON stated the LALM were set per manufacturer’s guidelines and on the resident’s weight. The DON stated Resident’s LALM settings at 450 lbs. were incorrect. The DON stated Resident 146 weight 127 lbs., on 8/4/2025. The DON stated Resident 146’s LALM settings should be set around the range of 127 lbs. The DON stated the purpose of the LALM was for wound management. The DON stated there could be potential for the delay in the healing process of Resident 146’s pressure ulcers when the resident’s LALM are kept on the wrong settings. During a review of the undated instruction manual titled “Domus 4 Instruction Manual”, the instruction manual indicated “General operation .According to the weight and heights of the patient, adjust the pressure setting to the most comfortable level without bottoming out, then the pressure mattress will slowly increase to the intended value after the air mattress is ready to use.” During a review of the facility’s policy and procedure (P&P) titled, “Low Air Loss Mattress General Procedure” dated 1/2025, the P&P indicated, “A physician’s order is required prior to initiating use of a low air loss or pressure redistribution mattress, as part of a clinically indicated intervention for residents assessed to be at risk…” The policy further indicated, “For residents who are cognitively impaired or non -verbal, pressure settings shall be determined based on a resident’s weight in accordance with manufacture’s specifications…” During a review of the facility’s policy and procedure (P&P) titled, “Prevention of Pressure Ulcers/Injuries” revised 1/2025, the P&P indicated, “Utilize LALM as per manufacture’s guidelines of resident comfort and in accordance with physician’s orders.” 2.During a review of Resident 205’s admission Record, the admission Record indicated the facility admitted Resident 205 on 7/28/2025, with diagnoses including malignant neoplasm of liver(cancerous tumor growing in the liver), nutritional anemia(not enough healthy red blood cells to carry oxygen),protein-calorie malnutrition(poor nutrition),), atherosclerotic heart disease of native coronary artery(buildup of fats, cholesterol in the artery walls), acute respiratory failure with hypoxia(lungs can’t get enough oxygen into the blood and the body isn’t getting enough oxygen overall), muscle weakness, difficulty walking and adult failure to thrive(a syndrome characterized by weight loss, decreased appetite, reduced physical activity , and impaired cognitive function). During a review of Resident 205's care plan titled Risk for skin breakdown, dated 7/28/2025, indicated interventions for Resident 52's LALM for patient preference. Date initiated: 8/5/2025. During a review of Resident 205’s Order Summary Report, dated 7/29/2025, indicated there was no order for a LALM. During a review of Resident 205’s MDS dated [DATE], the MDS indicated Resident 52 had severe cognitive (ability to think and reason) impairment skills for daily decision making, and was dependent (helper does all of the effort) from the staff for toileting hygiene and transfer, lower body dressing, sit to standing, chair/bed to chair transfer and required substantial/maximal assistance (helper does more than half the effort) from the staff with upper body dressing, rolling left and right, sit to lying and lying to sitting on the side of the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/4/25 at 10:25 a.m., Resident 205 was in bed with her eyes closed. Resident 205’s LALM was on and set to 450 pounds. During an interview on 8/5/2025 at 8:08 AM, with Licensed Vocational Nurse (LVN)3, LVN 3 stated the licensed nurses (in general) needed the orders for LAL mattress. LVN3 stated the licensed nurses (in general) needed to know how to set the LAL mattress. LVN 3 stated the licensed nurses (in general) needed to set the proper LAL mattress settings, otherwise it could cause harm to the resident. LVN3 stated the licensed nurses (unidentified) requested an order from the medical doctor for a proper setting for use. During a concurrent interview and record review on 8/5/2025 at 8:32a.m., with the Assistant Director of Nursing (ADON), the ADON stated the LAL mattress settings depended on the resident's weight, if not at the proper setting, it would defeat the purpose of the LAL mattress. The ADON stated the orders needed to be placed for settings. The ADON stated the resident’s weight was 137 pounds on admission, and no orders were placed for an LAL mattress on admission and that the orders were placed until 8/5/2025. During a review of the undated instruction manual titled “Domus 4 Instruction Manual”, the instruction manual indicated “General operation .According to the weight and heights of the patient, adjust the pressure setting to the most comfortable level without bottoming out, then the pressure mattress will slowly increase to the intended value after the air mattress is ready to use.” During a review of the facility’s policy and procedure (P&P) titled, “Low Air Loss Mattress General Procedure” dated 1/2025, the P&P indicated, “A physician’s order is required prior to initiating use of a low air loss or pressure redistribution mattress, as part of a clinically indicated intervention for residents assessed to be at risk…” The policy further indicated, “For residents who are cognitively impaired or non -verbal, pressure settings shall be determined based on a resident’s weight in accordance with manufacture’s specifications…” During a review of the facility’s e LALM as per manufacture’s guidelines of resident comfort and in accordance with physician’s orders.”

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services to provide respiratory care for four of four sampled residents (Resident 14, Resident 28, Resident 170, and Resident 175) by failing to ensure: 1. To label and date the oxygen (a chemical element, a gas that is colorless, odorless, and tasteless and a key component of the air we breathe) tubing according to physician's order for Resident 14. 2. To display a precaution sign on the door for Resident 170 who received continuous oxygen. 3. To provide a date for the humidifier (a medical device that adds moisture to oxygen delivered during oxygen therapy) for Resident 28 and Resident 175. These failures placed Resident 14, Resident 28, Resident 170, and Resident 175 at risk for respiratory infection and injury. Findings: 1. During a review of Resident 14’s admission Record, the admission Record indicated the facility admitted the resident on 5/4/2023 with the most recent readmission on [DATE] with diagnoses that included, but no limited to chronic heart failure (CHF - a long-term heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN - high blood pressure), end stage renal disease (ESRD - irreversible kidney failure) with dependence on dialysis, (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), anemia (a condition where the body does not have enough healthy red blood cells), muscle weakness, and mild intellectual disabilities (conditions that involve limitations on intelligence, learning and everyday abilities necessary to live independently). During a review of Resident 14’s Minimum Data Set (MDS - a resident assessment tool), dated 6/25/2025, the MDS indicated Resident 14 did not have disorganized thinking and was able to make his own decisions regarding daily tasks. The MDS indicated Resident 14 required set-up or clean-up assistance (the helper assists only prior to or following the activity, the resident completes the activity) with eating. The MDS indicated Resident 14 required supervision or touch assistance (the helper provides verbal cues and/or touching/steadying as the resident completes the activity, assistance may be provided throughout the activity or intermittently) with oral hygiene, toileting hygiene, and dressing the upper body. The MDS indicated Resident 14 required partial to moderate assistance (the helper lifts, holds, or supports trunk or limbs of the resident, but provides less than half the effort) with bathing, showering, and dressing the lower body. During a review of Resident 14’s Care Plan Report with a revision date of 7/3/2025, the Care Plan Report indicated Resident 14 was on oxygen therapy (a way to help your body get enough oxygen when it's not able to do so on its own) related to CHF. The Care Plan Report indicated nursing interventions to ensure the oxygen settings were followed as ordered and to monitor for signs and symptoms of respiratory distress. The Care Plan Report indicated a goal for Resident 14 was not to have signs and symptoms of poor oxygen absorption. During a review of Resident 14’s Order Summary Report, dated 7/15/2025, the Order Summary Report indicated the oxygen tubing was to be changed weekly and to label each component with date and initials. (continued on next page)

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Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 8/4/2025 at 10:11 AM, in Resident 14’s room, the resident was observed to be on oxygen therapy through a nasal cannula (a small plastic tube, which fits into the person’s nostrils for providing oxygen). Resident 14 stated that he was reliant (dependent) on continuous oxygen. Resident 14 stated his nasal cannula was changed on 8/3/2025 and that it was changed at least once a week. There was no label with a date observed on the nasal cannula. During an interview on 8/6/2025 at 8:24 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 14’s nasal cannula was changed once a week and as needed. LVN 1 stated the nasal cannula should be labeled with the date and time it was changed. LVN 1 stated that if the nasal cannula was not labeled, the staff (in general) would not know if it was contaminated. LVN 1 stated Resident 14 could get an infection from an unsanitary nasal cannula so it would be important to label it. During an interview on 8/6/2025 at 8:39 AM, with Registered Nurse Supervisor (RN) 1, RN 1 stated for Resident 14 who was on oxygen therapy, staff (in general) should check if the nasal cannula was cleaned and not damaged. RN 1 stated Resident 14’s nasal cannula should be changed every seven days and as needed. RN 1 stated Resident 14’s nasal cannula should be labeled to indicate the date it was changed. RN 1 stated if there was no date on Resident 14’s nasal cannula, it may end up being used for a long time and can cause an infection or allergy, therefore, the nasal cannula should be labeled and dated. During an interview on 8/6/2025 at 8:50 AM, with the Director of Nursing (DON), the DON stated Resident 14’s nasal cannula should be changed every week and as needed and would need to have the date on the label. The DON stated the date on the label would indicate when the nasal cannula was changed. The DON stated if Resident 14’s nasal cannula was not dated, staff (in general) would not know if the nasal cannula had been changed or not. The DON stated there would be a risk for damage to the nasal cannula and risk for infection with prolonged use. The DON stated Resident 14’s nasal cannula should be labeled and dated every time it was changed. During a review of the facility’s Policy and Procedure (P&P) titled “Oxygen Administration” dated January 2025, the P&P indicated “The purpose of this procedure is to provide guidelines for safe oxygen administration…The following equipment and supplies will be necessary when performing this procedure…Nasal cannula, nasal catheter, mask (as ordered); date nasal cannula once in use…” 2. During a review of Resident 170’s admission Record, the admission Record indicated the facility admitted the resident on 7/7/2025 with diagnoses that included metabolic encephalopathy (a condition where the brain's function is impaired due to chemical imbalances in the body, often caused by an underlying illness or organ dysfunction), atelectasis (condition where part or all of a lung collapses or deflates), pleural effusion (a buildup of fluid between the layers of tissue that line the lungs and chest cavity), muscle weakness, anxiety (a feeling of worry, nervousness, or unease), and benign prostatic hyperplasia (a common condition in men where the prostate gland gets larger, but it's not cancerous). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 170’s MDS dated [DATE], the MDS indicated Resident 170’s speech was slurred or mumbled. The MDS indicated Resident 170 was usually able to make himself understood and had the ability to usually understand others. The MDS indicated Resident 170 was dependent (the helper does all of the effort, the resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on staff (in general) for eating, oral hygiene, toileting hygiene, bathing, and dressing. The MDS indicated Resident 170 was also dependent on staff (in general) for mobility such as rolling left and right, moving from sitting to lying position, moving from sitting to standing position, and walking. The MDS indicated Resident 170 was on continuous oxygen therapy when it's not able to do so on its own) while in the facility. During a review of Resident 170’s Order Summary Report, dated 7/15/2025, the Order Summary Report indicated the resident was to have continuous oxygen therapy at three liters a minute via nasal cannula. During a review of Resident 170’s Care Plan Report with a revised of 7/21/2025, the Care Plan Report indicated the resident was at risk for complications with the respiratory system due to pleural effusion and atelectasis. The Care Plan Report indicated interventions that included assessing for signs and symptoms of hypoxia (low levels of oxygen in your body tissues), monitoring for shortness of breath, and positioning the head of the bed elevated to facilitate breathing. The Care Plan Report indicated a goal for Resident 170 was not to exhibit signs of respiratory distress. During an observation on 8/4/2025 at 12:08 PM, in Resident 170’s room, the resident was observed to be on oxygen therapy through a nasal cannula. There was no “Oxygen in Use” sign observed posted inside or outside of Resident 170’s room. During a concurrent observation and interview on 8/6/2025 at 8:35 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 observed there was no “Oxygen in Use” sign posted outside or inside of Resident 170’s room. LVN 1 stated Resident 170, who was on oxygen, should have the sign posted because it would be dangerous if there was faulty wiring that sparked or if the resident’s roommate smoked which would cause a fire or explosion. During an interview on 8/6/2025 at 8:44 AM, with Registered Nurse Supervisor (RN) 1, RN 1 stated that not having an “Oxygen in Use” sign posted outside of Resident 170’s room would not alert staff (in general) and visitors that oxygen was being used, and would cause a fire or explosion if a person smoked or if there was a spark in the room. During an interview on 8/6/2025 at 8:57 AM, with the Director of Nursing (DON), the DON stated there should be an “Oxygen in Use” sign posted for any resident on oxygen for safety reasons. The DON stated the sign should be posted for Resident 170’s room to make everyone aware that oxygen was in use. The DON stated oxygen was combustible (capable of catching fire and burning) and there would be potential for hazard, like fire, if there was smoking paraphernalia in the room. The DON stated it was very important to have the sign as a measure to indicate that Resident 170 was on oxygen. During a review of the facility’s Policy and Procedure (P&P) titled “Respiratory Care Policy” dated January 2025, the P&P indicated “Oxygen in use sign will be placed outside the patient’s room.” (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.During a review of Resident 28’s admission Record, the admission Record indicated the facility admitted the resident on 12/10/2023 with diagnoses of bronchiectasis (chronic lung condition where the airways [bronchial tubes] become damaged and widened, making it difficult to clear mucus), and acute respiratory failure with hypoxia (a severe medical condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low blood oxygen levels [hypoxia]). During a review of Resident 28’s MDS dated [DATE], the MDS indicated the resident was not oriented to time and had poor recall. The MDS indicated that Resident 28 needed continuous, intermittent and high-concentration oxygen therapy. During a review of Resident 175’s admission Record, the admission Record indicated the facility on 3/14/2025 with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic bronchitis (persistent inflammation of the bronchial tubes, the air passages to the lungs, leading to excessive mucus production and breathing difficulties), and acute respiratory failure (a sudden and potentially life-threatening condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide). During a review of Resident 175’s MDS dated [DATE] indicated that Resident 175 needed continuous, intermittent (occurring at irregular intervals), and high concentration of oxygen therapy. During an observation on 8/4/2025 at 11:40 AM in Resident 28’s room, Resident 28 was lying in bed side rails up, and the call light was within reach. Resident 28 had a nasal cannula dated 8/4/2025, the humidifier was not labeled with the date. During an observation on 8/4/2025 at 11:47 AM in Resident 175’s room, Resident 175 was lying in bed, family at the bedside. Resident 175’s nasal cannula was dated 8/4/2025 but the humidifier was not labeled with the date. During a review of Resident 175’s Order Summary Report dated 7/17/2025 indicated the resident to have continuous oxygen via nasal cannula at 2 liters/min and the oxygen tubing changed weekly and label each component with date and initials. During a concurrent observation and interview on 8/4/2025 at 11:43 AM with LVN 1 in Resident 28’s and Resident 175’s rooms, the humidifiers were observed not to be labeled with a date when it was changed. LVN 1 stated that the humidifiers should be labeled. LVN 1 stated that he (LVN1) was not sure if the practice of labeling the humidifier was per the facility policy. LVN 1 stated Resident 28 and Resident 175 were at risk of the humidifiers expiring if not labeled when the last time it was changed. During an interview on 8/6/2025 at 2:18 PM with the DON, the DON stated oxygen tubing and humidifiers should be labeled with the dated and changed weekly and as needed. The DON stated small sticky notes were provided for labeling the date. The DON stated Residents 28 and 175 were at risk of infections. The DON stated labeling the humidifier indicated when it needed to be changed, and the labeling is a good indicator for cleanliness and safety. During a review of the facility’s policy and procedures (P&P) titled, “Oxygen Administration, ” dated 1/2025, indicated to verify that there was a physician’s order for the procedure and to review the physician's order or facility protocol for oxygen administration.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate and sufficient nursing staff to meet the needs of three of 28 sampled residents (Resident 61, Resident 76, and Resident 171).These failures had the potential to result in the inadequate availability of nursing services to assure resident safety and attainment of the highest practicable, physical, mental, and psychosocial well-being of each resident. Findings:1.During a review of Resident 61's admission Record, the admission Record indicated the facility admitted the resident on 7/15/2025 with diagnoses that included multiple fractures of the ribs (broken ribs), rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility), difficulty in walking, muscle weakness, and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool) dated 7/21/2025, the MDS indicated the resident had moderate cognitive impairment (some impairment to the ability to think, understand, and reason). The MDS indicated Resident 61 had impairment on both sides of her upper and lower extremities. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) for eating and oral hygiene. The MDS indicated Resident 61 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, upper body dressing, lower body dressing, putting on footwear, taking off footwear, and personal hygiene. The MDS indicated Resident 61 was dependent on help (helper does all the effort) on showering and bathing herself.During an interview on 8/4/2025 at 12:23 PM with Resident 61, Resident 61 stated the night shift staff would take 30 to 45 minutes to respond to call lights (crucial communication tools that allow residents to summon help from nurses or staff when needed). Resident 61 stated this happened every night. Resident 61 stated she (Resident 61) felt frustrated because she (Resident 61) usually called for help to be changed. Resident 61 stated she (Resident 61) could not change herself because she (Resident 61) had arthritis in both hands. Resident 61 stated she (Resident 61) was worried about chafing (skin irritation caused by repeated rubbing against the skin, clothing, or other materials) and urine or stool irritating her skin when waiting too long to be changed.2.During a review of Resident 76's admission Record, the admission Record indicated the facility admitted the resident on 7/15/2025 with diagnoses that included cerebral infarction (stroke, a condition where the brain tissue dies due to a lack of blood supply), rheumatoid arthritis, atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), difficulty in walking, chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 76's MDS dated [DATE], the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 76 required supervision or touching assistance (helper provides verbal cues and/or touching, steadying, or contact guard assistance) for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 76 required substantial/maximal assistance for upper body dressing, showering, and bathing herself. The MDS indicated Resident 76 was dependent on help for toileting hygiene, lower body dressing, putting on footwear, and taking off footwear.During an interview on 8/4/2025 at 1:54 PM with Resident 76, Resident 76 stated staff did not attend to her quick enough to clean her up and change her. Resident 76 stated she (Resident 76) once waited three hours and a half to get assistance from staff (in general). Resident 76 stated she (Resident 76) once called the front desk to get assistance from staff (unidentified). Resident 76 stated this happened more often in the evening time (unidentified time and date).During an interview on 8/6/2025 at 6:26 AM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated the facility was short of Certified Nursing Assistants (CNAs). LVN 7 stated there were usually only four to five CNAs on the 11 PM to 7 AM shift. LVN 7 stated sometimes the CNAs (in general) were assigned up to 18 residents each. LVN 7 stated the LVNs (in general) helped the CNAs (in general) as much as they could but sometimes call lights would get answered late because they (nursing staff in general) were short staffed.3.During a review of Resident 171's admission Record, the admission Record indicated the facility admitted the resident on 7/11/2025 with diagnoses that included fracture of the lower end of the right radius (broken wrist joint), difficulty in walking, chronic kidney disease, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), dementia (a progressive state of decline in mental abilities), and a history of falling.During a review of Resident 171's MDS dated [DATE], the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure one of ten sampled residents (Resident 37) received Balsalazide Disodium (medication used to treat ulcerative colitis [a condition which causes swelling and sores in the lining of the colon [large intestine] and rectum]) 750 milligrams (mg, a unit of measurement) with meals as ordered.This failure had the potential for Resident 37 to experience an upset stomach and pain.Findings:During a review of Resident 37's admission Record, the admission Record indicated the facility admitted Resident 37 on 7/18/2025, with diagnoses including peritoneal abscess(a localized collection of pus within the abdominal cavity),other specified disorders of the peritoneum (a range of conditions affecting the thin lining of the abdominal cavity), ulcerative colitis(a chronic inflammatory bowel disease that causes ulcers in the lining of the large intestine), acute duodenal ulcer with both hemorrhage and perforation (a sudden severe sore in the upper part of the small intestine that is both bleeding and has created a hole), and surgical aftercare following surgery on the digestive system. During a review of Resident 37's Care Plan Report dated 7/18/2025 indicated Resident 37 was at risk for pain or discomfort due to Gastroesophageal reflux disease (stomach acid flows into the esophagus and causes heartburn), the Care Plan Report indicated nursing interventions to administer medications as ordered. During a review of Resident 37's Order Summary Report dated 7/19/2025, the Order Summary Report indicated for the resident to receive Balsalazide Disodium 750mg one capsule by mouth with meals three times a day. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool) dated 7/19/2025, the MDS indicated Resident 37 had moderate cognitive (ability to think and reason) impairment skills for daily decision making. During a medication pass observation on 8/5/2025 at 11:39 a.m., of Resident 37, Licensed Vocational Nurse (LVN)2, LVN 2 administered Balsalazide disodium 750mg PO (taken by mouth) to Resident 37. No lunch/ meal observed at bedside. The medication package had an additional blue label indicated with meals and green label indicating NOON, in capitalized letters. During an interview on 8/5/2025 at 11:44 a.m., LVN 2 stated lunch was served around 12 noon. During an interview on 8/5/2025 at 8:08a.m., with LVN 1, LVN1 stated medications that were not taken with food as ordered could cause an upset stomach, gastrointestinal (digestive system) problems. LVN1 stated medications that required to be taken with meals were to prevent an upset stomach and stomach pain. During an interview on 8/7/2025 at 10:34a.m., with the Director of Nursing (DON), the DON stated if medications that were given without food as ordered, a resident (in general) could experience gastric irritation (stomach lining getting irritated or inflamed), and discomfort. During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated 1/2025, the P&P indicated, Medications must be administered in accordance with the orders.

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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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of five sampled facility staff Certified Nursing Assistant 1 (CNA 1) maintained the necessary qualifications for employment at the facility. This failure had the potential to result for CNA 1 not to have the knowledge and qualifications necessary to care for the facility's residents and placed the residents at risk for harm.Findings:During a review of CNA 1's timecard (a record, either physical or digital, that tracks an employee's work hours, including start and end times, breaks, and overtime) dated [DATE] to [DATE], the timecard indicated CNA 1 worked at the facility as a CNA on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].During a review of CNA 1's timecard dated [DATE] to [DATE], the timecard indicated CNA 1 worked at the facility as a CNA on [DATE], [DATE], and [DATE].During a concurrent interview and record review on [DATE] at 9:23 AM, with the Director of Staff Development (DSD), CNA 1's employee file was reviewed. The employee file indicated the CNA Certificate for CNA 1 expired on [DATE]. The DSD stated CNA 1 last worked at the facility on [DATE]. The DSD stated that she (DSD) was just made aware that CNA 1's certification was expired. The DSD stated CNA 1 was working at the facility after her CNA certification expired on [DATE]. The DSD stated the CNA certification had to be active to work at the facility. The DSD stated CNA 1 was not in compliance with the facility's policy.During an interview on [DATE] at 1:43 PM with the Director of Nursing (DON), the DON stated he and the DSD usually review the CNA certification expiration dates monthly but missed that CNA 1's certification expired on [DATE]. The DON stated CNA 1 worked at the facility while her certification was expired. The DON stated CNA 1 had to maintain an active certification to work at the facility. The DON stated CNA 1 was not in compliance with the facility's policy. The DON stated there was a potential for CNA 1 to have less knowledge to care for the facility residents with an expired certification.During a review of the facility's Job Description titled Job Description: Certified Nursing Assistant dated 2/2024, the Job Description indicated Qualifications: Must be a licensed Certified Nursing Assistant in accordance with laws of the state.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure to follow infection control practices by failing to:1.Ensure Resident 186's sitter (refers to a caregiver who provides supervision and companionship to patients in healthcare settings) had proper personal protective equipment (PPE - garments designed to protect the wearer from injury or infection) [DATE] at 9:53 AM for Resident 186 who was on enhanced barrier precautions (EBP - infection control measures used in healthcare settings to reduce the spread of multidrug-resistant organisms [MDROs, bacteria that are resistant to one or more classes of antimicrobial agents]). 2. Ensure not to have expired hand sanitizer, disposal COVID-19 (a respiratory illness that can spread from person to person) testing kits, and disposable hand gloves in the facility's hallways, storage room, and medication carts. These failures had the potential to place the residents at increased risk of infection and cross-cross contamination (process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). Findings: 1.During a review of Resident 186’s admission Record, the admission Record indicated the facility admitted the resident on [DATE] with diagnoses including heart failure (a condition where the heart muscle cannot pump enough blood and oxygen to meet the body's needs) and metabolic encephalopathy (is a condition where brain dysfunction occurs due to a chemical imbalance in the body). During a review of Resident 186’s Minimum Data Set (MDS – a resident assessment tool), dated [DATE], indicated the resident was not oriented to time and had poor recall. The MDS indicated Resident 186 had trouble concentrating on things, felt down, sad, or hopeless. During an observation on [DATE] at 9:53 AM in Resident 186’s room, before entering Resident 186’s room, outside was a plastic draw with PPE present. Resident 186 was lying in bed, the bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed. Resident 186’s sitter was sitting in a chair next to Resident 186, with no PPE donned (put on). Resident 186 had a foley catheter (a flexible tube inserted into the bladder to drain urine) with a dignity bag (a discreet covering or holder for a urine drainage bag, designed to conceal the bag from view and maintain the user's privacy and dignity) over the drainage bag. The PPE was also available at the back of the door to Resident 186’s room. During an interview on [DATE] at 10 AM with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 186’s and the roommate were on EBP. CNA 1 stated the PPE was on the back side of the resident’s room door and a green laminated page indicated which bed was on EBP. CNA 1 stated the PPE that was outside the room could also be used for the room. During an interview on [DATE] at 10:02 AM with the sitter, the sitter stated that she (sitter) did not know that Resident 186 was on enhanced barrier precautions and to wear the PPE. The sitter stated that when she (sitter) arrived to the room, there was no sign outside the room. During an interview on [DATE] at 10:05 AM with the Assistant Director of Staff Development (ADSD), the ADSD stated sitters would have to receive orientation to the facility such as EBP, and abuse training. The ADSD stated that the Infection Preventionist (IP) Nurse would give the sitters infection control orientation. The ADSD stated Resident 186 would be at risk of cross-contamination of infection between the sitter and Resident 186. (continued on next page)

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Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:17 AM with the Director of Staff Development (DSD), the DSD stated family members would communicate whether the resident would have a caregiver/sitter. The DSD stated education would be provided to the caregiver/sitter. The DSD stated in this instance the facility was unaware the sitter was hired by the family. The DSD stated if a visitor/family member, or sitter were without proper PPE in a resident’s room on EBP then staff would educate those individuals. The DSD stated that any staff member should be able to provide education. The DSD stated that all staff were educated on the policy regarding PPE. The DSD stated Resident 186 would be at risk of cross-contamination. During an interview on [DATE] at 10:35 AM with the Director of Nursing (DON), the DON stated that families would inform the facility that a resident would have a sitter present. The DON stated the facility was not aware that Resident 186 had a sitter. The DON stated during morning huddle, residents with sitters would be discussed. The DON stated if any residents were on contact precautions or EBP then everyone must wear the PPE. The DON stated the signage on the outside of the room indicated the room was on contact precautions, but for EBP the signage and PPE would be on the back of the resident’s door. The DON stated Resident 186 would be at risk for increased infection without the sitter donning (put on) PPE. During an interview on [DATE] at 2:45 PM with the Infection Preventionist (IP), the IP stated she would educate the sitters infection control, EBP, and on how to don and doff (take off) PPE, provide handouts, and conduct demonstration for understanding. The IP stated that only a few residents have sitters. The IP stated upon admission families would notify nursing staff that the resident (in general) would have a sitter. The IP stated the nursing staff would then notify the IP nurse. During a review of the facility’s policy and procedures (P&P) titled, “Isolation – Transmission-Based Precautions & Enhanced Barrier Precautions”, dated 4/2025, indicated that standard precautions and enhanced barrier precautions are used when always caring for residents regardless of their suspected or confirmed infection status. The P&P indicated the facility will communicate to staff which residents require the use of EBP. The P&P indicated visitors should wear gowns and gloves if participating in high-contact care activities, especially if interacting with multiple residents. During a review of the facility’s policy and procedures (P&P) titled, “Infection Control”, dated 4/2025, indicated upon admission, and the suspect or diagnosis of infection, educate the resident, family/responsible party, visitor and staff regarding the prevention of the spread of infection. The P&P indicated that a review of the importance of hand hygiene and the use of PPE would be conducted. 2.During an observation on [DATE] at 11:24 PM on the first-floor hallway, a used two-liter (a metric unit of volume) bottle of hand sanitizer with an expiration of date of 1/2024 was found on top of the nurses’ station counter. During an interview on [DATE] at 11:29 PM with the DON, the DON stated the hand sanitizer was sticky and would not be effective since the alcohol was expired. During an interview on [DATE] at 3:31 PM with Infection Preventionist Nurse (IPN), IPN stated expired hand sanitizer would be ineffective since the alcohol level would decrease, it would be an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 1 PM, in the medication storage room located on the second floor, one open box that contained 15 COVID-19 test kits with expiration date of [DATE] were observed on top of the counter. During an observation on [DATE] at 1:22 PM, in medication cart number three, two expired COVID-19 antigen test kits were observed in the bottom drawer with an expiration of [DATE]. During a concurrent observation and interview on [DATE] at 1:39 PM, with Licensed Vocational Nurse (LVN) 5, one COVID-19 test kit was observed in the bottom drawer of medication cart number two with an expiration date of [DATE]. LVN 5 stated if an expired COVID test was used, the COVID test would give a false positive. During an interview on [DATE] at 1:45 PM with the DON, and Registered Nurse (RN) 2, they (DON and RN2) stated expired COVID test kits could give an inaccurate reading. During an interview on [DATE] at 1:58 PM with the IP nurse, the IP nurse stated expired COVID kits would not give an accurate reading and could give a false positive. During an observation on [DATE] at 8:39 AM of medication cart number one, there were two open boxes of expired medium sized gloves with an expiration date of [DATE]. Three open boxes of gloves with an expiration of [DATE], found in the hallway on top of a clear plastic container with PPE supplies. During an interview on [DATE] at 8:41 AM with LVN 6, LVN 6 stated using expired gloves would not provide any protection. LVN6 stated expired gloves could cause a rash. LVN 6 stated the nursing staff (in general) had the responsibility to check for expired items. During an observation on [DATE] at 8:43 AM in the storage supply room on level 1, there were 13 boxes of medium sized gloves with an expiration date of [DATE]. There were 19 boxes of expired medium sized gloves in supply storage room on level 2 with expiration date of [DATE]. During an interview on [DATE] at 8:52 AM with the DON and RN 2, the DON and RN2 stated expired gloves would not be usable. The DON and RN2 stated expired gloves would not provide any protection for residents against the spread of germs. During an observation on [DATE] at 8:55 AM of medication cart number three had one box of medium gloves with expiration of [DATE]. During an interview on [DATE] at 9:05 AM with the IPN stated, using expired gloves could break and could cause the spread of infections. During a review of the facility's policy and procedure (P&P) titled, Infection Control, dated [DATE], the P&P indicated It the policy of this facility to prevent the spread of infection.” During a review of the facility's policy and procedure (P&P) titled, Equipment and Supply Condition and Expiration Compliance, dated 1/2025, the P&P indicated … is committed to maintaining all equipment in good working condition and ensuring that no expired supplies are used in the care of residents.” The P&P indicated, “ Damaged, malfunctioning, or outdated equipment must be reported immediately… and removed from service.”

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that alerts healthcare providers that the patient needs assistance) was within reach for two of 28 sampled residents (Resident 25 and Resident 164)This deficient practice had the potential to result in delay in meeting Resident 25's and Resident 164's needs for assistance. Findings: 1.During a review of Resident 25’s admission Record, the admission Record indicated the facility admitted the resident on 9/17/2024 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), hypertension (HTN - high blood pressure), metabolic encephalopathy (a condition where the brain's function is impaired due to chemical imbalances in the body, often caused by an underlying illness or organ dysfunction), muscle weakness, and failure to thrive (a state of decline characterized by weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 25’s Minimum Data Set (MDS – a resident assessment tool), dated 5/27/2025, the MDS indicated the resident had the ability to sometimes make herself understood and sometimes understood others. The MDS indicated Resident 25 was dependent (the helper does all of the effort, the resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on staff (in general) for toileting hygiene, showering, and moving from sitting to standing position. The MDS indicated Resident 25 required substantial to maximum assistance (the helper lifts or holds trunk or limbs of the resident and provides more than half the effort) with oral and personal hygiene, rolling left and right, and moving from sitting to lying position. During a review of Resident 25’s care plan, reviewed and revised on 6/2/2025, Care Plan Report indicated the resident was at risk for falls related to muscle weakness and osteoarthritis. The Care Plan Report indicated intervention that included keeping the call light within reach. The Care Plan Report indicated a goal for Resident 25 to minimize risk for falls. During a concurrent observation and interview on 8/4/2025 at 11:05 AM, in Resident 25’s room, the call light was observed on the floor to the left side of the resident’s bed by her roommate’s nightstand, out of the Resident 25’s reach. Certified Nurse Assistant (CNA) 4 was observed unable to locate Resident 25’s call light. Activities Director (AT) observed Resident 25’s call light on the floor by her roommate’s nightstand. The AT stated the call light should be within Resident 25’s reach. The AT stated if there was an emergency and Resident 25 needed assistance, staff (in general) would not be alerted to the resident’s needs. During an interview on 8/6/2025 at 11:09 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the call light should be placed within Resident 25’s reach at all times. LVN 1 stated if Resident 25 could not reach the call light, she (Resident 25) would not be able to receive the help that she (Resident 25) needed. LVN 1 stated the call light could be clipped to Resident 25’s bedsheet to prevent the call light from falling off the bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/2025 at 11:13 AM, with Registered Nurse Supervisor (RN) 1, RN 1 stated if the call light was not within Resident 25’s reach, the resident could fall. RN 1 stated the call light should be within Resident 25’s reach. During an interview on 8/6/2025 at 1:35 PM, with the Director of Nursing (DON), the DON stated if Resident 25 could not reach the call light for assistance, the resident would not be able to have her needs met and the resident would be at risk for falling. The DON stated the call light could be clipped to Resident 25’s bedsheet or gown to keep the call light in place. The DON stated the call light should be within Resident 25’s reach at all times so that staff (in general) would be aware of the resident’s needs. During a review of the facility’s Policy and Procedure (P&P) titled “Answering the Call Light” dated January 2025, the P&P indicated “The purpose of this procedure is to respond to the resident’s requests and needs…When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident…” 2.During a review of Resident 164’s admission Record, the admission Record indicated the facility admitted the resident on 6/20/2025 with diagnoses of difficulty in walking, muscle weakness, history of falls, and age-related cataract (a common eye condition where the lens of the eye becomes cloudy, causing decreased vision). During a review of Resident 164’s Care Plan Report, dated 6/20/2025, the Care Plan Report indicated Resident 164 was at risk for falls with or without injury related to muscle weakness difficulty walking and history of falls. The Care Plan Report indicated under the interventions to keep the call light within reach. During a review of Resident 164’s Care Plan Report, dated 6/20/2025, the Care Plan Report indicated Resident 164 had impaired visual acuity which may impact activities of daily living (ADL - basic self-care tasks that individuals perform to maintain their well-being and independence). The Care Plan Report indicated under the interventions to have the call light within reach and answered timely. During a review of Resident 164’s Care Plan Report, dated 6/20/2025, the Care Plan Report indicated that Resident 164 was at risk for pain, joint stiffness, and/or spontaneous pathological fracture. The Care Plan Report indicated under the interventions to encourage the resident to use the call light to promptly notify staff of needs. During a review of Resident 164’s Care Plan Report, dated 6/20/2025, the report indicated that Resident 164 was at risk for ADL/mobility decline and requires assistant. The Care Plan Report indicated under interventions to encourage the use of the call light for assistance. During a review of Resident 164’s MDS dated [DATE], the MDS indicated the resident had impaired vision, needed some help with self-care, indoor mobility, and functional cognition. The MDS indicated that the resident needed partial and substantial assistance with eating, oral toileting, upper and lower dressing, and personal hygiene. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation interview on 8/4/2025 at 10:48 AM with the Director of Nursing (DON) in Resident 164’s room, Resident 164 was lying in bed, the bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed, and the call light was on the floor. The DON picked up the call light off the floor and placed it within Resident 164’s reach. The DON stated Resident 164 was at risk for unattended needs and falls. During a review of the facility’s policy and procedures (P&P) titled, “Answering the Call Light”, dated 1/2025, indicated when the resident was confined in the bed or wheelchair to be certain the call light was within easy reach of the resident.