STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 44244 Based on interview and record review, the facility failed to facilitate the inclusion of the resident in all aspects of person-centered care planning for one of one sampled resident (Resident 30) reviewed under the Choices care area by failing to encourage and include the resident during the interdisciplinary team (IDT - professional disciplines that work together to provide the greatest benefit to the resident) meetings. This deficient practice had the potential to violate Resident 30's right to be an active participant in her care. Findings: During a review of Resident 30's Admission Record, the record indicated the facility admitted the resident on 5/31/2024 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with unspecified severity; abnormalities of gait (manner of walking) and mobility; muscle weakness, and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 30's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/10/2024, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident had a Brief Interview for Mental Status Summary Score (BIMS, a brief cognitive screening measure that focuses on orientation and short-term word recall) of 13 (a score of 13 to 15 indicates a resident is cognitively intact). The MDS indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, personal hygiene, and dressing. During a review of Resident 30's history and physical dated 6/5/2024, the record indicated the resident had the capacity to understand and make decisions. During a review of Resident 30's physician orders, dated 5/31/2024, the order indicated the resident may participate with person-centered care planning. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/9/2024 at 8:30 a.m., Resident 30 lay in her bed and stated she was being held in the facility and wanted to leave. Resident 30 stated she did not want her Power of Attorney (POA, a legal document that allows someone else to act on one's behalf when they cannot act for themself) making decisions for her. Resident 30 stated the Social Services Assistant (SSA) told her she cannot leave because she does not have a safe discharge plan. Resident 30 stated the facility staff is not listening to her. During an interview on 7/10/2024 at 10 a.m., the Social Services Assistant (SSA) stated Resident 30 does not get along with her POA and the resident has a problem understanding. The SSA stated Resident 30 has a diagnosis of dementia and she was not sure if the resident had the capacity to understand and make decisions. During a concurrent follow up interview and record review on 7/11/2024 at 11:05 a.m., the SSA reviewed Resident 30's Social Services Notes for 6/2024 to 7/2024 and IDT Notes dated 6/12/2024 and 6/13/2024. The SSA stated there were two IDT meetings regarding Resident 30's plan of care that the SSA attended. The SSA stated she did not know Resident 30 has the capacity to understand and make decisions. The SSA stated the following: -On 6/12/2024, there was an IDT meeting attended by Resident 30's POA, and the resident did not attend due to impaired cognition due to dementia. The SSA stated the resident should have been involved in the IDT, but she (Resident 30) was not. -On 6/13/2024, there was an IDT meeting and Resident 30's POA attended, but the resident did not attend due to impaired cognition from dementia. During a concurrent interview and record review on 7/12/2024 at 10 a.m., the Social Services Director (SSD) reviewed Resident 30's IDT Notes dated 6/12/2024 and 6/13/2024. The SSD stated Resident 30 was not invited to attend, not encouraged to attend, and did not attend the IDT meetings. The SSD stated residents are involved with IDT meetings when they are capable to do so. The SSD stated Resident 30 was capable of attending IDT meetings. During an interview on 7/12/2024 at 4:35 p.m., the Assistant Director of Nursing (ADON) stated that all disciplines come together and to discuss a resident's plan of care during an IDT meeting. The ADON stated residents are encouraged to attend IDT meetings if they are capable of expressing themselves. The ADON stated Resident 30 was capable of expressing herself and should have been involved with the IDT meetings. The ADON stated when residents are not encouraged and involved with the IDT meetings there is a potential for the resident's concerns to not be addressed. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the Director of Nursing (DON) reviewed the facility policy and procedure regarding IDT care planning. The DON stated residents have to be involved in IDT meetings even if their representatives are also involved. The DON Stated residents have to be informed about what is happening with their care. The DON stated the facility policy was not followed because Resident 30 was not involved with the IDT meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedures titled, Care Plans - Interdisciplinary Team, last reviewed 7/2023, the policy and procedures indicated the interdisciplinary team is responsible for the development of resident care plans. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). The IDT includes but is not limited to the resident's attending physician, a registered nurse, a nursing assistant, a member of food and nutrition services staff, to the extent practicable the resident and/or resident representative, other staff as appropriate or necessary to meet the needs of the resident. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. During a review of the facility policy and procedures titled, Care Plans, Comprehensive Person-Centered, last reviewed 7/2023, the policy and procedures indicated the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. If the participation of the resident in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident in the process. During a review of the facility policy and procedure titled, Resident Rights, last reviewed 7/2023, the policy and procedures indicated federal and state laws guarantee certain basic rights to all residents of the facility. These rights include: be treated with respect, kindness, and dignity; self-determination; communication with and access to people and services inside the facility; exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; be supported by the facility in exercising his or her rights; and be informed of, and participate in, his or her care planning and treatment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to offer one of four sampled residents (Resident 91) or their resident representative assistance with formulating an Advance Directive (AD - a legal document telling the doctor one ' s wishes about their healthcare in the event they cannot make the decision for themselves) upon admission. Additionally, the facility failed to ensure resident's medical records were updated to show documented evidence that advance directives were discussed with three of five sampled residents (Residents 6, 118, and 114). This deficient practice violated the resident and/or their representative the right to fully be informed of the option to formulate an AD and had the potential to delay emergency treatment or the potential to force emergency, life-sustaining procedures against the resident's personal preferences. Findings: a. A review of Resident 91 ' s Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), lack of coordination, and muscle weakness. A review of Resident 91 ' s History and Physical (H&P) dated [DATE], did not indicate the resident had the capacity to understand and make decisions. A review of Resident 91 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE] indicated Resident 91 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance with eating, partial/moderate assistance with oral and personal hygiene, substantial/maximal assistance with mobility and dressing and total assistance with all other ADLs. A review of Resident 91 ' s Advance Directive Acknowledgement Form dated [DATE], did not indicate Resident 91 was asked for a presence of an AD and/or was offered assistance in the formulation of an AD. The form indicated Resident 91 was not capable of making a preferred intensity of care decisions at this time. A review of Resident 91 ' s Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their patients) Form dated [DATE], did not indicate Resident 91 ' s Advance Directive was discussed by the team. During a concurrent interview and record review on [DATE] at 3:21 p.m., Resident 91 ' s AD Acknowledgement Form, H&P, and IDT was reviewed with the Social Services Assistant (SSA). The SSA verified the AD Acknowledgment Form was not completed and she did not discuss the AD with Resident 91 during her admission visit as well as during the IDT meeting due to Resident 91 ' s diagnosis of dementia. The SSA stated the AD should have been discussed with the resident and assistance offered to ensure Resident 91 ' s wishes were honored in case of emergency. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 3:24 p.m., Resident 91 ' s AD Acknowledgement Form and H&P was reviewed with Registered Nurse 2 (RN 2). RN 2 stated the social services department oversees offering formulation of the Advance Directive (AD) to the resident, as well as completion of the form upon admission and/or during the initial IDT meeting. RN 2 verified the AD Acknowledge Form was not completed and did not indicate if AD was discussed with Resident 91. RN 2 verified the H&P did not indicate if Resident 91 had the capacity to understand and make decisions. RN 2 stated the AD Acknowledgement Form should have been completed to ensure the facility is honoring the resident ' s wishes in case of an emergency. RN 2 stated Resident 91 ' s capacity to make decisions should have been clarified with the physician. 44376 b. A review of Resident 6 ' s Admission Record indicated the facility admitted the resident on [DATE], and readmitted the resident on [DATE], with diagnoses that included metabolic encephalopathy (a disorder that affects brain function), acute respiratory failure (occurs when the lungs cannot release enough oxygen into the blood, which prevents the organs from properly functioning), and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). A review of Resident 6 ' s History and Physical (H&P), dated [DATE], indicated Resident 6 did not have the capacity to understand and make decisions. A review of Resident 6 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated Resident 6 usually had the ability to make self-understood and was able to understand others. During a concurrent interview and record review on [DATE], at 1:58 p.m., with the Director of Social Services (DSS), Resident 6 ' s Medical Chart was reviewed, the DSS stated there was no Advance Directive in the Medical Chart for Resident 6, and he would call the resident representative to offer the Advance Directive information. The DSS stated it was the Social Services Department ' s responsibility to ensure Advance Directive information was offered to the resident or resident representative by filling out an Advance Directive Acknowledgement Form and placing the form in the Medical Chart. The DSS added that the Advance Directive information should be offered to the resident or resident representative within 72 hours of admission. The DSS stated it was important to offer the Advance Directive information to the resident or resident representative to ensure the healthcare wishes of the resident was followed. During an interview on [DATE], at 6:12 p.m., with the Director of Nursing (DON), the DON stated it was important to ensure the Advance Directive information was offered to the resident or resident representative to know the healthcare wishes of the resident. The DON stated for example if the resident ' s wish was to die a natural death, but they performed cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) on the resident, they were not respecting the resident ' s right to self-determination. c. A review of Resident 118 ' s Admission Record indicated the facility admitted the resident on [DATE], with diagnoses that included metabolic encephalopathy, essential hypertension (high blood pressure that is not due to another medical condition), and acute cystitis (an infection of the bladder). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 118 ' s H&P, dated [DATE], indicated Resident 118 was unable to make decisions. A review of Resident 118 ' s MDS, dated [DATE], indicated Resident 118 sometimes had the ability to make self-understood and understand others. A review of Resident 118 ' s Social Services Notes, dated [DATE], indicated the DSS called Family Member 1 (FM 1) for the Interdisciplinary Team Meeting (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities), to ask some questions and obtain information for the assessment. The DSS left a voice message, but the voicemail was full and was unable to leave a message but left facility number to short message service (SMS, a test messaging service) notification. DSS will continue to follow up. During a concurrent interview and record review on [DATE], at 10:30 a.m., with the DSS, Resident 118 ' s Medical Chart was reviewed. The DSS stated there was no Advance Directive in the Medical Chart for Resident 118. The DSS stated he called FM 1 on [DATE] but the voice mail was full, and he did not have the chance to follow up after his initial call. The DSS stated it was the Social Services Department ' s responsibility to ensure Advance Directive information was offered to the resident or resident representative by filling out an Advance Directive Acknowledgement Form and placing them in the Medical Chart. The DSS added that the Advance Directive information should be offered to the resident or resident representative within 72 hours of admission. The DSS stated it was important to offer the Advance Directive information to the resident or resident representative to ensure the healthcare wishes of the resident was followed. During an interview on [DATE], at 6:12 p.m., with the DON, the DON stated it was important to ensure the Advance Directive information was offered to the resident or resident representative to know the healthcare wishes of the resident. The DON stated for example, if the resident ' s wish was to die a natural death, but they performed cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) on the resident, they were not respecting the resident ' s right to self-determination. d. A review of Resident 114 ' s Admission Record indicated the facility admitted the resident on [DATE], with diagnoses that included Alzheimer ' s disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task), severe sepsis (the body ' s extreme reaction to infection), and malignant neoplasm of prostate (a disease in which malignant [cancer] cells form in the tissues of the prostate). A review of Resident 114 ' s MDS, dated [DATE], indicated the resident sometimes had the ability to make self-understood and understand others. A review of Resident 114 ' s H&P, dated [DATE], indicated Resident 114 did not have the capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE], at 10:54 a.m., with the DSS, Resident 114 ' s Medical Chart was reviewed. The DSS stated there was no Advance Directive in the Medical Chart of Resident 114 and he would call the resident representative to offer the Advance Directive information. The DSS stated it was the social services department ' s responsibility to ensure Advance Directive information was offered to the resident or resident representative by filling out an Advance Directive Acknowledgement Form and placing them in the Medical Chart. The DSS added that the Advance Directive information should be offered to the resident or resident representative within 72 hours of admission. The DSS stated it was important to offer the Advance Directive information to the resident or resident representative to ensure the healthcare wishes of the resident was followed. During an interview on [DATE], at 6:12 p.m., with the DON, the DON stated it was important to ensure the Advance Directive information was offered to the resident or resident representative to know the healthcare wishes of the resident. The DON stated for example if the resident ' s wish was to die a natural death, but they performed cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) on the resident, they were not respecting the resident ' s right to self-determination. A review of the facility's recent policy and procedure titled, Advanced Directives, last reviewed on ,d+[DATE], indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical records the offer to assist and the resident ' s decision to accept or decline assistance. Information about whether the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44244 Based on interview and record review, the facility failed to ensure the physician was notified of a change of condition/status for one of one sample residents (Resident 30) reviewed under the Choices care area by failing to notify the primary physician regarding the facility ' s assessment of a decline in the resident ' s capacity to understand and make decisions that significantly affected the resident ' s right to leave the facility against medical advice. This deficient practice had the potential to result in a delay of care and confusion in Resident 30 ' s plan for discharge, potentially resulting in psychosocial harm to the resident. Findings: A review of Resident 30 ' s Admission Record indicated the facility admitted the resident on 5/31/2024 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) unspecified severity; abnormalities of gait (manner of walking) and mobility; muscle weakness, and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of Resident 30 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 6/10/2024, indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident had a Brief Interview for Mental Status Summary Score (BIMS, a brief cognitive screening measure that focuses on orientation and short-term word recall) of 13 (a score of 13 to 15 indicates a resident is cognitively intact). The MDS indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, personal hygiene, and dressing. A review of Resident 30 ' s history and physical dated 6/5/2024 and signed by the physician, indicated the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 7/9/2024 at 8:30 a.m., Resident 30 lay in her bed and stated she was being held in the facility and wanted to leave. Resident 30 stated the Social Services Assistant (SSA) told her she cannot leave because she does not have a safe discharge plan. Resident 30 stated the facility staff is not listening to her. During an interview on 7/10/2024 at 10 a.m., the SSA stated Resident 30 has a problem understanding and a diagnosis of dementia. The SSA stated she was not sure if the resident had the capacity to understand and make decisions. During an interview on 7/10/2024 at 11:20 a.m., the Director of Nursing stated Resident 30 did not have the capacity to understand and make decisions, and the facility was in the process of finding a conservator (a court process where a judge decides whether one can care for their own health, food, clothing, shelter, finances, or personal needs) for the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent follow up interview and record review on 7/11/2024 at 7:31 a.m., the DON reviewed Resident 30 ' s History and Physical (H&P) dated 6/5/2024. The DON stated Resident 30 ' s primary physician indicated on the H&P, that the resident has the capacity to understand and make decisions. The DON stated she really felt that the resident had cognitive impairment and was not safe to discharge, even if the physician determined the resident had capacity. The DON stated she cannot determine a resident ' s capacity, but she can make recommendations to the physician regarding her assessment. The DON stated only the physician can make the determination of a resident ' s capacity to understand and make decisions. The DON stated when she determined the resident had cognitive impairment, she should have notified the physician of her assessment and requested a more comprehensive assessment to determine the resident ' s capacity; but she did not contact the physician. During a follow up concurrent interview and record review on 6/12/2024 at 8 a.m., the DON reviewed Resident 30 ' s Initial Psychiatric Evaluation, dated 6/27/2024. The DON stated the resident ' s primary physician spent only a small amount of time with Resident 30 on admission when the resident ' s capacity to understand and make decisions was determined. The DON stated since the resident ' s admission on 5/31/2024, the DON determined the resident had cognitive deficits. The DON stated the psychiatric nurse practitioner determined on 6/27/2024 that the resident had impaired judgement and insight, and an inability to function in a less structured environment. The DON stated the psychiatric evaluation on 6/27/2024 was a change of condition in the resident ' s ability to understand and make decisions for herself and it contradicted the physician ' s assessment of the resident ' s capacity. The DON stated when there is a change of condition, the facility is responsible for notifying the physician. The DON stated Resident 30 ' s physician was not notified of the change of condition. The DON Stated when the physician was not notified regarding Resident 30 ' s change of condition, there was a potential for confusion over the resident ' s ability to make decisions for herself and to leave the facility against medical advice resulting in anxiety and depression in Resident 30. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the DON reviewed the facility policy and procedure regarding change of condition. The DON stated the facility policy and procedure was not followed because Resident 30 ' s primary physician was not notified that she had a cognitive deficit that would affect her capacity to understand and make decisions. A review of the facility policy and procedure titled, Change in a Resident ' s Condition or Status, last reviewed 7/2023, indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status (e.g. changes in level of care or resident rights). The nurse will notify the resident ' s attending physician or physician on call when there has been a need to alter the resident ' s medical treatment significantly, A significant change, of condition is a major decline in the residents status that impacts more than one area of the resident ' s health status, requires interdisciplinary review and/or supervision to the care plan, and is ultimately based on the judgement of the clinical staff. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident ' s mental status. The nurse will record in the resident ' s medical record information relative to changes in the resident ' s mental condition or status. A representative of the business office will notify the resident when there is a change in resident rights under federal or state law or regulations. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedure titled, Physician Services, last reviewed 7/2023, indicated the medical care of each resident is supervised by a licensed physician. Supervising the medical care of the resident includes (but is not limited to) monitoring changes in resident ' s medical status, providing consultation or treatment when called by the facility, overseeing a relevant plan of care for the resident. The attending physician will determine the relevance of any recommended interventions from other disciplines.

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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 - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44376 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident ' s body that he or she cannot easily remove that restricts freedom of movement or normal access to one ' s body) for one of four sampled residents (Resident 4 by failing to: 1. Complete a Physical Restraint Assessment Form prior to the application of both upper side rails (adjustable rigid plastic bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) as a restraint. 2. Obtain an informed consent from the resident or resident representative prior to the application of both upper side rails as a restraint. 3. Obtain an order from the attending physician prior to the application of both upper side rails as a restraint. These deficient practices had the potential to result in the restriction of residents ' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: Cross Reference F700 A review of Resident 4 ' s Admission Record indicated the facility admitted the resident on 1/15/2015, and readmitted the resident on 3/6/2024, with diagnoses that included major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the right hand. A review of Resident 4 ' s Side Rail/Entrapment Assessment/Care Plan, dated 3/6/2024, indicated a recommendation for side rails was not indicated. A review of Resident 4 ' s History and Physical (H&P), dated 3/12/2024, indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/3/2024, indicated Resident 19 sometimes had the ability to make self-understood and to understand others. The MDS indicated Resident 19 had impaired upper and lower extremities and was mostly dependent on mobility and activities of daily living (ADLs). (continued on next page)

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	555707	A. Building B. Wing	07/12/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4 ' s Fall Risk Assessment, dated 6/8/2024, indicated Resident 19 was a high risk for falls and injuries. During an observation on 7/9/2024, at 8:58 a.m., during resident screening, inside Resident 4 ' s room, Resident 4 was lying down in bed with both upper side rails up. During an observation and interview on 7/10/2024, at 5:45 p.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 4 ' s room, Resident 4 was observed lying down in bed with both upper side rails up. CNA 3 stated she places both upper side rails up during the evening shift to prevent the resident from falls and injuries. CNA 3 stated she knows there was no order for both upper side rails to be up. During a concurrent interview and record review on 7/10/2024, at 6:21 p.m., with Registered Nurse 4 (RN 4), Resident 4 ' s Order Summary Report, Physical Restraint Assessment Form, and Informed Consent was reviewed. RN 4 stated there was no physician order for both upper side rails to be on the resident, no physical restraint assessment form, and no informed consent from the resident or resident representative prior to the application of restraint-both upper side rails use in the resident ' s medical chart. RN 4 stated it was important to obtain a physician ' s order, perform a physical restraint assessment, and obtain an informed consent for the use of the restraint-both upper side rails up, to ensure appropriate use of the restraint, to prevent injuries and physical decline to residents. RN 4 stated obtaining an informed consent from the resident or resident representative for the use of the restraint side rails honors the right of the resident to decide after being explained the risks and benefits of side rails if they want to use them. During an interview on 7/12/2024, at 6:15 p.m., with the Director of Nursing (DON), the DON stated it was important to obtain a physician ' s order for the use of both upper side rails as a restraint, complete a Physical Restraint Assessment, and obtain an informed consent from the resident or resident representative prior to application of the restraint both upper side rails, to ensure the safety and appropriate use of the restraint side rails and to prevent the resident from potential injuries such as entrapment. A review of the facility's recent policy and procedure titled, Physical Restraints, last reviewed on 7/2023, indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly. The licensed nurse shall be responsible for obtaining an order from the attending physician, which include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision-maker. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Plan of Care shall specify the reason for the use of the restraint, the type, when and where it is to be used. A review of the facility's most recent policy and procedure titled, Informed Consent, last reviewed on 7/2023, indicated this facility will verify that the patient's health record contains documentation that the patient has given informed consent before initiating the administration of psychotherapeutic drugs or physical restraints. Before initiating the administration of psychotherapeutic drugs or physical restraints, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan (CP, a written course of action that helps a patient achieve outcomes that improve their quality of life) for residents by failing to: 1. Develop and implement a person-centered care plan regarding Post Traumatic Stress Disorder (PTSD, a mental health condition caused by very stressful, frightening, or distressing events) for one of five residents (Resident 39) reviewed under the Behavioral-Emotional care area. 2. Develop and implement a comprehensive person-centered care plan for the use of insulin glargine-yfgn (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) for one (1) out of five (5) sampled residents (Resident 74). 3. Develop and implement a comprehensive person-centered care plan for one of four sampled residents (Resident 4) reviewed under physical restraints (devices that limit a patient ' s movement) and side rails (metal rails that normally hang on the side of the patient ' s bed) care areas. These deficient practices had the potential to result in a delay in the provision of necessary care and services for Residents 39, 74, and 4. Findings: 1. A review of Resident 39 ' s Admission Record indicated the facility admitted the resident on 10/3/2023 and readmitted the resident on 10/27/2023 with diagnoses that included bipolar disorder (a mental health disorder that causes extreme mood swings), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one ' s daily functioning), Alzheimer ' s disease (a type of dementia [a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life])), suicidal ideations (the act of thinking about or a state of preoccupation with taking one's own life), and PTSD. A review of Resident 39 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 4/11/2024, indicated Resident 39 was sometimes able to understand others and sometimes was able to make herself understood. The MDS further indicated Resident 39 had feelings of feeling down, depressed, or hopeless two to six days a week. The MDS indicated Resident 39 was dependent on staff for bathing, required substantial assistance for dressing, and required partial assistance for personal hygiene, toileting, and oral hygiene. A review of Resident 39 ' s Trauma Care Evaluation (a tool used to recognize trauma symptoms and acknowledge the role that trauma plays in a person ' s life), dated 4/11/2024, indicated Resident 39 stated that she was A survivor of Hitler ' s time when Jewish people were in concentration [NAME]. During an observation on 7/9/2024 at 9 a.m., Resident 39 was observed lying in bed awake and did not respond to the surveyor ' s questions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 7/12/2024 at 8:18 a.m. the Assistant Director of Nursing (ADON) reviewed Resident 39 ' s Trauma Care Evaluation dated 4/11/2024 and Care Plans. The ADON stated PTSD occurs after a traumatic event and a resident may have episodes of stress from the trauma. The ADON stated Resident 39 had a diagnosis of PTSD when admitted to the facility. The ADON stated the interdisciplinary team (IDT) has a care plan meeting to identify resident problems, establish goals, and interventions to meet the goals. The ADON stated Resident 39 had an evaluation that indicated the resident had PTSD and a care plan should have been developed, but it was not. The ADON stated without a PTSD CP it could potentially lead to undiscovered or a delay in discovering episodes of PTSD in a timely manner. The ADON stated without a CP there were no interventions to prevent or properly care for episodes of PTSD with the potential for not meeting the resident ' s psychological care needs. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m. the Director of Nursing (DON) reviewed the facility policy and procedure regarding comprehensive care plans. The DON stated CPs are based on the resident ' s diagnoses, general condition, and physician ' s order. The DON stated CPs are used to properly care for residents and to show what is being implemented and whether or not it is effective. The DON stated for Resident 39, the facility policy regarding CPs was not followed because a CP was not provided at admission to identify the triggers of Resident 39 ' s PTSD and they did not have the proper goals to provide services or identify a significant change in the resident ' s condition. The DON stated without the PTSD CP, it could potentially result in increased anxiety and depression due to trauma and triggering factors for the resident. 43988 2. A review of Resident 74 ' s Admission Record indicated the facility admitted the resident on 12/6/2023 and readmitted to the facility on [DATE] with diagnoses that included abnormalities of gait and mobility, osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection), and type two diabetes mellitus (DM 2 - a long-term medical condition in which the body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer. A review of Resident 74 ' s MDS dated [DATE], indicated Resident 74 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene and partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 74 received insulin injections. A review of Resident 74 ' s History and Physical, dated 6/12/2024, indicated Resident 74 did not have the capacity to understand and make decisions. A review of Resident 74 ' s Order Summary Report indicated the following physician ' s order dated 5/27/2024 to administer insulin glargine solution-yfgn (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) subcutaneous (SQ - administered under the skin) solution (insulin glargine-yfgn)100 unit/ml inject 15 units SQ every 12 hours for DM 2 and rotate injection sites. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/2024 at 11 a.m., Resident 74 ' s physician ' s orders and care plans were reviewed with Registered Nurse 2 (RN 2). RN 2 verified Resident 74 was currently receiving insulin and there was no documented evidence that a care plan was developed and implemented for the use of insulin glargine. RN 2 stated care plans should have been developed within seven (7) days of the date of the MDS assessment so the staff would be aware the resident is on insulin to prevent delay in the delivery of necessary care and services Resident 74 needs. 44376 3. A rereview of Resident 4 ' s Admission Record indicated the facility admitted the resident on 1/15/2015, and readmitted on [DATE], with diagnoses that included major depressive disorder, anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the right hand. A review of Resident 4 ' s History and Physical (H&P), dated 3/12/2024, indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4 ' s MDS, dated [DATE], indicated Resident 4 sometimes had the ability to make self-understood and to understand others. The MDS indicated the resident had impaired upper and lower extremities and was mostly dependent on mobility and activities of daily living (ADLs). A review of Resident 4 ' s Side Rail/Entrapment Assessment/Care Plan, dated 3/6/2024, indicated a recommendation for side rails was not indicated. A review of Resident 4 ' s Fall Risk Assessment, dated 6/8/2024, indicated the resident was high risk for falls and injuries. During an observation on 7/9/2024, at 8:58 a.m., during resident screening, inside Resident 4 ' s room, observed the resident lying down in bed with both upper side rails up. During a concurrent interview and record review on 7/10/2024, at 6:21 p.m., with Registered Nurse 4 (RN 4), Resident 4 ' s Order Summary Report, Physical Restraint Assessment Form, Informed Consent, and Care Plans was reviewed. RN 4 stated there was no physician order for both upper side rails to be used for the resident, no Physical Restraint Assessment Form, and no Informed Consent from the resident or resident representative prior to the application of restraint both upper side rails use in the resident ' s medical chart, and Care Plan on the use of restraint side rails. RN 4 stated it was important to obtain a physician ' s order, do a physical restraint assessment, obtain an informed consent, and care plan on the use of the restraint both upper side rails up to ensure appropriate use of the restraint to prevent injuries and physical decline to residents. RN 4 stated obtaining an informed consent from the resident or resident representative on the use of the restraint side rails honors the right of the resident to decide after being explained the risks and benefits of side rails if they want to use them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/2024, at 6:15 p.m., with the Director of Nursing (DON), the DON stated it was important to obtain a physician ' s order on the use of both upper side rails as a restraint, complete a Physical Restraint Assessment, obtain an informed consent from the resident or resident representative, and develop a care plan on the use of the restraint side rails to ensure the safety and appropriate use of the restraint side rails and to prevent the resident from potential injuries such as entrapment. A review of the facility ' s policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed 7/2023, 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. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The CP includes measurable objectives and timeframes, describes services that are to be furnished, the resident ' s stated goals and desired outcomes, builds on the resident ' s strengths, and reflects currently recognized standards of practice for problem areas and conditions. Services provided for or arranged by the facility and outlined in the CP are culturally competent and trauma informed. A review of the facility's recent policy and procedure titled, Physical Restraints, last reviewed on 7/2023, indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly. The licensed nurse shall be responsible for obtaining an order from the attending physician, which include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision-maker. The Plan of Care shall specify the reason for the use of the restraint, the type, when and where it is to be used.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility ' s licensed nursing staff failed to provide care in accordance with professional standards for two of two sampled residents (Residents 20 and 74) investigated under insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. This deficient practice had the potential to result in adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: 1. A review of Resident 20 ' s Admission Record indicated the facility admitted theresident on 8/10/2021, and readmitted the resident on 4/2/2023, with diagnosesthat included type 2 diabetes mellitus (a disease that occurs when the bloodglucose, also called blood sugar, is too high), glaucoma (a group of eye diseasesthat can cause vision loss and blindness by damaging a nerve in the back of theeye called the optic nerve), and chronic kidney disease (the kidneys are damagedand cannot filter blood the way it should). A review of Resident 20 ' s Order Summary Report, dated 9/19/2022, indicated anorder for Humulin R Solution (Insulin Regular Human). Inject as per sliding scale(varies the dose of insulin based on blood glucose level): if 70-180= 0; 181-200= 2units (the amount of insulin required to lower the fasting blood sugar); 201-250= 3units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units greater than (>) 400or less than (<) 70 call MD, subcutaneously before meals and at bedtime fordiabetes type 2 (DM II). May give orange juice 8 ounces (oz., a unit of weight thatis equal to one-sixteenth of a pound) or glucose gel orally (PO) if blood sugar (BS)is below 60. A review of Resident 20 ' s History and Physical (H&P), dated 9/7/2023, indicatedResident 20 had decision-making capacity. A review of Resident 20 ' s Location of Administration Report for insulin from4/2024 to 7/12/2024, indicated insulin was administered on the following dates: -Humulin R Solution 4/6/2024 at 9:51 p.m. on the Abdomen-Right Upper Quadrant (RUQ) 4/6/2024 at 9:52 p.m. on the Abdomen-RUQ 4/7/2024 at 8:52 p.m. on the Abdomen-RUQ 4/10/2024 at 5:29 p.m. on the Abdomen-Left Upper Quadrant (LUQ) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/10/2024 at 9:09 p.m. on the Abdomen-LUQ 4/14/2024 at 12:08 p.m. on the Abdomen RUQ 4/14/2024 at 8 p.m. on the Abdomen-RUQ 4/18/2024 at 6:52 p.m. on the Abdomen-RUQ 4/19/2024 at 7:56 p.m. on the Abdomen-RUQ 4/30/2024 at 11:42 a.m. on the Abdomen-RUQ 4/30/2024 at 6:23 p.m. on the Abdomen-RUQ 5/1/2024 at 12:27 p.m. on the Abdomen-RUQ 5/2/2024 at 5:52 p.m. on the Abdomen-Left Lower Quadrant (LLQ) 5/3/2024 at 6:35 a.m. on the Abdomen-LLQ 5/14/2024 at 6:40 p.m. on the Abdomen-LLQ 5/15/2024 at 4:27 p.m. on the Abdomen-LLQ 5/18/2024 at 6:12 p.m. on the Abdomen-Right Lower Quadrant (RLQ) 5/20/2024 at 10:29 p.m. on the Abdomen-RLQ 5/24/2024 at 11:18 a.m. on the Abdomen-RUQ 5/25/2024 at 4:40 p.m. on the Abdomen-RUQ 6/1/2024 at 8:36 p.m. on the Abdomen-LLQ 6/2/2024 at 8:11 p.m. on the Abdomen-LLQ 6/8/2024 at 6:10 p.m. on the Abdomen-RLQ 6/10/2024 at 7:59 a.m. on the Abdomen-RLQ 6/13/2024 at 10:04 p.m. on the Abdomen-RLQ 6/14/2024 at 4:03 p.m. on the Abdomen-RLQ 6/16/2024 at 8:51 p.m. on the Abdomen-LUQ 6/17/2024 at 9:19 p.m. on the Abdomen-LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/19/2024 at 10:32 p.m. on the Abdomen-LLQ 6/20/2024 at 11:47 a.m. on the Abdomen-LLQ 6/27/2024 at 3:43 p.m. on the Abdomen-LLQ 6/28/2024 at 4:48 p.m. on the Abdomen-LLQ During a concurrent interview and record review on 7/11/2024, at 11:45 a.m., with Registered Nurse 3 (RN 3), Resident 20 ' s Order Summary Report, Medication Administration Record (MAR), and the Location of Administration of insulin for 4/2024 to 7/12/2024 was reviewed. RN 3 stated there were multiple instances that the insulin was administered on the same site from 4/2024 to 7/12/2024. RN 3 stated it was important to rotate insulin administration sites of insulin to prevent bruising and lipodystrophy to residents. During an interview on 7/12/2024, at 6:17 p.m., with the Director of Nursing (DON), the DON stated it was basic nursing knowledge to rotate insulin administration sites. The DON stated if we do not rotate the administration sites of the insulin, the resident will develop skin damage and absorption will be compromised. The DON stated the best area to administer was the abdominal area. A review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 7/2023, indicated Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). A review of the facility provided Information for the Physician Humulin-R Regular Insulin Human Injection, USP, (rDNA Origin) 100 units per ml (U-100), issued 3/2011, indicated Humulin R U-100 may be administered by subcutaneous injection in the abdominal wall, the thigh, the gluteal region or in the upper arm. Subcutaneous injection into the abdominal wall ensures a faster absorption than from other injection sites. Injection into a lifted skin fold minimizes the risk of intramuscular injection. Injection sites should be rotated within the same region. 43988 2. A review of Resident 74 ' s Admission Record indicated the facility admitted the resident on 12/6/2023 and was readmitted on [DATE] with diagnoses that included abnormalities of gait and mobility, osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection), and type two diabetes mellitus (DM 2 - a long-term medical condition in which the body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 74 ' s Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/3/2024, indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene and partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident received insulin injections. A review of Resident 74 ' s History and Physical, dated 6/12/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 74 ' s Order Summary Report indicated the following physician ' s order dated 5/27/2024 to administer insulin glargine solution-yfgn (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) subcutaneous (SQ - administered under the skin) solution (insulin glargine-yfgn) 100 unit/ml inject 15 units SQ every 12 hours for DM 2 and rotate injection sites. A review of Resident 74 ' s Location of Administration Report for insulin from 4/2024 to 7/2024 indicated insulin glargine solution 100 UNIT/ML was administered as follows: 4/01/24 21:00 4/01/24 20:57 subcutaneously Abdomen - RUQ 4/02/24 09:00 4/02/24 16:44 subcutaneously Abdomen - RUQ 4/06/24 21:00 4/06/24 23:05 subcutaneously Abdomen - RUQ 4/07/24 09:00 4/07/24 14:53 subcutaneously Abdomen - RUQ 4/12/24 09:00 4/12/24 09:15 subcutaneously Abdomen - RLQ 4/12/24 21:00 4/12/24 21:27 subcutaneously Abdomen - RLQ 4/18/24 21:00 4/18/24 20:41 subcutaneously Abdomen - RLQ 4/19/24 09:00 4/19/24 13:47 subcutaneously Abdomen - RLQ 4/26/24 09:00 4/26/24 09:20 subcutaneously Abdomen - RLQ 4/26/24 21:00 4/26/24 20:07 subcutaneously Abdomen - RLQ 5/07/24 21:00 5/07/24 21:22 subcutaneously Abdomen - RUQ 5/08/24 09:00 5/08/24 09:55 subcutaneously Abdomen - RUQ 6/20/24 21:00 6/20/24 20:16 subcutaneously Abdomen - LUQ 6/21/24 09:00 6/21/24 09:43 subcutaneously Abdomen - LUQ (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/24 at 11:15 a.m., Resident 74 ' s insulin glargine Location of Administration Sites in the Medication Administration Record (MAR) for the month of 4/2024, 5/2024, 6/2024, and 7/2024 and physician ' s order were reviewed with Registered Nurse 2 (RN 2). RN 2 verified the physician ' s order for the insulin glargine indicated to rotate injections site. RN 2 verified the administration sites for the insulin glargine were not rotated. RN 2 stated the administration sites should have been rotated to prevent bruising, bleeding, and irritation on the site which may lead to poor absorption of the medication and the resident not receiving the required amount of insulin. A review of the facility's most recent policy and procedure titled, Insulin Administration, last reviewed 7/2023, indicated the purpose is to provide guidelines for the safe administration of insulin to residents with diabetes. The policy indicated the following: - Select an injection site. - Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. - Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). A review of the insulin glargine patient information provided by the facility, dated 2022, indicated to rotate the injection sites with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The package insert indicated to not use the same spot for each injection, or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred, or damaged.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44244 Based on observation, interview, and record review the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers (PU, also called pressure injuries, pressure sores, and decubitus ulcers - injuries to skin and underlying tissue resulting from prolonged pressure) for two of two sampled residents (Resident 21 and Resident 93) reviewed under the care area Pressure Ulcer/Injury by failing to: 1. Ensure Resident 93 ' s low air loss mattress (LALM- a support surface composed of inflatable air cushions used to relieve pressure on body parts and help prevent skin breakdown) was set to the correct weight. 2. Turn Resident 93, who had a stage 4 pressure injury (full thickness tissue loss with exposed bone, tendon, or muscle) in the coccyx (the small bone at the bottom of the spine) every two hours in bed and follow the facility ' s policy on repositioning residents to indicate the position the resident was placed during repositioning. 3. Ensure Resident 93 ' s Pressure Injury Weekly Wound Assessment and Measurement was done per facility protocol. The wound was not assessed the week of 4/28/2024 to 5/4/2024. These deficient practices had the potential to result in the development and/or worsening of resident pressure ulcers. Findings: 1. A review of Resident 21 ' s Admission Record indicated the facility admitted Resident 21 on 11/11/2020, and readmitted Resident 21 on 4/11/2020, with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), pressure ulcer stage four (full thickness tissue loss with exposed bone, tendon or muscle) of sacral region (region at the bottom of the spine lying between the lumbar spine [L5] and the coccyx [tailbone]), type 2 diabetes mellites (a chronic condition that affects the way the body processes blood sugar [glucose]), and non-pressure chronic ulcer of right heel and midfoot with unspecified severity. A review of Resident 21 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 4/9/2024, indicated Resident 21 sometimes was able to understand others and sometimes was able to make himself understood. The MDS further indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, personal hygiene, dressing, and mobility. The MDS indicated the resident had a stage 4 PU with a pressure reducing device for the bed as treatment. A review of Resident 21 ' s physician orders indicated an order for a LALM for prevention/management for pressure sores, dated 4/11/2022. A review of Resident 21 ' s Care Plan titled, Actual Pressure Sore, Resident noted with stage 4 pressure ulcer, site: Sacro coccyx, initiated 4/11/2022, indicated to administer treatment as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/9/2024 at 9:25 a.m., Resident 21 was lying in bed on a LALM, the resident did not respond to the surveyor. The LALM pump (device that adds and removes air from the mattress) set to a resident weight of 120 pounds (lbs). During an observation on 7/10/2024 at 7:15 a.m., Resident 21 was lying in bed on a LALM. The LALM pump was set to 280 lbs. During a concurrent observation and interview on 7/10/2024 at 7:20 a.m., Certified Nursing Assistant 3 (CNA 3) entered Resident 21 ' s room and stated the LALM was set to 280 lbs. CNA 3 stated she did not think the resident weighed 280 lbs. CNA 3 stated the LALM was set to 280lbs when she arrived that morning. During a concurrent observation, interview, and record review on 7/10/2024 at 7:35 a.m. Licensed Vocational Nurse 4 (LVN 4) reviewed Resident 21 ' s weights and stated the resident weighed 110 lbs. LVN 4 entered Resident 21 ' s room and stated the LALM was not set to the correct weight because it was set to 280lbs, but it should be set to 120lbs the setting nearest the resident ' s weight. LVN 4 stated the LALM is for safety, comfort and pressure injuries. LVN 4 stated when the LALM is set to a higher weight it makes the mattress harder and could disrupt the pressure injury healing process. During a concurrent interview and record review on 7/10/2024 at 7:40 a.m., Registered Nurse 2 (RN 2) reviewed Resident 21 ' s weight. RN 2 stated LALM mattresses are calibrated by weight and set to a setting nearest to the resident ' s weight. RN 2 stated Resident 21 weighed 110lbs and the LALM should be set to 120lbs to promote pressure injury healing. During an interview and record review on 7/12/2024 at 10:30 a.m. with the Assistant Director of Nursing (ADON) reviewed Low Air Los Mattress 1 ' s (LALM 1) Operation Manual. The ADON stated the Operation Manual indicated to select the resident ' s correct weight on the pump device. The ADON stated setting the LALM to the wrong weight will make the mattress firmer and the wound could become worse, or a new pressure injury may develop. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the Director of Nursing (DON) reviewed LALM 1 ' s Operation Manual and the facility policy regarding pressure ulcer prevention. The DON stated the LALM is set to the resident ' s weight. The DON stated if the LALM is set to a weight that is too low or high then it could potentially be a contributing factor to delayed wound healing. The DON stated if the LALM is too firm then the surface is hard, and the mattress is not functioning properly. The DON stated the facility policy and LALM 1 Operation Manual was not followed which had a potential for delayed wound healing, an increase in the size of the pressure injury, and hospitalization from infection. A review of the facility policy and procedure titled, Pressure-Reducing Mattresses, last reviewed 7/2023, indicated the objective of the policy was to provide mattresses that will prevent and/or minimize pressure on the skin. A review of the facility policy and procedure titled, Prevention of Pressure Injuries, last reviewed 7/2023, indicated the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Prevention includes selecting appropriate support surfaces based on the resident ' s risk factors, in accordance with current clinical practice. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s undated Operation Manual for LALM 1, indicated LALM 1 is designed for prevention, treatment, and management of pressure ulcers. The manual indicated to select the up or down buttons on the pump unit to select the correct patient weight. Users can adjust the mattress to a desired firmness according to the patient ' s weight or the suggestion from a health care professional. 44376 2. A review of Resident 93 ' s Admission Record indicated the facility admitted the resident on 4/1/2024, with diagnoses that included lack of coordination, muscle weakness, and a Stage 4 pressure ulcer of the sacral region. A review of Resident 93 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/12/2024, indicated Resident 93 sometimes had the ability to make self-understood and understand others. The MDS indicated the resident had impaired upper and lower extremities and was dependent on mobility and activities of daily living (ADLs). The MDS indicated the resident was at risk for further developing pressure ulcer/injuries and had an unhealed Stage 4. The MDS did not indicate that Resident 93 was on a turning/repositioning program. A review of Resident 93 ' s History and Physical (H&P), dated 6/3/2024, indicated Resident 93 did not have the capacity to understand and make decisions. A review of Resident 93 ' s Order Summary Report, dated 7/2/2024, indicated an order Irrigate the Sacro coccyx Stage 4 Pressure Ulcer- with normal saline (a mixture of salt and water), pat dry, apply Santyl ointment (to help the healing of burns and skin ulcers), pack with calcium alginate (super absorbent dressings that absorb excess wound drainage), cover with super absorbative foam dressing daily. Every day shift for 30 days and monitor for pain during treatment through pain ad 0-10). A review of Resident 98 ' s Care Plan titled, Actual pressure sore: Resident is noted with: Stage 4 pressure ulcer, site: Sacro coccyx, last revised on 5/27/2024, indicated an intervention to encourage Resident 93 to assist with turning and positioning changes as tolerated, turn and position as needed when in bed or wheelchair, and weekly body checks per facility protocol. A review of Resident 98 ' s Monitoring Sheet for Turning and Repositioning on 7/10/2024, indicated Resident 93 was turned at 4:30 a.m. and 1:43 p.m. The entries on the flow sheet were entered before the end of the CNA 1 shift. During an observation on 7/10/2024, Resident 93 was positioned in bed at the following times: 8:53 a.m. Resident was facing the window or the left side. 11:43 a.m. Resident was facing the door or the right side. 1:53 p.m. Resident was facing the door or the right side. 2:44 p.m. Resident was facing the door or the right side. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/10/2024, at 2:50 p.m., with Certified Nursing Assistant 1 (CNA 1), inside Resident 93 ' s room, Resident 93 was facing the door or the right side. CNA 1 stated the last time she turned the resident was 1:43 p.m. on the right side. CNA 1 stated that she was not the only one turning the resident but other staff as well. CNA 1 stated she cannot remember what the position of the resident was before she turned the resident to the right. CNA 1 stated they only document the turning/repositioning of the resident once a shift as done, and they do not indicate position of the resident. CNA 1 stated the resident needed to be turned every 2 hours to prevent worsening of pressure injury. During an observation on 7/11/2024, Resident 93 was positioned in bed at the following times: 8:10 a.m. Resident was facing the door or to the right side. 9:54 a.m. Resident was facing the window or to the left side. 11:53 a.m. Resident was facing the door or to the right side. 3:31 p.m. Resident was facing the door or to the right side. During a concurrent observation and interview on 7/11/2024, at 3:32 p.m., with Certified Nursing Assistant 2 (CNA 2), inside Resident 93 ' s room, Resident 93 was facing the door or to the right side. CNA 2 stated he just got there, and the resident was facing the door or to the right side when he came in. CNA 2 stated he has not repositioned the resident yet. During an interview on 7/11/2024, at 5:35 p.m., with Treatment Nurse 1 (TN 1), TN 1 stated the staff need to turn the resident every 2 hours to relieve pressure to the bony prominences of the body and it should be documented in a timely manner and make sure that the position was indicated to prevent confusion on which side the resident will be facing next to prevent further skin breakdown. TN 1 stated the wound was not assessed on the week of 4/28/2024 to 5/4/2024. TN 1 stated it was important to consistently perform the weekly assessment and measurement of the pressure ulcer to ensure the wound was responding well to the treatment. During an interview on 7/12/2024, at 6:21 p.m., with the Director of Nursing (DON), the DON stated it was important to reposition the resident every two hours to promote circulation to the skin, if there was decreased circulation, there will be an increased risk for skin damage. The DON stated that turning the resident every two hours was important for skin maintenance and to prevent other skin complications. The DON stated TN 1 should do weekly wound assessment and measurement to keep track if the wound was responding to the current treatment, to evaluate the interventions being provided if it needed to continue or not. The DON stated the importance of placing the position of the resident when repositioning was to keep track of where the resident was turned to prevent turning on the same side for continuity of care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled, Repositioning, last reviewed on 7/2023, indicated the purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed-or-chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Residents who are in bed should be repositioned frequently and as needed. The following information should be recorded in the resident's medical record: 1. The position in which the resident was placed. This may be on a flow sheet. 7. The signature and title of the person recording the data. A review of the facility's recent policy and procedure titled, Prevention of Pressure Injuries, last reviewed on 7/2023, indicated to assess the resident on admission for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44376 Based on interview and record review the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion (ROM, how far and in what direction the joint or muscle can move) and/or prevent further decrease in range of motion for one of two sampled residents (Resident 4) by failing to conduct a consistent restorative nursing weekly summary for the month of April 2024. This deficient practice had the potential to place the resident at increased risk of ROM decline. Findings: A review of Resident 4 ' s Admission Record indicated the facility admitted the resident on 1/15/2015, and readmitted the resident on 3/6/2024, with diagnoses that included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), obesity (having too much fat), and contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the right hand. A review of Resident 4 ' s History and Physical (H&P), dated 3/12/2024, indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4 ' s Order Summary Report, dated 4/4/2024, indicated an order for Restorative Nursing Aide (RNA) to provide passive range of motion exercises (PROME, joint movement caused by another person or a specialized device) on both lower extremities (LE) as tolerated. Everyday (Qd) 5 times per week (x/wk). A review of Resident 4 ' s Care Plan titled, Limitation(s) in range of motion/contractures related to muscle weakness, general dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person ' s daily life and activities), last revised on 4/4/2024, indicated an intervention of restorative nursing treatment as ordered and RNA to provide PROME on both LE as tolerated. Qd (Every day) 5x/wk. A review of Resident 4 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/3/2024, indicated Resident 4 sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 4 had impaired upper and lower extremities and was mostly dependent in mobility and activities of daily living (ADLs). During a concurrent interview and record review on 7/11/2024, at 11:30 a.m., with Restorative Nursing Aide 1 (RNA 1), Resident 4 ' s Restorative Nursing Weekly Summary for Range of Motion was reviewed. RNA 1 stated there was only one Restorative Nursing Weekly Summary for range of motion that was done for the resident for the month of April 2024. RNA 1 stated there should be at least four per month. RNA 1 stated it was important to perform a Restorative Nursing Weekly Summary range of motion for the resident to check if the resident was responding well to the therapy and to assess if the resident was having a decline in function to intervene as soon as possible by reporting to the Director of Rehabilitation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024, at 6:28 p.m., with the Director of Nursing (DON), the DON stated it was important for the RNA to do a weekly RNA summary to prevent a decline in range of motion. A review of the facility's most recent policy and procedure titled, Restorative Nursing Program, last reviewed on 7/2023, indicated the purpose of the policy is to maintain resident's functional ability, and to reduce further decline. Weekly assessment is to be made of the resident's progress in the Restorative Nursing Program by the restorative nurse and documented in the resident's medical record. Any change in resident's condition or response to treatment is reported to nursing and documented in the medical record. The Director of Nursing, or designee, shall design a schedule for the facility's staff to ensure the residents receive appropriate restorative programs. Residents who are completely incapacitated are to be scheduled for a range of motion exercise when turned or repositioned, or during dressing and bathing. The restorative nurse assistant shall be scheduled for specific restorative and rehabilitative duties by the Director of Nursing, or designee, in regular consolation with the physical therapist.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards, ensure residents received adequate supervision, and implement interventions to prevent accidents for five (5) of 5 sampled residents (Resident 54, 58, 27, 77, and 60) investigated under the Accidents care area by failing to: 1. Ensure Resident 58 ' s left side floor mat was not overlapping with Resident 54 ' s right side floor mat during a random observation. This deficient practice placed Resident 54 and 58 at risk for fall incidents which may lead to injuries. 2. Ensure Resident 27 ' s sensor pad alarm (a device consisting of a pressure-sensing pad that sends a signal to a nearby receiver to sound when the resident rises and their weight shifts) was functioning properly when the resident tried to get out of bed unassisted during a random observation. This deficient practice placed Resident 27 at risk for exiting the bed without staff knowledge and sustaining injuries from falls. 3. Ensure the sensor pad alarms (a device consisting of a pressure-sensing pad that sends a signal to a nearby receiver to sound when the resident rises and their weight shifts) were connected and functioning for Resident 77 and Resident 60. This deficient practice had the potential to place Resident 60 and 77 at risk for falls and injuries. Findings: a. A review of Resident 58 ' s Admission Record indicated the facility admitted Resident 58 on 8/14/2020 and readmitted to the facility on [DATE] with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury due to trauma). A review of Resident 58 ' s History and Physical (H&P) dated 2/12/2024, indicated Resident 58 did not have the capacity to understand and make decisions. A review of Resident 58 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/15/2024 indicated Resident 58 had a severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating; partial/moderate assistance with mobility, walking, oral, toileting, and personal hygiene; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 58 ' s Fall Risk Assessments indicated the following: 1. 2/9/2024 was assessed as high risk for falls with a score of 26 due to a fall incident. 2. 2/14/2024 was assessed as high risk for falls with a score of 26 during readmission. 3. 5/25/2024 was reassessed as high risk for falls with a score of 28 during a quarterly assessment. A review of Resident 58 ' s care plans indicated the following: 1. Resident is at risk for falls/injury related to generalized weakness, history of falls, and impaired cognition initiated 2/15/2024 indicated to provide low bed with floor mat as ordered as one of the interventions. 2. Actual fall related to balance deficit, cognitive impairment, and history of falls initiated 2/9/2024 indicated to provide low bed with floor mat as ordered, administer pain medications as ordered, apply cold compress as ordered as some of the interventions. During a concurrent observation and interview on 7/9/2024 at 10:05 a.m. inside Resident 58 ' s room with Certified Nursing Assistant 7 (CNA 7), observed Resident 58 ' s left lower side floor mat was on top of Resident 54 ' s right lower side floor mat. CNA 7 verified Resident 58 ' s floormat was overlapping with Resident 54 ' s floor mat and stated it was not supposed to be overlapping as it had the potential for both residents to trip and fall causing injury. CNA 7 stated the floor mats were supposed to be properly placed and not overlapping. During a concurrent observation and interview on 7/9/2024 at 10:07 a.m. inside Resident 58 ' s room with Registered Nurse 2 (RN 2), Resident 58 ' s left lower side floor mat was on top of Resident 54 ' s right lower side floor mat. RN 2 verified Resident 58 ' s floormat was overlapping with Resident 54 ' s floor mat and stated it was supposed to be properly placed on the floor and not overlapping as it had the potential for both residents to trip and fall causing injury. A review of the facility ' s policy and procedure titled, Accident reduction: Useful Interventions, last reviewed 7/2023, indicated useful interventions will be utilized to reduce accidents and injuries. The policy indicated padding on the floor and low bed as some of the interventions. A review of the facility ' s policy and procedure titled, Falling Star Program, last reviewed 7/2023, indicated recommendations to ensure successful program would be to include evaluation for appropriate useful interventions for fall reduction. b. A review of Resident 54 ' s Admission Record indicated the facility admitted Resident 54 on 8/2/2023 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), generalized weakness, restlessness and agitation, and delirium (a mental state in which a person is confused and has reduced awareness of their surroundings). A review of Resident 54 ' s History and Physical (H&P) dated 8/8/2023, indicated Resident 54 did not have the capacity to understand and make decisions. (continued on next page)

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Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 54 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/15/2024 indicated Resident 54 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance with showers, supervision with eating, partial/moderate assistance with mobility, walking, oral and personal hygiene, and transfers, and substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 54 ' s Order Summary Report indicated a physician ' s order dated 9/16/2023 for low bed with floor mat to decrease potential injury every shift. A review of Resident 54 ' s Fall Risk Assessments indicated the resident was assessed as a high risk for falls with a score of 24 on 2/11/2024 and 5/19/2024 during quarterly assessments. A review of Resident 54 ' s care plans indicated the following: - Actual fall related to auditory deficits, balance deficit, cognitive impairment, decreased strength/endurance, history of falls, non-compliant with requests for assistance/non-use of call light, poor safety awareness/judgment, unsteady gait initiated 11/27/2023 target date 8/9/2024 indicated to provide a low bed with floor mat as ordered as one of the interventions. During a concurrent observation and interview on 7/9/2024 at 10:05 a.m. inside resident 58 ' s room with Certified Nursing Assistant 7 (CNA 7), Resident 58 ' s left lower side floor mat was on top of Resident 54 ' s right lower side floor mat. CNA 7 verified Resident 58 ' s floormat was overlapping with Resident 54 ' s floor mat and stated it was not supposed to be overlapping as it had the potential for both residents to trip and fall causing injury. CNA 7 stated the floor mats were supposed to be properly placed and not overlapping. During a concurrent observation and interview on 7/9/2024 at 10:07 a.m. inside Resident 58 ' s room with Registered Nurse 2 (RN 2), Resident 58 ' s left lower side floor mat was on top of Resident 54 ' s right lower side floor mat. RN 2 verified Resident 58 ' s floormat was overlapping with Resident 54 ' s floor mat and stated it was supposed to be properly placed on the floor and not overlapping as it had the potential for both residents to trip and fall causing injury. A review of the facility ' s policy and procedure titled, Accident reduction: Useful Interventions, last reviewed 7/2023, indicated useful interventions will be utilized to reduce accidents and injuries. The policy indicated padding on floor and low bed as some of the interventions. 44376 c. A review of Resident 27 ' s Admission Record indicated the facility admitted Resident 27 on 2/23/2021 with diagnoses that included Alzheimer ' s Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and congestive heart failure (a condition that develops when the heart does not pump enough blood for the body's needs). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 27 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/23/2024 indicated Resident 27 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and bed mobility; substantial/maximal assistance walking, shower transfer, and lower body dressing; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 27s History and Physical (H&P) dated 7/10/2024, indicated Resident 27 did not have the capacity to understand and make decisions. A review of Resident 27 ' s Order Summary Report indicated the following physician ' s orders: 1. 7/14/2024: Bed pad alarm to alert staff when resident attempts to stand up from bed unassisted every shift. 2. 7/14/2024: Monitor for function and placement of bed pad alarm every shift. 3. 7/17/2023: Monitor episodes of resident attempting to stand up from bed unassisted every shift. A review of Resident 27 ' Fall Risk Assessments indicated the following: 1. 11/18/2023: Resident was assessed as a high risk for falls with a score of 20 during a quarterly assessment. 2. 2/18/2023: Resident was assessed as a high risk for falls with a score of 16 during an annual assessment. 3. 5/25/2024: Resident was assessed as a high risk for falls with a score of 16 during a quarterly assessment. A review of Resident 27 ' s care plans indicated the following: 1. Actual fall related to cognitive impairment, decreased strength/endurance, poor gait and balance initiated 7/14/2023 with target date 8/21/2024 indicated to apply bed alarm to alert staff that resident is attempting to get up from the bed unattended as one of the interventions. 2. Resident is at risk for falls/injury related to dementia, impaired cognition, poor safety awareness/judgment initiated 2/24/2021 target date 8/21/2024 indicated to apply a bed alarm to alert staff that resident is attempting to get up from the bed unattended and ensure bed pad alarm is in place and monitor for function and placement as some of the interventions. During an observation on 7/9/2024 at 9:51 a.m., inside Resident 27 ' s room, observed Resident lying in bed in a supine position then got up in a sitting position at the edge of the bed. Observed a bed pad alarm hanging on the right side of the bed with a red blinking light and the pad alarm did not function. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/9/2024 at 9:53 a.m. inside Resident 27 ' s room, Certified Nursing Assistant 8 (CNA 8) assisted Resident 27 to the restroom and the bed alarm did not function. CNA 8 verified the bed alarm did not make a sound when she assisted the resident to the restroom. CNA 8 stated the bed alarm should have made a sound when the Resident 27 moved in the bed as it placed the resident at risk for falls and injuries. During a concurrent observation and interview on 7/9/2024 at 9:55 a.m. inside Resident 27 ' s room, Certified Nursing Assistant 7 (CNA 7) stated they checked the bed pad alarm for functionality by pressing on the pad and letting go for the alarm to make a sound. CNA 7 checked Resident 27 ' s bed pad alarm for functionality and the alarm did not make a sound. CNA 7 stated the bed pad alarm should have made a sound when pressed and let go for the staff to be aware that the resident got up unassisted and placed Resident 27 at risk for falls. During a concurrent observation and interview on 7/9/2024 at 10 a.m. inside Resident 27 ' s room, Registered Nurse 2 (RN 2) verified Resident 27 ' s bed pad alarm did not make a sound when she checked the functionality. RN 2 stated the bed pad alarm should have made a sound when pressed and let go to alert staff that the resident was trying to get up unassisted as it placed Resident 27 at risk for falls and injuries. A review of the facility ' s policy and procedure titled, Personal Alarm, last reviewed 7/2023, indicated the facility will use a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall. The policy indicated the following: - Check the alarm system every day for proper functioning. - Nursing will monitor proper functioning and positioning of personal alarm. d. A review of Resident 77 ' s Admission Record indicated the facility admitted Resident 77 on 6/22/2021 and readmitted on [DATE] with diagnoses that included a fracture (a break) of unspecified part of neck of right femur (the region just below the ball of the hip joint), difficulty walking, osteoarthritis (condition that causes the joints to become very painful and stiff) of right hip, pathological fracture (broken bone caused by disease) of hip, and unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of Resident 77 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 4/26/2024, indicated Resident 77 was able to understand others and was able to make herself understood. The MDS further indicated Resident 77 was dependent on staff for toileting, dressing, and mobility, and required partial assistance from staff for eating and personal hygiene. A review of Resident 77 ' s Care Plan titled, Resident is at risk for falls/injury related to dementia, generalized weakness, history of falls, and impaired cognition, initiated 5/31/2024 indicated a goal that the resident would have reduced risk of falls and injury through appropriate interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 77 ' s Care Plan titled, Sensor Pad Alarm. Resident requires sensor pad alarm when in bed due to spontaneous act/behavior of trying to get up unassisted. Alarm used to alert staff from any unsafe mobility initiated 4/19/2024, indicated to apply the sensor pad alarm as ordered, monitor the alarm for good working condition and proper placement as needed. During an observation on 7/9/2024 at 8:30 a.m., Resident 77 lay in bed with her eyes closed. Observed a sensor pad alarm at the foot of the resident ' s bed with the alarm connection cord disconnected from the sensor pad. During a concurrent observation and interview on 7/9/2024 at 8:50 a.m., Certified Nursing Assistant 4 (CNA 4) entered Resident 77 ' s room and stated the bed alarm was disconnected. CNA 4 reconnected the alarm and stated maybe the resident disconnected it. CNA 4 stated she was not caring for Resident 77. During an interview on 7/9/2024 at 8:55 a.m., Certified Nursing Assistant 5 (CNA 5) entered Resident 77 ' s room and stated she was caring for the resident. CNA 5 stated she made rounds when she delivered the breakfast trays and did not notice the alarm disconnected. CNA 5 stated she had never seen the resident disconnect her alarm and maybe the nightshift disconnected it. CNA 5 stated it was important to make sure the alarm was functioning for safety and to know if there were any emergencies, like a fall. During a concurrent interview and record review on 7/12/2024 at 10:18 a.m., the Assistant Director of Nursing (ADON) reviewed the facility policy on personal alarms. The ADON stated Resident 77 needs the sensor pad alarm because she is a fall risk and had a history of a fractured hip. The ADON stated staff must make sure alarms are connected and functioning well because staff need to timely assist the residents. The ADON stated if the alarm was not connected there was a potential for injury from a fall including bruising, pain, and fractures. The ADON stated the facility policy was not followed because the alarm was disconnected. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the Director of Nursing (DON) reviewed the facility policy on personal alarms. The DON stated Resident 77 had a physician ' s order for a pad alarm so staff would be alerted that the resident was trying to get up unassisted. The DON stated the resident was a high risk for falls and the pad alarm is an intervention for fall prevention. The DON stated when the alarm was disconnected, the resident could sustain a fall with the potential for injury including fractures and head trauma. The DON stated the facility policy was not followed. A review of the facility policy and procedure titled, Accident Reduction: useful Interventions, last reviewed 7/2023, indicated useful interventions will be utilized to reduce accidents and injuries. The following useful interventions should help reduce accidents and injuries: bed alarms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, Falls and Fall Risk, Managing, last reviewed 7/2023, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident conditions that may contribute to risk for falls includes cognitive and functional impairments. The staff with the input from the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. A systemic evaluation of a resident ' s fall risk identifies several possible interventions. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. A review of the facility policy and procedure titled, Personal Alarm, last reviewed 7/2023, indicated the facility will use, as indicated, a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed reminding the resident to return to a safe position while alerting staff to a potential fall. Nursing will monitor proper functioning and positioning of personal alarm. e. A review of Resident 60 ' s Admission Record indicated the facility admitted Resident 60 on 12/1/2021 and readmitted the resident on 10/24/2022 with diagnoses that included unspecified dementia, age-related osteoporosis (a condition in which there is a decrease in the amount and thickness of bone tissue), restlessness and agitation, pathological fracture right femur, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one ' s daily functioning). A review of Resident 60 ' s Care Plan titled, Resident is at risk for falls/injury related to dementia, cognitive impairment, and poor safety awareness, initiated 10/25/2022 indicated a goal that the resident would have reduced risk of falls and injury through appropriate interventions. A review of Resident 60 ' s Care Plan titled, Actual Fall, related to .balance deficit, cognitive impairment, history of falls, poor safety awareness, initiated 3/1/2024 indicated interventions including the bed pad alarm. A review of Resident 60 ' s physician orders indicated an order for a bed pad alarm secondary to unassisted transfer for safety awareness, dated 3/4/2024. A review of Resident 60 ' s Care Plan titled, Sensor Pad Alarm. Resident requires sensor pad alarm when in bed due to spontaneous act/behavior of trying to get up unassisted. Alarm used to alert staff from any unsafe mobility initiated 3/4/2024 indicated to apply the sensor pad alarm as ordered, monitor the alarm for good working condition and proper placement as needed. A review of Resident 60 ' s MDS dated [DATE], indicated Resident 60 was rarely/never able to understand others and was rarely/never able to make herself understood. The MDS further indicated Resident 60 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/9/2024 at 8:32 a.m., Resident 60 lay in bed with the bed in the lowest position, Resident 60 did not respond to the surveyor. A sensor pad alarm was observed on the floor with the alarm connection cord disconnected from the sensor pad. During a concurrent observation and interview on 7/9/2024 at 8:50 a.m., Certified Nursing Assistant 4 (CNA 4) entered Resident 60 ' s room and stated the bed alarm was disconnected and on the floor. CNA 4 stated Resident 60 moves around a lot. CNA 4 reconnected the alarm and the alarm sounded. CNA 4 stated she was not caring for Resident 60, but maybe when the assigned CNA was feeding the resident the alarm fell and became disconnected. During an interview on 7/9/2024 at 8:55 a.m., Certified Nursing Assistant 5 (CNA 5) entered Resident 60 ' s room and stated she was caring for the resident. CNA 5 stated she made rounds when she delivered the breakfast trays and did not notice the alarm was disconnected. CNA 5 stated she had never seen the resident disconnect her alarm and maybe the nightshift disconnected it. CNA 5 stated it was important to make sure the alarm was functioning for safety and to know if there were any emergencies, like a fall. During a concurrent interview and record review on 7/12/2024 at 10:18 a.m., the Assistant Director of Nursing (ADON) reviewed the facility policy on personal alarms. The ADON stated Resident 60 needs the sensor pad alarm because she had spontaneous movements. The ADON stated Resident 60 does not have the ability to disconnect the alarm. The ADON stated staff must make sure alarms are connected and functioning well because staff need to timely assist the residents. The ADON stated if the alarm was not connected there was a potential for injury from a fall including bruising, pain, and fractures. The ADON stated the facility policy was not followed because the alarm was disconnected. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the Director of Nursing (DON) reviewed the facility policy on personal alarms. The DON stated the resident had a physician ' s order for a bed alarm so staff would be alerted that the resident was trying to get up unassisted. The DON stated the resident was a high risk for falls and the bed alarm is an intervention for fall prevention. The DON stated when the alarm was disconnected, the resident could sustain a fall with the potential for injury including fractures and head trauma. The DON stated the facility policy was not followed. A review of the facility policy and procedure titled, Accident Reduction: useful Interventions, last reviewed 7/2023, indicated useful interventions will be utilized to reduce accidents and injuries. The following useful intervention should help reduce accidents and injuries: bed alarms. A review of the facility policy and procedure titled, Falls and Fall Risk, Managing, last reviewed 7/2023, indicated based on previous evaluations and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident conditions that may contribute to risk for falls includes cognitive and functional impairments. The staff with the input from the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. A systemic evaluation of a resident ' s fall risk identifies several possible interventions. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, Personal Alarm, last reviewed 7/2023, indicated the facility will use, as indicated, a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed reminding the resident to return to a safe position while alerting staff to a potential fall. Nursing will monitor proper functioning and positioning of personal alarm.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44376 Based on observation, interview, and record review the facility failed to ensure a resident receiving enteral feeding (any method of feeding that uses the gastrointestinal tract to deliver nutrition and calories) received appropriate care and services to prevent complications of enteral feeding for one out of one sampled resident (Resident 93) being investigated under enteral nutrition by failing to label the irrigation syringe (a specialized medical instrument designed for the irrigation or cleansing of wounds, cavities, or body orifices) pouch with the name of the resident and the date it was last changed. The deficient practice had the potential for complications associated with enteral feeding such as peritonitis (a redness and swelling [inflammation] of the lining on the abdomen). Findings: A review of Resident 93 ' s Admission Record indicated the facility admitted Resident 93 on 4/1/2024, with diagnoses that included gastrostomy (a surgical procedure used to insert a tube, often referred to as a g-tube, through the abdomen and into the stomach), enterocolitis (an inflammation of the intestines) due to clostridium difficile (a bacterium that causes an infection of the colon, the longest part of the large intestine), and sepsis (a serious condition in which the body responds improperly to an infection). A review of Resident 93 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/12/2024, indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident had a feeding tube while a resident in the facility. A review of Resident 93 ' s History and Physical (H&P), dated 6/3/2024, indicated Resident 93 did not have the capacity to understand and make decisions. A review of Resident 93 ' s Care Plan titled, Risk for infection. Resident at moderate risk for infection secondary to history of colonization (infection that is present in the body but cannot cause illness) with Multi-resistant Organisms (MDRO, bacteria that have become resistant to certain antibiotics), and indwelling medical devices (relating to device that is left inside the body), was initiated on 7/2/2024, indicated an intervention of indwelling device care if indicated. A review of Resident 93 ' s Order Summary Report, dated 7/9/2024, indicated an order for enteral feeding. The order indicated to hang Jevity 1.2 (provides complete, balanced nutrition for long- or short-term tube feeding) alternatives until Fiber source (a nutritionally complete tube feeding formula with fiber) feeding is available at 70 cubic centimeters (cc, a unit of volume) per hour for 20 hours via pump to provide 1400 cc/1680 kilocalories (kcal, a unit of energy) per day. Every shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/10/2024, at 8:50 a.m., with Registered Nurse 1 (RN 1), inside Resident 93 ' s room, Resident 93 ' s irrigation syringe was observed inside a plastic pouch hanging on a feeding pole pump with a date of 7/9/2024. RN 1 stated the irrigation syringe should be changed every 24 hours or daily to prevent growth of germs on the barrel of the irrigation syringe that can cause illness to the resident. RN 1 stated it was the responsibility of the night shift licensed staff to ensure the irrigation syringes were replaced daily. RN 1 stated the plastic pouch of the irrigation syringe should be dated when it was last changed. During an interview on 7/12/2024, at 2:13 p.m., with the Infection Preventionist (IP), the IP stated the irrigation syringe should be dated and replaced every 24 hours to ensure there was no growth of bacteria on the irrigation syringe that can cause infection to residents. The IP stated further that residents with g-tube are susceptible to infection because bacteria can grow on the irrigation syringe that can be flushed in the resident's system causing gastrointestinal (GI, relating to, affecting, or including both stomach and intestine) infections. During an interview on 7/12/2024, at 6:31 p.m., with the Director of Nursing (DON), the DON stated the staff needed to change the irrigation syringe daily and should date them when it was last change to ensure there was no bacterial growth on the syringe that can cause potential GI infection. A review of the facility's recent policy and procedure titled, Enteral Feedings, last reviewed on 7/2023, indicated to ensure the safe administration of enteral nutrition. Feeding syringe shall be changed every 24 hours or whenever if there is a damage or is contaminated.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44376 Based on observation, interview, and record review the facility failed to ensure the safe and appropriate use of side rails (adjustable rigid plastic bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) to one of four sampled residents (Resident 4) investigated during review of physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident ' s body that he or she cannot easily remove that restricts freedom of movement or normal access to one ' s body) by failing to: 1. Complete a Physical Restraint Assessment Form prior to the application of both upper side rails as a restraint. 2. Obtain an informed consent from the resident or resident representative prior to the application of both upper side rails as a restraint. 3. Obtain an order from the attending physician prior to the application of both upper side rails as a restraint. These deficient practices had the potential to result in the restriction of residents ' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: Cross Reference F604 A review of Resident 4 ' s Admission Record indicated the facility admitted Resident 4 on 1/15/2015, and readmitted the resident on 3/6/2024, with diagnoses that included major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the right hand. A review of Resident 4 ' s Side Rail/Entrapment Assessment/Care Plan, dated 3/6/2024, indicated a recommendation of side rail was not indicated. A review of Resident 4 ' s History and Physical (H&P), dated 3/12/2024, indicated Resident 4 did not have the capacity to understand and make decisions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/3/2024, indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident had impaired upper and lower extremities and was mostly dependent on mobility and activities of daily living (ADLs). A review of Resident 4 ' s Fall Risk Assessment, dated 6/8/2024, indicated Resident 4 was high risk for falls and injuries. During an observation on 7/9/2024, at 8:58 a.m., during resident screening, inside Resident 4 ' s room, Resident 4 was observed lying down in bed with both upper side rails up. During an observation and interview on 7/10/2024, at 5:45 p.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 4 ' s room, Resident 4 was observed lying down in bed with both upper side rails up. CNA 3 stated she places both upper side rails up during evening shift to prevent the resident from falls and injuries. CNA 3 stated she knows that there was no order for both upper side rails to be on. During a concurrent interview and record review on 7/10/2024, at 6:21 p.m., with Registered Nurse 4 (RN 4), Resident 4 ' s Order Summary Report, Physical Restraint Assessment Form, and Informed Consent were reviewed. RN 4 stated there was no physician order for both upper side rails to be on the resident, no Physical Restraint Assessment Form, and no Informed Consent from the resident or resident representative prior to the application of restraint both upper side rails use on the resident ' s medical chart. RN 4 stated it was important to obtain a physician ' s order, do a physical restraint assessment, and obtain an informed consent on the use of the restraint both upper side rails up to ensure appropriate use of the restraint to prevent injuries and physical decline to residents. RN 4 stated obtaining an informed consent from the resident or resident representative on the use of the restraint side rails honors the right of the resident to decide after being explained the risked and benefits of side rails if they want to use them. During an interview on 7/12/2024, at 6:15 p.m., with the Director of Nursing (DON), the DON stated it was important to obtain a physician ' s order on the use of both upper side rails as a restraint, complete a Physical Restraint Assessment, and obtain an informed consent from the resident or resident representative prior to application of the restraint both upper side rails to ensure the safety and appropriate use of the restraint side rails and to prevent the resident from potential injuries such as entrapment. A review of the facility's recent policy and procedure titled, Side Rail Use when Not a Restraint, last reviewed on 7/2023, indicated use of both side-rails in up position is not considered a restraint when resident is immobile and cannot voluntarily get out of bed due to a physical limitation. Complete a Physical restraint Assessment Form. Complete Informed Consent. If the Physical Restraint Assessment Form demonstrates that the resident is immobile and cannot voluntarily get out of bed due to a physical limitation, then proceed with the accompanying IDT for Use of both Side rails as non-Restraint. The license nurse should obtain an order from the attending physician that may include the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident may have both side rails up when in bed, resident does not have voluntary or involuntary movement and resident is immobile and cannot voluntarily get out of bed due to physical limitation. This use of both Side Rails for this resident is not considered a restraint. Complete Care Plan entry for both side rails up. A review of the facility's recent policy and procedure titled, Physical Restraints, last reviewed on 7/2023, indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The IDT shall evaluate the outcome of all measures attempted and make recommendations accordingly. The licensed nurse shall be responsible for obtaining an order from the attending physician, which include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision-maker. The Plan of Care shall specify the reason for the use of the restraint, the type, when and where it is to be used. A review of the facility's recent policy and procedure titled, Informed Consent, last reviewed on 7/2023, indicated this facility will verify that the patient's health record contains documentation that the patient has given informed consent before initiating the administration of psychotherapeutic drugs or physical restraints. Before initiating the administration of psychotherapeutic drugs or physical restraints, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44244 Based on interview and record review, the facility failed to: 1.Ensure Licensed Vocational Nurse 2 (LVN 2) completed documentation indicating reconciliation (a system of recordkeeping that ensures an accurate inventory of medications that have been received, dispensed, administered, and wasted) for Resident 83 ' s clonazepam (a controlled substance [medications that are considered to have a strong potential for abuse and may also lead to physical or psychological dependence] to treat anxiety [feeling of worry, nervousness, or restlessness) on the Antibiotic or Controlled Drug Record form (a document used to track the administration of controlled substances) in one of two observed medication carts (Medication Cart 3) observed during the Medication Storage and Labeling task. 2.Ensure licensed nursing staff completed documentation indicating reconciliation of controlled medications at every change of shift on the Narcotic Count Sheet form in one of two medication carts (Medication Cart 3) observed during the Medication Storage and Labeling task. These deficient practices had the potential for inaccurate reconciliation of controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of prescription drugs for their use for unintended purposes) of controlled medications. Findings: a. A review of Resident 83 ' s Admission Record indicated the facility admitted the resident on 9/16/2021 and readmitted the resident on 10/30/2023 with diagnoses that included unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), anxiety disorder (persistent and excessive worry that interferes with daily activities), schizophrenia (mental disorder in which people interpret reality abnormally), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of Resident 83 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 5/17/2024, indicated the resident sometimes was able to understand others and sometimes was able to make herself understood. The MDS further indicated the resident was dependent on staff for eating, oral hygiene, toileting, bathing, personal hygiene, and dressing. The MDS indicated the resident was taking antianxiety medication. A review of Resident 83 ' s physician orders indicated orders for the following: -Clonazepam oral tablet 0.5 milligrams (mg, a unit of measurement), give 0.5 mg by mouth three times a day for anxiety manifested by inability to cope with daily living activities causing stress, dated 10/30/2023. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent Medication Storage observation and interview on 7/10/2024 at 2:38 p.m., Licensed Vocational Nurse 1 (LVN 1) reviewed Medication Cart 3 and Resident 83 ' s Antibiotic or Controlled Drug Record form for clonazepam 0.5 mg tab and Medication Administration Record (MAR) for 7/2024. LVN 1 stated in order to ensure the controlled medication count is accurate, controlled medications are kept in a locked drawer and the licensed nurse documents on the Controlled Drug Record the date, time, and the administering nurse ' s initials for every dose removed from the bubble pack (packaging that have a preformed plastic pocket or shell where a product sits securely in place). LVN 1 stated the MAR is used to document the date, time, and nurse ' s initials when the controlled substance is administered to the resident. LVN 1 reviewed Resident 83 ' s Antibiotic or Controlled Drug Record form for Clonazepam and MAR for July and noted the following: -On 7/8/2024 at 5 p.m., clonazepam tablet number 16 was removed from the bubble pack by LVN 4 and LVN 4 administered the medication. -On 7/8/2024 at 5 p.m., clonazepam tablet number 15 was removed from the bubble pack by LVN 2 and there was no documented evidence that the dose was administered or wasted. LVN 1 further stated the 7/8/2024 8 p.m. dose of clonazepam was removed by two different nurses, but only documented as administered by one of them. LVN 1 stated maybe LVN 2 wasted the medication. LVN 1 stated when a controlled drug is wasted there must be a licensed nurse that witnesses the wasting of the medication and documents on the Controlled Drug Record, but there was no documentation indicating the clonazepam was wasted. During an interview and record review on 7/11/2024 at 8:04 a.m., the Director of Nursing (DON) reviewed Resident 83 ' s Antibiotic or Controlled Drug Record form for clonazepam 0.5 mg tab. The DON stated controlled drugs need to be reconciled and accounted for because there is a potential for addiction to these medications and a risk that someone besides the resident would take the drug and then the medication would not be available for the resident. The DON stated there was a dose of clonazepam that was unaccounted for because it was removed from the bubble pack by LVN 2 and not documented as administered to Resident 83. During an interview and record review on 7/11/2024 at 5:48 p.m., LVN 2 reviewed Resident 83 ' s Antibiotic or Controlled Drug Record form for clonazepam 0.5 mg tab and stated he removed Resident 83 ' s clonazepam from the bubble pack on 7/8/2024 to administer to Resident 83. LVN 2 stated he wasted the medication because he found it was already administered, but there was no documented evidence that the medication was wasted. LVN 2 stated there was no licensed nurse around to witness the wasting of clonazepam on 7/8/2024 and he wasted the medication by himself. LVN 2 stated it was important to have a witness because it could potentially look like he took the medication home and didn ' t give it to the resident, or it could look like he double dosed the resident. LVN 2 stated he knew it was very serious that he did not have a witness to the wasting of Resident 83 ' s clonazepam. LVN 2 stated he was overwhelmed that day and he slipped up. During a concurrent interview and record review on 7/12/2024, the DON reviewed the facility policies on controlled substances. The DON stated the facility policy was not followed because LVN 2 did not document the waste of a controlled medication with a witness present. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, Controlled Substances, last reviewed 7/2023, indicated the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Medications that are opened and subsequently not given (refused or only partly administered) are destroyed. Waste and/or disposal of controlled medications are done in the presence of the nurse and witness who also signs the disposition sheet. A review of the facility policy and procedure titled, Controlled Substances Wasting, last reviewed 7/2023, indicated medication is included in Drug Enforcement Administration (DEA) classification as controlled Substances are subject to special handling, storage, disposal, and record keeping in the facility according with federal and state laws and regulations. When a dose of medication is removed from container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. b. During a concurrent Medication Storage observation and interview on 7/11/2024 at 7:41 p.m., Licensed Vocational Nurse 5 (LVN 5) reviewed Medication Cart 3 and the Narcotic Count Sheet for 7/2024. LVN 5 stated at the beginning and end of each shift the oncoming and outgoing licensed nurses count the narcotics together and sign the Narcotic Count Sheet. LVN 5 stated narcotics must be counted by two nurses because they are controlled substances and must be accounted for because there is a higher likelihood of theft and abuse and it was important to ensure the medications were available for the residents they belonged to. LVN 5 reviewed the Narcotic Count Sheet for 7/2024 and noted the following: -On 7/10/2024 the outgoing nurse ' s signature was missing at 7 a.m. During a concurrent interview and record review on 7/12/2024 at 10:30 a.m., the ADON reviewed the Medication Cart 3 Narcotic Count Sheet for 7/2024. The ADON stated narcotics are medications that are high risk for causing impaired mobility and thinking and are at higher risk for addiction by patients and other people that use them. The ADON stated narcotics must be locked because people may steal them. The ADON stated the Narcotic Count Sheet is used at the beginning and end of each shift by the oncoming and outgoing nurse to document the count of narcotics. The ADON stated there must be two nurses because they are controlled medications and staff must make sure there is nothing missing. The ADON reviewed the Medication Cart 3 Narcotic Count Sheet for 7/2024 and noted the following: -On 7/10/2024 the outgoing nurse ' s signature was missing at 7 a.m. -On the space intended for 7/11/2024, there was no date indicated and the oncoming nurse ' s signature was missing at 11 p.m. - On the space intended for 7/11/2024, there was no date indicated and the outgoing nurse ' s signature was missing for 7 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the DON reviewed the facility policy and procedure regarding controlled substances. The DON stated the controlled drug reconciliation process occurs at the change of every shift by two nurses acknowledging that the oncoming nurse received the correct count. The DON stated it was important to document the reconciliation of controlled substances to identify any missing doses and proceed with an investigation to know why they have a missing dose because controlled substances have a tendency for dependence and diversion. A review of the facility policy and procedure titled, Controlled Substances, last reviewed 7/2023, indicated the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately. The director of nursing services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties and reports the findings to the administrator. The director of nursing services consults with the provider pharmacy and the administrator to determine whether further legal action is indicated.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to ensure the residents entire medication regimen was managed and monitored to promote the resident ' s highest practicable mental, physical, and psychosocial well-being for two of five sampled residents (Resident 74) selected for the unnecessary medications review by failing to ensure the monthly Psychotropic Monthly Summary Sheet was completed and readily available from 2/2024 to 6/2024. This deficient practice placed the resident at risk for not being accurately evaluated by the physician and experiencing side effects for the use of psychotropic medications (a type of medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) which may lead to unnecessary use of psychotropic medications. Findings: A review of Resident 74's Admission Record indicated the facility admitted Resident 74 on 12/6/2023 and readmitted on [DATE] with diagnoses that included abnormalities of gait and mobility, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), psychosis (a mental condition in which a person loses touch with reality), anxiety disorder, and major depressive disorder (MDD - a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 74 ' s care plan on the use divalproex initiated on 12/21/2023 and last updated on 5/28/2024, indicated to monitor and record episodes per policy, and observe for side effects and document occurrence of side effects per the psychotropic policy. A review of Resident 74's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/3/2024, indicated Resident 74 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene and partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 74 received insulin injections. A review of Resident 74's History and Physical, dated 6/12/2024, indicated Resident 74 did not have the capacity to understand and make decisions. A review of Resident 74 ' s Order Summary Report indicated the following physician ' s orders dated 5/27/2024: 1. Clonazepam (a type of medication that produces a calming effect on the brain and nerves, which helps to reduce anxiety, prevent seizures, and promote relaxation) oral tablet 0.5 milligrams (mg - a unit of measurement) give 0.5 mg by mouth two times (2x) a day for anxiety manifested by constant movement to exhaustion. Hold for sedation/drowsiness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Divalproex sodium tablet delayed release (a type of medicine used to treat the manic phase of bipolar disorder) 500 mg give 500 mg by mouth three times a day for mood disorder manifested by uncontrollable extreme mood swings causing anger outburst interfering with daily living activities. 3. Quetiapine fumarate (a type of medicine used to treat certain mental/mood disorders such as bipolar disorder, schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions], and MDD) tablet 50 mg give 50 mg by mouth twice a day for psychosis manifested by inability to process internal stimuli causing anger outburst or stress affecting daily living activities. 4. Monitor for episodes of anxiety manifested by constant movement to exhaustion and tally by hashmarks for clonazepam use every shift. 5. Monitor for episode/s of mood disorder manifested by uncontrollable extreme mood swings causing anger outburst interfering with daily living activities, and tally by hash marks for divalproex use every shift. 6. Monitor for episode/s of psychosis manifested by inability to process internal stimuli causing anger outburst or stress affecting daily living activities and tally by hashmarks every shift for quetiapine use. During a concurrent record review and interview on 7/12/2024 at 9:21 a.m., Resident 74 ' s physician orders, care plans, and Psychotropic Summary Sheets for the use of quetiapine fumarate, divalproex sodium, and clonazepam in paper form and in the electronic health record (EHR) from 2/2024 to 6/2024 were reviewed with Registered Nurse 2 (RN 2). RN 2 verified there was no documented evidence both in paper form and in the EHR that Resident 74 ' s monthly behavior or Psychotropic Summary Sheets were completed from 2/2024 to 6/2024. RN 2 stated if unable to find the monthly Psychotropic Summary Sheets in the EHR, then the form was not initiated. RN 2 stated the summary sheets in the EHR or paper form should have been completed and readily available for the physician, pharmacy consultant, and the Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) to accurately evaluate if a GDR is indicated for the resident and prevent unnecessary use of psychotropic medications as well as side effects. A review of the facility ' s policy and procedure titled, Psychotherapeutic Medications, last reviewed 7/2023, indicated a purpose to provide psychotherapeutic medication for adjunct behavioral management to the least amount possible in consideration of a resident ' s overall health and well-being. The policy indicated the following: 1. Data shall be collected on all episodes of this specific behavior for the physician to use in evaluating the effectiveness of the medication. 2. The data collected is to be made available to the physician in a consolidated manner on a monthly basis. A review of the facility ' s policy and procedure titled, Psychotropic Medication Use, last reviewed 7/2023, indicated that residents will not receive medications that are not clinically indicated to treat a specific condition. The policy indicated the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. a. Antipsychotics b. Antidepressants c. Antianxiety medications; and d. Hypnotics 2. Psychotropic medication management includes: a. Indications for use. b. Dose including duplicate therapy. c. Duration d. Adequate monitoring for efficacy and adverse consequences. e. Preventing, identifying, and responding to adverse consequences. 3. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident whether a particular medication is clinically indicated to manage the symptoms or condition. A review of the facility ' s policy and procedure titled, Medication Regimen Review, last reviewed 7/2023, indicated the following: 1. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medications. 2. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. 3. The consultant pharmacist provides a written report to the attending physicians for each resident identified with irregularities which may include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 44376 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber ' s order, manufacturer ' s specifications, and accepted professional standards) for one out of two sampled residents (Resident 20) investigated under insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) and one out of five sampled residents (Resident 74) reviewed under unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: A review of Resident 20 ' s Admission Record indicated the facility admitted Resident 20 on 8/10/2021, and readmitted the resident on 4/2/2023, with diagnoses that included type 2 diabetes mellitus (a disease that occurs when the blood glucose, also called blood sugar, is too high), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye called the optic nerve), and chronic kidney disease (the kidneys are damaged and cannot filter blood the way it should). A review of Resident 20 ' s Order Summary Report, dated 9/19/2022, indicated an order for Humulin R Solution (Insulin Regular Human). Inject as per sliding scale (varies the dose of insulin based on blood glucose level) subcutaneously before meals and at bedtime for diabetes type 2 (DM II) as follows: 1. If 70-180= 0; 181-200= 2 units (the amount of insulin required to lower the fasting blood sugar). 2. 201-250= 3 units; 251-300= 4 units. 3. 301-350= 6 units. 4. 351-400= 8 units. 5. Greater than (>) 400 or less than (<) 70 call MD. 6. May give orange juice 8 ounces (oz., a unit of weight that is equal to one-sixteenth of a pound) or glucose gel orally (PO) if blood sugar (BS) is below 60. A review of Resident 20 ' s History and Physical (H&P), dated 9/7/2023, indicated the resident had decision-making capacity. (continued on next page)

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	555707	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20 ' s Location of Administration Report for insulin from 4/2024 to 7/12/2024, indicated insulin was administered on the following dates: -Humulin R Solution 4/6/2024 at 9:51 p.m. on the Abdomen- Right Upper Quadrant (RUQ) 4/6/2024 at 9:52 p.m. on the Abdomen-RUQ 4/7/2024 at 8:52 p.m. on the Abdomen-RUQ 4/10/2024 at 5:29 p.m. on the Abdomen- Left Upper Quadrant (LUQ) 4/10/2024 at 9:09 p.m. on the Abdomen-LUQ 4/14/2024 at 12:08 p.m. on the Abdomen RUQ 4/14/2024 at 8 p.m. on the Abdomen-RUQ 4/18/2024 at 6:52 p.m. on the Abdomen-RUQ 4/19/2024 at 7:56 p.m. on the Abdomen-RUQ 4/30/2024 at 11:42 a.m. on the Abdomen-RUQ 4/30/2024 at 6:23 p.m. on the Abdomen-RUQ 5/1/2024 at 12:27 p.m. on the Abdomen-RUQ 5/2/2024 at 5:52 p.m. on the Abdomen- Left Lower Quadrant (LLQ) 5/3/2024 at 6:35 a.m. on the Abdomen-LLQ 5/14/2024 at 6:40 p.m. on the Abdomen-LLQ 5/15/2024 at 4:27 p.m. on the Abdomen-LLQ 5/18/2024 at 6:12 p.m. on the Abdomen- Right Lower Quadrant (RLQ) 5/20/2024 at 10:29 p.m. on the Abdomen-RLQ 5/24/2024 at 11:18 a.m. on the Abdomen-RUQ 5/25/2024 at 4:40 p.m. on the Abdomen-RUQ 6/1/2024 at 8:36 p.m. on the Abdomen-LLQ 6/2/2024 at 8:11 p.m. on the Abdomen-LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/8/2024 at 6:10 p.m. on the Abdomen-RLQ 6/10/2024 at 7:59 a.m. on the Abdomen-RLQ 6/13/2024 at 10:04 p.m. on the Abdomen-RLQ 6/14/2024 at 4:03 p.m. on the Abdomen-RLQ 6/16/2024 at 8:51 p.m. on the Abdomen-LUQ 6/17/2024 at 9:19 p.m. on the Abdomen-LUQ 6/19/2024 at 10:32 p.m. on the Abdomen-LLQ 6/20/2024 at 11:47 a.m. on the Abdomen-LLQ 6/27/2024 at 3:43 p.m. on the Abdomen-LLQ 6/28/2024 at 4:48 p.m. on the Abdomen-LLQ During a concurrent interview and record review on 7/11/2024, at 11:45 a.m., with Registered Nurse 3 (RN 3), Resident 20 ' s Order Summary Report, Medication Administration Record (MAR), and Location of Administration of insulin for 4/2024 to 7/12/2024 was reviewed. RN 3 stated there were multiple instances that the insulin was administered on the same site from 4/2024 to 7/12/2024. RN 3 stated it was important to rotate insulin administration sites to prevent bruising and lipodystrophy to residents. RN 3 stated it was nursing professional practice to rotate insulin administration sites, and she has read the insulin manufacturer's guideline and it indicated to rotate insulin administration sites. RN 3 stated not rotating insulin administration sites was a medication error. During an interview on 7/12/2024, at 6:17 p.m., with the Director of Nursing DON, the (DON) stated it was basic nursing knowledge to rotate insulin administration sites. The DON stated if we do not rotate the administration sites, the patient will develop skin damage and absorption will be compromised. The DON stated the best area to administer was the abdominal area. The DON stated the failure to rotate the insulin administration sites was considered a medication error because the staff did not follow nursing professional practice and the manufacturer ' s guideline on the use of subcutaneous insulin injection. 43988 2. A review of Resident 74 ' s Admission Record indicated the facility admitted Resident 74 on 12/6/2023 and readmitted in the facility on 5/27/2024 with diagnoses that included abnormalities of gait and mobility, osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection), and type two diabetes mellitus (DM 2 - a long-term medical condition in which the body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 74 ' s Order Summary Report indicated the following physician ' s order dated 5/27/2024: insulin glargine solution-yfgn (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) subcutaneous (SQ - administered under the skin) solution (insulin glargine-yfgn) 100 unit/ml inject 15 units SQ every 12 hours for DM 2. Rotate injection sites. A review of Resident 74 ' s Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/3/2024, indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene and partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident received insulin injections. A review of Resident 74 ' s History and Physical, dated 6/12/2024, indicated Resident 74 did not have the capacity to understand and make decisions. A review of Resident 74 ' s Location of Administration Report for insulin from 4/2024 to 7/2024 indicated insulin glargine solution 100 UNIT/ML was administered as follows: 04/01/24 21:00 04/01/24 20:57 subcutaneously Abdomen - RUQ 04/02/24 09:00 04/02/24 16:44 subcutaneously Abdomen - RUQ 04/06/24 21:00 04/06/24 23:05 subcutaneously Abdomen - RUQ 04/07/24 09:00 04/07/24 14:53 subcutaneously Abdomen - RUQ 04/12/24 09:00 04/12/24 09:15 subcutaneously Abdomen - RLQ 04/12/24 21:00 04/12/24 21:27 subcutaneously Abdomen - RLQ 04/18/24 21:00 04/18/24 20:41 subcutaneously Abdomen - RLQ 04/19/24 09:00 04/19/24 13:47 subcutaneously Abdomen - RLQ 04/26/24 09:00 04/26/24 09:20 subcutaneously Abdomen - RLQ 04/26/24 21:00 04/26/24 20:07 subcutaneously Abdomen - RLQ 05/07/24 21:00 05/07/24 21:22 subcutaneously Abdomen - RUQ 05/08/24 09:00 05/08/24 09:55 subcutaneously Abdomen - RUQ 06/20/24 21:00 06/20/24 20:16 subcutaneously Abdomen - LUQ 06/21/24 09:00 06/21/24 09:43 subcutaneously Abdomen - LUQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/24 at 11:15 a.m., Resident 74 ' s insulin glargine Location of Administration Sites in the Medication Administration Record (MAR) from 4/2024 to 7/2024 and physician ' s order were reviewed with Registered Nurse 2 (RN 2). RN 2 verified the physician ' s order for the insulin glargine indicated to rotate injections site. RN 2 stated there were multiple repeated insulin administration on the same sites to Resident 74 between 4/2024 to 7/2024. RN 2 stated the site of insulin administration should be rotated to prevent bruising, bleeding, and irritation on the site which may lead to poor absorption of the medication and the resident not getting the required amount of insulin. RN 2stated it was a professional practice as a nurse to rotate insulin administration sites and not rotating administration sites is a medication error due to not following physician ' s order. A review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed 7/2023, indicated its purpose is to provide guidelines for the safe administration of insulin to residents with diabetes. The policy indicated the following: - Select an injection site. - Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two inches around the navel. - Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). A review of the insulin glargine patient information provided by the facility, dated 2022, indicated to rotate the injection sites with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The package insert indicated to not use the same spot for each injection, or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred, or damaged. A review of the facility provided Information for the Physician Humulin-R Regular Insulin Human Injection, USP, (rDNA Origin) 100 units per ml (U-100), issued 3/2011, indicated Humulin R U-100 may be administered by subcutaneous injection in the abdominal wall, the thigh, the gluteal region or in the upper arm. Subcutaneous injection into the abdominal wall ensures a faster absorption than from other injection sites. Injection into a lifted skin fold minimizes the risk of intramuscular injection. Injection sites should be rotated within the same region. A review of the facility's policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed 7/2023, indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview and record review, the facility failed to ensure medication and biologicals were stored with currently accepted professional standards for one of two medication carts (Medication Cart 3) reviewed during the Medication Storage and Labeling task and for one of eight sample residents (Resident 48) reviewed during the Medication Administration task by failing to: 1.Ensure residents ' insulin pens were labeled with the open date in Medication Cart 3 for four randomly sampled residents (Residents 49, 101, 21, and 33). 2.Ensure the licensed nurse labeled the Artificial Tears (an eye drop medication administered in the eye to provide moisture) in Medication Cart 1 with the resident ' s name for one of eight sample residents (Resident 48). These failures increased the potential for residents in the facility to receive medications that were ineffective or contaminated due to the inadequate storage, and potentially experience medication adverse consequences resulting in the negative impact to residents ' health and well-being. Findings: 1.a. A review of Resident 49 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and type two diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]) without complications. A review of Resident 49 ' s physician orders indicated an order for insulin glargine (basalglar) solution, inject ten units (a measurement) subcutaneously (under the skin) at bedtime for diabetes, hold (do not give) if blood sugar is less than 60, dated [DATE]. 1.b. A review of Resident 101 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included Alzheimer ' s disease (a brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out the simplest tasks), and type two diabetes mellitus with diabetic polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues) and hypoglycemia (low blood sugar) with coma (in a state of deep sleep and cannot be awakened). A review of Resident 101 ' s physician orders indicated the following order: - Humulin N (Insulin NPH) subcutaneous solution, inject 31 units subcutaneously in the morning for diabetes, hold if blood sugar is less than 60, dated [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Humulin N subcutaneous solution, inject 6 units subcutaneously in the evening for diabetes, hold if blood sugar is less than 60 at dinner, dated [DATE]. 1.c. A review of Resident 21 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included unspecified dementia and type 2 diabetes mellites. A review of Resident 21 ' s physician orders indicated the following order: - Lantus subcutaneous solution (Insulin glargine), inject 20 units subcutaneously at bedtime for diabetes, hold if blood sugar is less than 100, dated [DATE]. 1.d. A review of Resident 33 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included Alzheimer ' s disease, and type two diabetes mellitus without complications, and hyperglycemia (high blood sugar). A review of Resident 33 ' s physician orders indicated the following order: - Insulin Glargine Solution, inject 20 units subcutaneously at bedtime for diabetes mellites type 2, hold for blood sugar less than 100 and rotate injection site, dated [DATE]. During a concurrent Medication Storage and Labeling observation and interview on [DATE] at 2:38 p.m., reviewed Medication Cart 3 with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated Insulin Pens expired 28 days after opening them. LVN 1 noted the following: -Resident 49 ' s Basalglar Insulin pen was open, and the pen was not labeled with the open date. -Resident 101 ' s Humulin insulin pen was open, and the pen was not labeled with the open date. LVN 1 further stated the licensed nurses do not always label the pen with the date opened, but sometimes they do. LVN 1 stated the bags that hold the pens are labeled with the open date. LVN 1 stated it was important to label the insulin pen because the labeled bag may be lost, and the expiration date would not be known. LVN 1 stated it puts the resident at risk if expired insulin is used. During a follow up Medication Storage and Labeling observation on [DATE] at 07:41 p.m., reviewed Medication Cart 3 with Licensed Vocational Nurse 5 (LVN 5). LVN 5 noted the following: -Resident 21 ' s Insulin Lantus pen was open, and the pen was not labeled with the open date. -Resident 33 ' s Insulin Lantus pen was open, and the pen was not labeled with the open date. LVN 2 further stated the bags that contained the pens were labeled with the open date. LVN 2 stated the insulin pens should be labeled with the date opened because the bag for the insulin pens could be lost resulting in the administration of expired insulin to the residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 10:30 a.m. the Assistant Director of Nursing (ADON) reviewed the facility policy and procedure regarding insulin and medication administration. The ADON stated insulin pens expire 28 days after opening and are labeled with the date opened on the sticker placed on the pen itself. The ADON stated the facility policy indicates vials (small containers usually made of glass) should be labeled and an insulin pen should be labeled with the date opened. The ADON stated insulin pens should be labeled in the same manner as an insulin vial. The ADON stated it was important to label the pen because more than one pen may be delivered at the same time or the bag may be lost. The ADON stated the facility policy was not followed for multidose container labeling. During an interview on [DATE] at 6:12 p.m., the Director of Nursing (DON) reviewed the facility policy regarding insulin and medication storage. The DON stated the open date should be labeled on the actual medication and the plastic bag containing the medication. The DON stated the importance of labeling the actual medication is to know when to discard the pen. The DON stated expired insulin loses its effectiveness and potentially may not control the resident ' s blood sugar resulting in hyperglycemia with further complications like kidney failure. A review of the facility policy and procedure titled, Administering Medications, last reviewed ,d+[DATE], indicated medications are administered in a safe manner. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. A review of the facility policy and procedure titled, Insulin Delivery, last reviewed ,d+[DATE], indicated the purpose of the policy and procedure was to provide guidelines for the safe administration of insulin to residents with diabetes. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacture recommendations for expiration after opening). A review of the facility provided manufacture instructions for Humulin N KwikPen, last revised ,d+[DATE], indicated store the pen currently in use at room temperature and throw away the pen after using for 14 days, even if insulin is still left in it. A review of the facility provided manufacture instructions for Basalglar KwikPen, dated 2022, indicated do not use the pen for more than 28 days after you first start using the pen. A review of the facility provided manufacture instructions for Lantus Insulin Glargine Injection, dated 2022, indicated once open, store the pen currently in use at room temperature and throw opened pen away after using for 28 days, even if insulin is still left in it. 2. A review of Resident 48 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses that included major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy), and type two diabetes mellitus without complications. A review of Resident 48 ' s MDS, dated [DATE], indicated the resident was usually able to understand others and was usually able to make herself understood. A review of Resident 48 ' s physician orders indicated the following order: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Artificial Tears Solution instill 1 drop in both eyes three times a day for dry eye syndrome, dated [DATE]. During a concurrent medication pass observation on [DATE] at 5:18 p.m., Licensed Vocational Nurse 2 (LVN 2) administered Resident 48 ' s medication from Medication Cart 1. LVN 2 stated the resident ' s Artificial Tears were not in the medication cart. LVN 2 retrieved a new box of Artificial Tears and used a pen to write the date opened and the resident ' s room number. Observed LVN 2 did not write the resident ' s name on the Artificial Tears Solution. LVN 2 administered the Artificial Tears to Resident 48 and returned the Artificial Tears to Medication Cart #1. During a follow up interview on [DATE] at 5:48 p.m., LVN 2 stated he wrote Resident 48 ' s room number and the date opened on the Artificial Tears. LVN 2 stated he does not write resident ' s names on the Artificial Tears. LVN 2 opened the drawer of Medication Cart 1 to observe other Artificial Tears containers stored in the cart. LVN 2 stated based on the other Artificial Tears containers he should write the resident ' s name. LVN 2 Stated it was important to write the resident ' s name because they were resident specific and the room number only indicates the resident room and residents can move rooms and the eye drops could be given to the wrong resident. LVN 2 stated when eye drops are given to the wrong resident it could affect their wellbeing because they may be allergic to the medication. During a concurrent observation and interview on [DATE] at 6:12 p.m. the DON reviewed the facility policy and procedure regarding medication storage. The DON stated when a new box of Artificial Tears is opened, the licensed nurse writes the resident ' s room number and the date opened on the box. The DON stated nurses are supposed to also label the resident name because a resident can move rooms and there is a potential that the medication would be used on the wrong resident resulting in cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another). A review of the facility policy and procedure titled, Medication Storage, last reviewed ,d+[DATE], indicated medications and biologicals are stored safely, securely, and properly, following manufacture ' s recommendations or those of the supplier. A review of the facility policy and procedure titled, Administering Medications, last reviewed ,d+[DATE], indicated medications are administered in a safe manner. Staff follows established facility infection control procedures. Medications ordered for a particular resident may not be administered to another resident. A review of the facility policy and procedure titled, Medication Ordering and Receiving From Pharmacy, last reviewed ,d+[DATE], indicated nonprescription medications not labeled by the pharmacy are kept in the manufacturer ' s original container and identified with the resident ' s name. Facility personnel may write the resident ' s name on the container or label as long as the required information is not covered.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 43988 Based on interview and record review, the facility failed to follow up on the recommendation by the dentist for one (1) out of one sampled resident (Resident 9) during an interview by failing to schedule a full mouth x-ray (FMX - a safe and painless test that uses a small amount of radiation to make an image of bones, organs, and other parts of the body) for a new full upper denture (FUD). This deficient practice had the potential to result in the inability to effectively chew foods, weight loss, lack of energy and loss of muscle mass of the residents. Findings: A review of Resident 9 ' s Admission Record indicated the facility admitted Resident 9 on 4/14/2017 and readmitted the resident on 12/8/2022 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and osteoarthritis (a type of arthritis that only affects the joints, usually in the hands, knees, hips, neck, and lower back. It's the most common type of arthritis). A review of Resident 9 ' s Order Summary Report indicated a physician ' s order for dental consult and treatment as needed for dental problems dated 12/8/2022. A review of Resident 9 ' s History and Physical (H&P) dated 12/22/2023, indicated Resident 9 did not have the capacity to understand and make decisions. A review of Resident 9 ' s Social Services notes dated 3/14/2024 indicated the Social Services Assistant (SSA) called Dental Provider 1 (DP 1) to schedule the resident due to the dentures hurting her gums. A review of Resident 9 ' s Dental Notes forms by Dental Provider 1 (DP 1) dated 4/23/2024, indicated Resident 9 required a FMX (Full Mouth Series) and new FUD (Full Upper Dentures). A review of Resident 9 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/15/2024 indicated Resident 9 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an interview on 7/9/2024 at 11:15 a.m. in the downstairs dining room, Resident 9 stated her gums hurt and she needed to be seen by a dentist. Resident 9 stated she mentioned it to the facility staff and was still waiting to be seen by the dentist. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/11/2024 at 6:05 p.m., Resident 9 ' s Dental Notes were reviewed with the SSA. The SSA verified Resident 91 had a dental consultation on 4/23/2024 with recommendations for a FMX and new FUD as the current FUD was too high and the resident was unable to eat and talk well. The SSA stated she was not aware of the dentist recommendation as DP 1 does not notify social services department or nursing prior to leaving the facility. The SSA sated DP 1 ' s recommendations should have been followed up as it had the potential for the resident to feel uncomfortable when talking and eating. During a concurrent interview and record review on 7/12/2024 at 9 a.m., Resident 9 ' s Dental Notes and DP 1 ' s Dental Visit Summary for 4/2024 were reviewed with the Social Services Director (SSD). The SSD stated when ancillary services such as DP 1 come and provide services to the residents, they provide a list of the residents they have seen and attach their notes and recommendations to the social services department then the note will be filed in the resident ' s medical record. The SSD verified DP 1 recommendations should have been followed up on by the SSA as it had the potential to affect the way Resident 9 talks and eat. A review of the facility ' s policy and procedure titled, Dental Consultation, last reviewed 7/2023 indicated the following: 1. The social services and/or designee will coordinate with the dental consultant for their needed visit and follow up on their recommendations as indicated. 2. The consultant dentist is responsible for providing necessary information concerning residents to appropriate staff, care planning conferences, and/or committees.

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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** 43988 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1. Ensure open bags of flour tortilla, frozen chocolate chip cookies, and a box of lentils were labelled with open date. 2. Indicate the received or delivery date on a bag of fresh cilantro and a bag of fresh parsley. 3. Ensure a bottle of chocolate syrup with an open date of [DATE] had a cap on it and covered tightly with plastic wrap. 4. Ensure a can of applesauce with dent was placed in the shelf for dented cans. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 117 out of 121 medically compromised residents who receive food from the kitchen. Findings: During a brief tour of the kitchen on [DATE] at 7:46 a.m., with the Dietary Supervisor (DS), the following was observed in the walk-in refrigerator and freezer: 1. A bag of flour tortilla with no open date in the walk-in refrigerator. 2. A bag of fresh cilantro and a bag of fresh parsley in the walk-in refrigerator that did not indicate the date they were received. 3. A bag of opened frozen chocolate chip cookies in the freezer that did not indicate the date it was opened. The DS verified the opened bag of flour tortilla and frozen chocolate chip cookies did not indicate the date of when they were opened. The DS stated the bags of flour tortilla and frozen chocolate chip cookies should have been labeled with the date they were opened so the staff would know when to discard unused or leftover tortillas and cookies from the bags. The DS stated the bags of fresh cilantro and parsley should have been labeled with the date they were delivered or received so the staff would know which food item should be used first. During a follow up tour of the dry storage room on [DATE] at 10:30 a.m., with the DS, the following was observed in the dry storage room: 4. A bottle of chocolate syrup with an open date of [DATE] had a cap on and was covered with plastic wrap. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A can of applesauce with dent remained in the shelf for cans without dent. 6. An opened box of lentils which did not indicate the date it was opened. The DS verified the box of lentils did not indicate the date it was opened, a can of applesauce with dent remained in the shelf for cans without dent, and the bottle of chocolate syrup did not have a cap on and was only covered with a plastic wrap. The DS stated the can of applesauce with dent should have been removed in the shelf and placed in the corner for cans with dents as the dent already compromised the seal of the can. The DS stated the box of lentils should have been labeled with the date it was opened so the staff would know if it was already past the date it can remain open in the storage room. The DS stated the bottle of syrup should have been covered tightly after opening as it had the potential to get contaminated if not covered tightly. The DS stated the deficient practices can compromise resident safety and can place the residents at risk of getting sick. During an interview on [DATE] at 2:38 p.m., the Registered Dietitian (RD) stated safe and proper food storage should be observed at all times to ensure resident safety and prevent them from getting sick. A review of the facility ' s policy and procedure titled, Refrigerator/Freezer Storage, last reviewed ,d+[DATE], indicated the following: 1. All items should be properly covered, dated, and labeled. Food items should have the following dates: 1. Delivery date - upon receipt 2. Open date - opened containers 3. Thaw date - any frozen items 2. Older food items should be rotated using the FIFO method (First-in First-out). 3. No food item that is expired or beyond the best by date are in stock. A review of the facility ' s policy and procedure titled, Storage of Canned and Dry Goods, last reviewed , d+[DATE], indicated that food and supplies will be stored in a safe manner. The policy indicated the following: 1. Canned items should be inspected for damage such as dented, leaking, or building cans and will be stored separately in the designated area - DENTED CNAS for return to the vendor or disposed of properly. 2. All food products will be used according to the specified Food Storage Guidelines. 3. Open food items will be tightly closed to prevent exposure to pests. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided undated Dry Good Storage Guidelines, indicated items with asterisk are to be refrigerated after opening and to keep them dry and tightly covered. The guideline indicated the following: 1. Dry beans including lentils can be stored open in the shelf for one (1) year. 2. *Syrups can be stored opened on a shelf for up to six (6) months. 3. Tortillas, corn and flour can be stored opened on a shelf or refrigerated for up to 1 week.

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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** 44244 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) were implemented for one of eight sampled residents (Resident 67) observed during the Medication Administration task. 2. Ensure a potentially contaminated box of tissues and an eye drop container were not placed in Medication Cart 1 for two of eight sampled residents (Residents 95 and 221) observed during the Medication Administration task. 3. The facility offered hand hygiene to the resident prior to serving the lunch tray on 7/9/2024, at noon inside the Dining Room to one of eleven sampled residents observed during dining observation (Resident 98). 4. The linen covers in the nursing stations were protected from external contaminants such as dust, viruses, and bacteria by using a permeable (having pores or openings that permit liquids or gasses to pass through)/ loosely woven material to cover the mobile linen carts to two out of two linen carts (Carts A and B) observed during infection control facility task. These deficient practices had the potential to spread infections and illnesses among residents. Findings: 1. A review of Resident 67 ' s Admission Record indicated the facility admitted the resident on 2/13/2024 and readmitted the resident on 4/12/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), dysphagia (a condition that makes it difficult to swallow), gastrostomy (also called as gastric tube [GT], a tube inserted through the abdomen that delivers nutrition or medication directly to the stomach), and paraplegia (the inability to voluntarily move the lower parts of the body). A review of Resident 67 ' s Minimum Data Set (MDS - an assessment and care screening tool) dated 5/30/2024, indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident was dependent on staff for oral hygiene, toileting, dressing, and mobility. The MDS indicated the resident had a GT. A review of Resident 67 ' s physician orders indicated an order to crush all crushable medications and administer via GT, dated 5/23/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 67 ' s Care Plan titled, Risk for infection. Resident is at high risk of infection secondary to . indwelling medical device, initiated 4/16/2024, indicated a goal to reduce the risk of MDRO transmission daily by performing hand hygiene, wearing gowns and gloves while performing high contact activities. A review of Resident 67 ' s Care Plan titled, Enhanced Standard Precautions, high risk for infection .feeding tubes, ostomy, initiated 5/24/2024, indicated to reduce the risk of infection. During a medication pass observation on 7/11/2024 at 9:13 a.m., Licensed Vocational Nurse 1 (LVN 1) gathered Resident 67 ' s medications from Medication Cart 3, entered Resident 67 ' s room, performed hand hygiene, and placed gloves on his hands. LVN 1 assessed the resident ' s GT and then administered medications via the GT. Observed a sign on the wall above the head of Resident 67 ' s bed indicating EBP. Observed LVN 1 did not don (put on) a gown prior to or during administering the resident ' s medication. During a follow up interview on 7/11/2024 at 10:09 a.m., immediately upon exiting Resident 67 ' s room after the completion of the medication pass, LVN 1 stated he wore gloves during Resident 67 ' s GT medication pass. LVN 1 stated he was not sure what EBP was. Observed LVN 1 enter the resident ' s room to read the EBP sign on the wall. LVN 1 stated EBP included wearing a gown, but it slipped his mind. LVN 1 stated he was not sure why Resident 67 was on EBP, but he should have worn a gown during the medication pass. LVN 1 stated EBPs protect the resident from exposure to germs and bacteria that could cause infection. During an interview on 7/12/2024 at 10:30 a.m., the Assistant Director of Nursing (ADON) stated EBPs are used to prevent residents from getting an infection from staff. The ADON stated staff wear gowns and gloves when providing hands on patient care. The ADON stated EBPs are implemented for residents with GTs because it is an indwelling device. During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the Director of Nursing (DON) reviewed the facility policy regarding EBP. The DON stated EBP are a precaution taken to prevent transmission of bacteria for residents that have some type of indwelling device. The DON stated the facility policy was not followed because the LVN did not wear a gown during a GT medication pass. A review of the facility policy and procedure titled, Enhanced Barrier Precautions, last reviewed 7/2023, indicated EBP are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs emply targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Device care or use is an example of high-contact resident care requiring the use of gown and gloves for EBP. EBP are indicated for residents with indwelling medical devices. EBPs remain in place for the duration of the resident ' s stay or discontinuation of the indwelling medical device that places them at increased risk. 2.a. A review of Resident 95 ' s Admission Record indicated the facility admitted the resident on 11/3/2022 and readmitted on [DATE] with diagnoses that included unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and shortness of breath. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 95 ' s MDS dated [DATE], indicated the resident was rarely/never able to understand others and was rarely/never able to make herself understood. A review of Resident 95 ' s physician orders indicated an order for carboxymethylcellusose sodium ophthalmic eye solution (a medication to relieve dry, irritated eyes), instill one drop in both eyes two times a day for lubrication, dated 2/22/2023. 2.b. A review of Resident 221 ' s Admission Record indicated the facility admitted the resident on 6/27/2024 with diagnoses that included psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and eosinophilia (the presence of too many white blood cells [responsible for protecting your body from infection] in the body). A review of Resident 221 ' s MDS dated [DATE], indicated the resident was usually able to understand others and was usually able to make herself understood. The MDS further indicated the resident required partial assistance from staff for oral hygiene, toileting, dressing, personal hygiene, and mobility. A review of Resident 221 ' s Care Plan titled, Risk for infection. Resident is at high risk for infection ., initiated 6/29/2024, indicated to clean and disinfect high touch surface areas, and to notify the physician of any sign or symptom of infection. During a medication pass observation on 7/11/2024 at 8:40 a.m., Licensed Vocational Nurse 3 (LVN 3) gathered Resident 95 ' s medications from Medication Cart 1 including a box of tissues and a small container holding carboxymethylcellusose sodium ophthalmic eye drops. Observed LVN3 enter Resident 95 ' s room and placed the tissue box and container on Resident 95 ' s plastic nightstand. Observed LVN 3 did not clean Resident 95 ' s nightstand prior to placing the tissue box and container. LVN 3 administered the eye drops, used a tissue on Resident 95 ' s eyes, then exited the room and returned the box of tissues and container to Medication Cart 1. LVN 3 did not disinfect the box of tissue or container prior to placing the tissue box and container in the medication cart. LVN 3 then entered Resident 221 ' s room and administered medication to the resident from Medication Cart 1. During a follow up interview on 7/11/2024 at 9:07 a.m., immediately after the medication pass observation, LVN 3 stated she removed the tissue box and Resident 95 ' s eye drop container from Medication Cart 1, set them down on the resident ' s nightstand without cleaning the nightstand, and then placed the tissue box and eye drop container back in Medication Cart 1. LVN 3 stated it looked like the nightstand surface was clean and she didn ' t see any dirt. LVN 3 stated she should have cleaned the surface before placing the tissue box and container and then disinfected them prior to placing them back in the medication cart. LVN 3 stated it was possible the tissue box and eye drop container could become contaminated with germs and bacteria and then cause infection of other residents whose medication is stored in the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/2024 at 6:12 p.m., the DON reviewed the facility policy regarding infection control. The DON stated the facility policy was not followed when the LVN did not disinfect the surface prior to placing the tissue box and eye drop container on the nightstand and prior to placing them back in the medication cart. The DON Stated there was a potential for cross contamination from bacteria on one surface moving to another surface which increased the risk of infections in residents. A review of the facility policy and procedure titled, Medication Storage, last reviewed 7/2023, indicated medications and biologicals are stored safely, securely, and properly, following manufacture ' s recommendations or those of the supplier. Medication storage areas are kept clean. 44376 3.A review of Resident 98 ' s Admission Record indicated the facility admitted the resident on 12/21/2022, and readmitted the resident on 2/4/2024, with diagnoses including urinary tract infection (UTI, a condition in which bacteria invade and grow in the urinary tract), systemic inflammatory response syndrome (SIRS, an exaggerated defense response from the body to a harmful stressor), and Coronavirus Disease 2019 (COVID-19, a highly contagious disease spread from person to person through droplets released when an infected person coughs, sneezes, or talks). A review of Resident 98 ' s History and Physical (H&P), dated 2/7/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 98 ' s MDS, dated [DATE], indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident needed supervision or touching assistance on eating, oral hygiene, personal hygiene, and always had urine and bowel incontinence (unable to control excretions, to hold urine in the bladder, or to keep feces in the rectum.) A review of Resident 98 ' s Care Plan titled, COVID-19. Resident is at risk for (shortness of breath, irregular respiration, cough, rhonchi (are continuous gurgling or bubbling sounds typically heard during both inhalation and exhalation), activity intolerance, fever of greater than (>) 99.6, nausea & vomiting, sore throat, runny nose) related to COVID-19 pandemic, last revised on 2/7/2024, indicated an intervention to practice hand hygiene technique. During an observation and interview on 7/9/2024, at 12:33 p.m., with the Activity Assistant (AA), inside the Dining Room Area, observed staff serving the tray of Resident 98 without offering hand hygiene. The AA stated the staff should offer the resident a hand sanitizer or bring the resident to their rooms to wash their hands before eating to prevent infection. During an interview on 7/12/2024, at 2:12 p.m., with the Infection Preventionist (IP), the IP stated it was important that the staff offered the residents hand hygiene prior to eating and after eating to stop the spread of germs and bacteria among residents. During an interview on 7/12/2024, at 6:33 p.m., with the DON, the DON stated the staff should have offered hand hygiene to the resident because hands can transmit bacterial infection. The DON also stated hand washing stops transmission of infection to residents that can cause gastrointestinal (GI, of, relating to, affecting, or including both stomach and intestines) issues. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled, Hand Washing, last reviewed on 7/2023, indicated hand washing must also be performed as follows: - Before and after eating. 4.During a concurrent observation and interview on 7/12/2024, at 9:42 a.m., with Certified Nursing Assistant 6 (CNA 6), observed Linen Cart A covered with loosely woven/permeable material to protect the clean linens of the residents. CNA 6 stated she preferred the cover used by Laundry Department in distributing supplies in the mobile cart that was made of plastic without pores that prevents bacteria or viruses from entering the cart. During a concurrent observation and interview on 7/12/2024, at 9:52 a.m., with Licensed Vocational Nurse 1 (LVN 1), observed Linen Cart B covered with loosely woven/permeable material to protect the clean linens of the residents. LVN 1 stated he preferred the cover used by Laundry Department in distributing supplies in the mobile cart that was made of plastic without pores that prevents bacteria or viruses from entering the cart. During an interview on 7/12/2024, at 2:04 p.m., with the IP, the IP stated the linen carts should be covered with a non-permeable (do not allow water-vapor and air pass through below an agreed upon threshold) material that inhibits the bacteria or viruses from permeating (to spread or diffuse) inside the clean linens. The IP stated using permeable or loosely woven material for covering the clean linens predisposes the clean linens to be contaminated with bacteria, viruses, and external contaminants such as splashes of liquid and sprays that can cause illness to spread to the residents. During an interview on 7/12/2024, at 6:37 p.m., with the DON, the DON stated they should use a non-permeable cover on their mobile linen carts to prevent contamination of the linen that can transmit infection to the resident. The DON stated the permeable cover can let viruses and bacteria inside the cart. A review of the facility's recent policy and procedure titled, Health Services Operations Manual, last revised on 7/2023, indicated all clean linen must be covered during delivery to prevent potential contamination.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 43988 Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and patient care equipment in safe operating condition for one (1) of 1 sampled resident (Resident 91) investigated during a random observation when Resident 91 ' s bed controller (device used to change the height and angle of the bed) cable was observed with frayed and exposed wires. This deficient practice had the potential to place Resident 91 at risk for injury. Findings: A review of Resident 91 ' s Admission Record indicated the facility admitted the resident on 5/8/2024 with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), lack of coordination, and muscle weakness. A review of Resident 91 ' s History and Physical (H&P) dated 5/10/2024, did not indicate the resident had the capacity to understand and make decisions. A review of Resident 91 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/15/2024 indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required set up assistance with eating; partial/moderate assistance with oral and personal hygiene; substantial/maximal assistance with mobility and dressing; total assistance with all other ADLs. During an observation on 7/9/2024 at 9:20 a.m., inside Resident 91 ' s room, Resident 91 was observed lying in bed with the bed controller placed on top of the resident ' s overbed table and within reach. Observed the base of the bed controller cable with the white, red, brown, and yellow wires were exposed and the brown wire frayed and sticking out (exposed). During a concurrent observation and interview, with the Director of Nursing (DON), on 7/9/2024, at 9:35 a.m., the DON verified the cable to Resident 91 ' s bed controller had exposed wires and stated it is not safe for the resident to have exposed wires next to them. The DON stated she will notify the Maintenance Supervisor (MS) to change the bed controller. During an interview on 7/12/2024 at 10:00 a.m., the Administrator (Adm) stated the MS makes rounds every month to ensure the building and all resident care equipment are in good working condition. The Adm stated the exposed wire could potentially result in accident and injure the resident. During a follow up interview on 7/12/2024 at 7:30 p.m., the DON stated the bed controller wires should not be exposed for resident safety as it can cause injury to the resident. A review of the facility ' s policy and procedure titled, Maintenance Service, last reviewed 7/2023, indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Maintenance of a safe and sanitary environment ensures safety, affords protection, and enhances the well-being of the residents, public, and staff. maintenance activities include ensuring that all equipment, buildings, spaces, and fixtures are kept in operable condition. - The facility shall employ safe and proper methods in maintaining the facility to protect against injury to the residents, staff, or visitors. facility shall hold weekly maintenance inspections as part of a general facility safety inspection. - Inspect all electric beds at least quarterly and after a resident is discharged . check controls, cords, and plugs for damage and replace cords as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	07/12/2024

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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 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review the facility failed to meet the requirement for no more than four residents per room for two of 45 resident rooms (rooms [ROOM NUMBERS]). This deficient practice had the potential to result in inadequate space to provide sufficient nursing care and privacy for the residents. Findings: A review of the Client Accommodation Analysis form completed by the facility indicated rooms [ROOM NUMBERS] housed five beds per room. During the Resident Council Meeting on 7/10/2024, at 2:08 p.m., when the residents were asked about their room space, there were no concerns or issues brought up. During the recertification survey from 7/9/2024 to 7/12/2024, it was observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 7/10/2024, the Administrator submitted a letter requesting for a waiver for room with more than four residents per room for the following rooms: - room [ROOM NUMBER]- with five residents = 394.28 square feet per room - room [ROOM NUMBER]- with five residents = 398.94 square feet per room A review of the waiver letter, undated, indicated, There is enough space to provide for each resident care, dignity, and privacy. The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident ' s health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. A review of the facility's recent policy and procedure titled, Bedrooms, last reviewed on 7/2023, indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. Bedrooms accommodate no more than two residents at a time. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. (Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the resident's health and safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview and record review, the facility failed to ensure that 2 of 45 resident rooms (rooms [ROOM NUMBERS]) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. The room size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During the Resident Council Meeting 7/10/2024, at 2:08 p.m., when the residents were asked about their room space, there were no concerns or issues brought up. During the recertification survey from 7/9/2024 to 7/12/2024, it was observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 7/10/2024, the Administrator submitted the application for the Room Variance Waiver for 16 resident rooms. The room variance letter indicated that these rooms did not meet the 80 square feet per resident requirement per federal regulation. The room waiver request showed the following: Room # Square Footage Number of Beds 16 394.28 5 45 398.94 5 The minimum requirement for a 2 bedroom should be at least 160 sq. ft. The minimum requirement for a 3 bedroom should be at least 240 sq. ft. The minimum requirement for a 4 bedroom should be at least 320 sq. ft. A review of the room waiver letter, undated, indicated, There is enough space to provide for each resident care, dignity, and privacy. The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident ' s health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	07/12/2024

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled, Bedrooms, last reviewed on 7/2023, indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. Bedrooms accommodate no more than two residents at a time. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. (Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the resident's health and safety.