STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555701	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simi Healthcare Center	5270 E Los Angeles Ave Simi Valley, CA 93063

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 40560 Based on observation, interview and record review, the facility failed to ensure one of twenty sampled residents (Resident 443) was free from physical restraints. This facility failure had the potential to violate Resident 443's rights and lead to psychosocial and physical harm. Findings: During a concurrent observation and interview on 7/23/24 at 2:12 p.m. with Resident 443, Resident 443 was observed lying in bed. Resident 443's bed was observed pushed up against a wall on one side, while the other side of the bed was blocked with a locked transfer chair. Resident 443 verbalized, family wanted the chair positioned next to the bed for safety reasons, as Resident 443 had previously fallen while in the facility. During a concurrent observation and interview on 7/25/24 at 10:20 a.m. with Licensed Nurse (LN 4), the transfer chair had a sign placed on it, outside Resident 443's room which indicated, SAFETY NOTICE Please do not remove the Geri chair. The Geri chair has to be placed next to (Resident 443's bed) for patient's safety. DO NOT REMOVE. LN 4 verbalized Resident 443's spouse had requested to leave the chair by Resident 443's bed because Resident 443 had sustained a previous fall in the facility. LN 4 stated, I know it's not right and verbalized it was a family request to have the transfer chair next to Resident 443's bed. LN 4 verbalized there was no physician order for the transfer chair to be next to the bed, the resident had not been assessed if the resident was able to move the transfer chair, no care plan had been developed, and having the transfer chair next to the bed would be a physicial restraint. During an interview on 7/25/24 at 11:14 a.m. with the Director of Nursing (DON), the DON verbalized Resident 443 was not assessed for restriction of movement when the transfer chair was added per family request. The DON verbalized Resident 443's bed being pushed up against the wall on one side and having the locked transfer chair on the other was a form of physical restraint. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Restraints, (undated), the P&P indicated in part, The resident has the right to be free from any physical or chemical restraint imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The policy further indicated, Physical restraint is any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement . before a resident is restrained, the facility must first: determine the response of a specific medical symptom that would require the use of restraints . implement, assess and evaluate alternative measures to restraint use . The facility shall verify that the physician has obtained informed consent from the resident or responsible party before initiating the restraint . Residents on restraint shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive method of restraints, or total restraint elimination. The policy further indicated in part, It is the facility's responsibility to educate the resident and their family/legal surrogate regarding restraint use.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50132 Based on observation, interview, record review, the facility failed to ensure the Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities) information was accurate for two of two sampled residents (Residents 8 and 13) when: 1. Resident 8's MDS indicated, the resident was not taking anticoagulant medication (medications that reduce the blood's ability to clot). 2. Resident 13's MDS indicated, the resident was comatose (a state of unconsciousness). These failures resulted in inaccurate MDS assessments for Residents 8 and 13, and for the residents to potentially receive inadequate care. Findings: 1. During a record review of Resident 8's MDS Assessments, dated 6/25/24 and 7/7/24, the MDS Assessment indicated under the section for medications, the resident was on anticoagulant medication. Review of the resident's MDS assessments dated 7/14/24 and 7/17/24, under the section for medications, the MDS did not indicate resident was taking anticoagulants. Review of Resident 8's Order Summary Report, dated 7/12/24, indicated, an active order for Warfarin Sodium Oral Tablet 4mg (milligram) (medication prescribed to treat and prevent blood clots) Give 2 tablets by mouth in the evening every Sat, Sun ., dated 6/20/24 with a start date of 6/22/24. During a concurrent interview and record review on 7/26/24 at 10:39 a.m. with licensed nurse (MDS 1), Resident 8's MDS assessments were reviewed for the following dates: 6/25/24, 7/7/24, 7/14/24, and 7/17/24 with medication orders. MDS 1 confirmed the resident was taking an anticoagulant medication. MDS 1 stated, I must have missed that one. 50232 2. During a review of Resident 13's MDS assessment, dated 6/20/24, the MDS assessment indicated in part, Resident 13 was comatose. During a concurrent observation and interview on 7/24/24 at 11 a.m., in Resident 13's room, Resident 13 was alert and able to make needs known through nonverbal and verbal communication during an interview. During a concurrent record review and interview on 7/25/24 at 3:10 p.m. with MDS 1, Resident 13's MDS assessment dated [DATE], was reviewed. MDS 1 verbalized the MDS assessment for Resident 13 was incorrect when the MDS assessment indicated Resident 13 was comatose, when Resident 13 was not comatose. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated 3/22, the P&P indicated in part, All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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. 45741 Based on observation, interview, and record review, the facility failed to ensure comprehensive person-centered care plans were developed and implemented for two of eight sampled residents (Residents 79 and 13) when: 1. Resident 79's care plan intervention for risk for shortness of breath was not followed. 2. Resident 13 did not have a care plan to address their hearing needs. These failures had the potential for Residents 79 and 13 to not receive the appropriate care and services, based on problem areas identified during admission and current health issues. Findings: 1. During a review of Resident 79's Clinical Record, the Clinical Record indicated Resident 79 was admitted with diagnoses including, heart failure, and sleep apnea (a sleeping disorder where breathing is interrupted repeatedly during sleep). Review of Resident 79's physician orders dated 7/12/24, indicated, Oxygen inhalation at 2 liters per minute (lpm) via nasal cannula (a device that delivers extra oxygen through a tube and into your nose) to keep oxygen saturation (a measure of the oxygenation of the blood) above 90 percent. During a review of Resident 79's Care Plan, dated 5/17/24, the Care Plan indicated, Resident 79 was at high risk for shortness of breath. Interventions indicated medication as ordered, 2 lpm via nasal cannula to keep the O2 sat above 90. During a concurrent observation and interview on 7/24/24 at 3:05 p.m. with a licensed Nurse (LN 6), in the resident's room, Resident 79's oxygen settings was observed at 5 lpm via nasal cannula. LN 6 stated, It should be on 2 lpm and not 5 lpm. LN 6 acknowledged that shortness of breath care plan was not followed correctly. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, The comprehensive, person-centered care plan: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. 50232 2. During a review of Resident 13's Admission Record, dated 7/30/23, the Admission Record indicated, Resident 13 was admitted with diagnoses including, cerebral infarct (stroke - damage to tissues in the brain due to a loss of oxygen to the area), encephalopathy (any brain disease that alters brain function or structure), heart disease, and unspecified hearing loss, unspecified ear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 07/25/24 at 3:10 p.m. with the MDS (Minimum Data Set) licensed nurse (MDS 1), MDS 1 confirmed a care plan addressing hearing loss for Resident 13 could not be located in the electronic medical record (EHR) nor in the paper chart. During a concurrent interview and record review on 07/25/24 at 4:31 p.m. with the director of nursing (DON), the DON confirmed that active care plans are filed within either the resident's EHR or paper chart. The DON confirmed the absence of a hearing loss care plan for Resident 13. During record review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last revised in March 2022, the policy indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38585 Based on interview and record review, the facility failed to ensure one resident (Resident 43) received adequate nutrition when a recommendation by the Registered Dietitian to increase gastrostomy tube feedings was not ordered and implemented. This failure resulted in the resident having significant weight loss and the potential for delayed healing of pressure ulcers. Findings: During a review of Resident 43's Admission Record, the Admission Record indicated, Resdient 43 was originally admitted on [DATE] with most recent re-admitted [DATE] with diagnoses including, cerebral infarction (stroke - disrupted blood flow to the brain due to problems with the blood vessels that supply it), encephalopathy (brain disease that alters brain function or structure), chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy tube (GT - a tube inserted through the belly that brings nutrition directly to the stomach), pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time), and bilateral above the knee amputations. During a review of Resident 43's Weights and Vitals Summary, the Summary indicated the following weights, 1/4/24 - 94 lbs. (pounds), 2/13/24 - 91 lbs., 3/5/24 - 92 lbs., 5/8/24 - 87 lbs., 6/12/24 - 85 lbs., 7/17/24 - 83 lbs. During a review of Resident 43's Progress Note, dated 5/8/24 by the Registered Dietitian (RD), the Note indicated, Resident is alert, reactive to stimuli, unable to make needs known. Estimated increased nutrient needs related to wound healing = 1300 - 1500 kcal/day (calories). Recommendation: Increase GTF (GT Feeding) to Glucerna 1.2 (calorically dense formula) at 50ml/hr (milliliters per hour) for 20 hours to provide 1200 kcal (calories), Prostat (concentrated liquid protein medical food) 30ml (100 calories) every day. During a review of Resident 43's Progress Note - Weight Change Note, dated 6/15/24 by the RD, the Note indicated, Resident has had significant weight loss the last three (3) months, with a 7 lb. weight loss (7.6 % decrease in weight). Resident remains within adjusted Ideal Body Weight Reference (IBWR). Recommendation: Increase GTF to Glucerna 1.2 at 55ml/hr for 20 hours to provide 1320 kcal. During a review of Resident 43's Progress Note - Weight Change Note, dated 7/24/24 by the RD, the Note indicated, Resident has had significant weight loss the last six (6) months, with a 11 lb. weight loss (7.6 % decrease in weight). GT feeding (GTF) was Glucerna 1.2 at 50ml/hr for 20 hours, providing 1200 kcal and Prostat 30ml every day. Estimated increased nutrient needs related to wound healing = 1300 - 1500 kcal/day. Recommendation: Increase GTF to Glucerna 1.2 at 55ml/hr for 20 hours to provide 1320 kcal. This is the same recommendation as on 6/15/24. The recommendation was not ordered or implemented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 43's Order Summary Report (OSR), dated Active as of 07/25/2024, the OSR indicated, . GT feeding: Glucerna 1.2 at 50cc/hr. x 20 hrs to provide 1200kcal . There was no increase in Glucerna from 50cc/hr to 55cc/hr ordered as recommended by the RD. During an interview on 7/26/24 at 11:40 a.m. with the RD, the RD explained subacute residents are seen a minimum of monthly. The RD explained the process after a recommendation is written. The RD writes the recommendations for all residents and gives them to the nurses. The nurses notify the physician to get the order. This did not happen in June. In response to is there follow-up by the RD, the RD stated, I haven't needed to. The nurses usually take care of it, but I can if I need to. During a review of Resident 43's RD Report, dated 6/15/24, the Report indicated, (Resident's name) under Reason: Monthly Wt (weight) Changed + GTF + Skin F/U (follow-up). Under Recommendations: 1. Increase GTF to Glucerna 1.2 @ 55ml/h x 20h, to provide 1100ml, 1320 kcal. During a review of the facility's policy and procedure (P&P) titled, Nutritional Screening/Assessments/Resident Care Planning, dated 2020, the P&P indicated, PROCEDURE: . The Food and Nutrition Services Director (FNS) will complete the dietary recommendations within three days of receiving the Consultant Dietitian report . During an interview on 7/26/24 at 11:50 a.m. with licensed nurse (LN 5), LN 5 stated they receive the list of recommendations from the RD and they call the physician to get the order. Then they mark off the box that it is done. LN 5 was unable to find the June list and stated, I don't know what happened to it.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38585 Based on observation, interview, and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment (POLST - a form that communicates a person's wishes for healthcare treatment during a medical emergency) was signed by the physician for one of six sampled residents (Resident 68). This failure had the potential for Resident 68 to not receive his wishes during a medical emergency. Findings: During a concurrent interview and record review on 07/24/24 at 11:18 a.m.,with licensed nurse (LN 2), the POLST for Resident 68, dated 5/9/2024 was reviewed. The POLST indicated, no physician's signature was on the order. LN 2 stated, I can't speak to why it isn't signed. It is flagged with a sticker to sign. Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 613, in the section titled, Medication Administration, indicated in part . Order needs to have all the following parts: . Signature of health care provider . If a . order is incomplete inform the health care provider and ensure completeness before carrying out any . order.

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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. 38585 Based on observation, interview, and record review, the facility failed to ensure an optimal temperature was maintained in the medication storage refrigerator in Nurse Station One. This failure had the potential to result in refrigerated medications being less effective. Findings: During a concurrent observation and interview on 7/25/24 at 10:11 a.m. with licensed nurse (LN 6), inside Nurse Station One's Medication Storage Room, the refrigerator thermostat read 50 degrees Fahrenheit (F). LN 6 confirmed the thermostat read 50 F and stated, Yes it is 50 F, that's too warm. During a review of the facility's policy and procedure (P&P) titled, Medication Storage and Labeling, (undated), the P&P indicated, Temprature Control 2. Drugs requiring refrigeration shall be stored in a refrigerator between . (36 F and .46 F). A daily Medication Refrigerator Temperature Log will be kept to assure that the temperature is maintained.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43745 Based on interview and record review, the facility failed to employ a qualified dietary supervisor, in the absence of a full-time registered dietitian, to oversee its kitchen and food service operations. This failure had the potential to result in residents not receiving correct diets and increased risk of food-borne illness (illness caused by food contaminated with bacteria, viruses, parasites or toxins) to the residents due to lack of proper staff education and training. Findings: During an interview on 7/23/24 at 10:10 a.m. with the facility's dietary supervisor (DS 1), DS 1 verbalized that he's been an employee of the facility for the past [AGE] years and had assumed the position as DS a month and a half ago. DS 1 verbalized he was not certified as a dietary supervisor. During a review of kitchen staff credentials posted on the kitchen's consumer board, DS 1 had been certified as a Food Handler (a permit that shows a person completed a food safety course approved by the State). During an interview on 7/24/24 at 9:36 a.m. with the Administrator (ADM), ADM verbalized the facility's registered dietitian was not employed full-time. ADM further verbalized DS 1 attended a dietary supervisor training program but could not provide documentation of the training. During a review of the facility's job description (JD) for Director of Food Services, [undated], the JD indicated in part, Education . Be a graduate of an accredited course in dietetic training approved by the American Dietetic Association . Specific Requirements . Must be registered as a Food Service Director in this state

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43745 Based on observation, interview, and record review, the facility failed to ensure kitchen and food storage sanitation was maintained when: 1. A pair of used gloves was observed on the food preparation counter. 2. One of two ice machines was not properly maintained according to manufacturer's guidelines. 3. A kitchen staff (KS 1) was observed transferring food trays, wiping down stove top and counters with ungloved hands and not performing hand hygiene in between these activities. These failures had the potential to result in an increased risk of food-borne illness (illness caused by food contaminated with bacteria, viruses, parasites or toxins) to residents. Findings: 1. During the initial tour of the kitchen on 7/23/24 at 10:10 a.m., a pair of used gloves was observed on the food preparation counter. 2. During a concurrent observation and interview on 7/24/24 at 10:40 a.m. with the facility's on-call dietary supervisor (DS 2), an ice machine was observed. The ice machine was located in a room just outside the kitchen. The ice machine was manufactured by [NAME]. DS 2 verbalized the ice machine was used by residents and staff. There were calcium deposits observed on the ice machine tray and no ice machine cleaning log was found in the room. DS 2 verbalized the facility's maintenance supervisor (MS) kept the log. During an interview and record review on 7/24/24 at 12:40 p.m. with MS, MS verbalized there was no cleaning log for the ice machine. MS stated [NAME] serviced the ice machine every four months and provided copies of the service records for review. MS confirmed the ice machine should have been cleaned regularly as per manufacturer's instructions. During a review of the facility's policy and procedure (P&P) titled, Ice Machines, [undated], the P&P indicated in part, Policy Statement . Ice machines will be used and maintained per user/manufacturer's manual to assure a safe and sanitary supply of ice . Policy Interpretation and Implementation . 3) Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. During a review of the [NAME] Ice Machine's, Manufacturer's Instructions for Use (MIFU), [undated], the MIFU indicated in part, V. Maintenance . Cleaning and Sanitizing GENERAL . Clean and sanitize the ice machine every three months for efficient operation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on 7/24/24 at 10:45 a.m., KS 1 was observed cooking mixed vegetables and meatballs with ungloved hands. KS 1 was further observed transferring food trays from the stove to the meal preparation area, then wiping down the stove top and counters with ungloved hands. KS 1 also failed to perform hand hygiene in between these activities. During an interview on 7/24/24 at 10:50 a.m., with DS 2, DS 2 verbalized KS 1 should have put on clean gloves and performed hand hygiene in between these activities.

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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. 32661 Based on observation, interview, and record review, the facility failed to ensure infection control measures on storing oxygen therapy equipment were maintained for two of five sampled residents (Residents 83 and 57). These failures had the potential to result in the transmission of infectious microorganisms and increase the risk of respiratory infection of residents, visitors, and staff. Findings: During a concurrent observation and interview on 7/23/24 at 10:32 a.m. with Infection Preventionist Nurse (IP), Resident 83's nasal cannula was observed on the floor while still connected to the oxygen concentrator. Resident 57's (roommate) nasal cannula was observed on the bedside table at the left side of the bed while the nebulizer mask was observed on top of the side of table (right side of bed). Both the oxygen nasal cannula and the nebulizer mask had plastic bags provided as storage when not in use. The IP Nurse concurred with the finding and stated, They (nasal cannula and nebulizer mask) should have been stored in the provided plastic bags. During a review of the facility's policy and procedures (P&P) titled, Oxygen Equipment/Humidifier (Non Subacute Residents), dated 10/2017, the P&P indicated, Tubing, mask and cannula will be placed in a plastic bag and bag is labelled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555701	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simi Healthcare Center	5270 E Los Angeles Ave Simi Valley, CA 93063

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 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** 40560 Based on interview and record review, the facility failed to provide documentation indicating it had offered or explained the risks and benefits of a Covid -19 vaccination, for one of five sampled residents (Resident 443). This facility failure had the potential to lead to negative outcomes for Resident 443. Findings: During a review of Resident 443's Admission Record, (undated), the Assessment Record indicated in part, Resident 443 was admitted to the facility on [DATE]. Resident 443's Admission Record further indicated, Resident 443 was later diagnosed with Covid-19, with an onset date of 6/7/24. During a concurrent record review and interview on 7/26/24 at 10:12 a.m. with the Infection Preventionist (IP), Resident 443's medical record was reviewed. The IP verbalized the facility offers immunizations and/or education regarding immunizations to residents shortly after admission. The IP verbalized there was no documentation indicating Resident 443 had been offered the Covid-19 vaccine, refused the Covid-19 vaccination or had previously received the Covid-19 vaccination prior to admission to the facility. During a review of the facility's policy and procedure (P&P) titled, Refusal of Covid-19 Vaccination, (undated), the P&P indicated in part, All residents will be offered vaccines that aid in preventing infectious diseases such as Covid-19 vaccine unless the vaccine is medically contraindicated and for religious beliefs or the resident has already been vaccinated . Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations . Provision of such education shall be documented in the resident's medical record . All new residents shall be assessed for current vaccination status upon admission . Should the resident refuse to accept Covid-19 vaccine, detailed information relating to the refusal must be entered into the resident's medical record.

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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. 40560 Based on observation, interview and record review, the facility failed to ensure a call light was within reach for one unsampled resident (Resident 12). This facility failure had the potential for Resident 12's needs to go unmet and/or result in a delay in care. Findings: During an observation on 7/25/24 at 9:43 a.m. Resident 12's call light was observed on the floor and out of reach of Resident 12, who was lying in bed. During an observation and concurrent interview on 7/25/24 at 10:03 a.m. with Certified Nursing Assistant (CNA 1), Resident 12's call light was still on the floor and out of reach of Resident 12, who was lying in bed. CNA 1 confirmed the call light was on the floor and verbalized the call light should not be on the floor. CNA 1 acknowledged it was out of the reach of Resident 12. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 10/20, the P&P indicated in part, The purpose of this policy 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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40560 Based on observation, interview and record review, the facility failed to maintain a homelike environment for three unsampled residents (Residents 9, 12, and 14). This failure had the potential to negatively impact residents psychosocial status. Findings: During a concurrent observation and interview on 7/25/24 at 9:20 a.m. with the maintenance supervisor (MS), a tour of resident rooms was conducted. The following was observed: -Resident 9's room, a portion of the wall had peeling paint and missing plaster. -Resident 12's room a portion of the wall had peeling paint and missing plaster. -Resident 14's room a portion of the ceiling had cracked and peeling paint. The MS confirmed Resident 9 and Resident 12's walls were in a state of disrepair, as well as a portion of Resident 14's ceiling. The MS verbalized these areas would need to be repaired. The MS verbalized none of these environmental issues had been brought to the attention of the MS by staff, nor had they been logged in the facility maintenance log, as items that needed to be addressed. During a review of the facility's policy and procedure (P&P) tilted, Environmental Safety Policy and Procedure, (undated), the P&P indicated in part, It is the policy of this facility to provide a safe, functional and comfortable environment for the residents, staff and visitors. During a review of the facility's P&P titled, Maintenance Service, dated 12/09, the P&P indicated in part, The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . Maintaining the building in good repair and free from hazards.