STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Subacute and Nursing Center	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48142 Based on observation, interview, and record review, the facility failed to ensure an indwelling urinary catheter (a flexible tube inserted into the bladder and left in place to continuously drain urine) collection bag (attached to the catheter tube for the purpose of collecting urine) was covered with a privacy bag (dignity bag- a bag that conceals urine in the collection bag) for one of two sampled residents (Resident 58). This deficient practice had the potential to affect the residents' sense of self-worth and self-esteem. Findings: A review of Resident 58's Admission Record indicated the facility admitted the resident on 5/20/2024, with diagnoses of multiple sclerosis (a condition that happens when the immune system attacks the brain and spinal cord) and benign prostatic hyperplasia (prostate gland [gland in the male reproductive system] enlargement that can cause urination difficulty). A review of Resident 58's History and Physical (H&P - a formal assessment of a patient and their problem), dated 5/23/2024, indicated the resident had the capacity to make decision. A review of Resident 58's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/24/2024, indicated that Resident 58's cognition (mental process) was intact. A review of Resident 58's physician's orders, dated 5/21/2024, indicated an order for an indwelling urinary catheter French (FR - unit used to measure the size of a urinary catheter) 18 with 10 cubic centimeters (cc - unit of volume) balloon to drainage bag. During a concurrent observation and interview on 6/10/2024 at 8:37 a.m., with the Infection Preventionist (IP), observed Resident 58 laying in bed with a urinary catheter bag hanging on the left side of the bed with urine visible. The IP verified by stating that Resident 58's drainage bag did not have a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag so it is not visible) and must have one for resident's dignity and infection control. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Quality of Life - Dignity, last reviewed on 7/2023, indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for three of 24 sampled residents (Resident 2, 7, and 70). This deficient practice had the potential to cause a delay in resident care and for the residents' needs to remain unmet. Findings: a. A review of Resident 2's Admission Record indicated the facility originally admitted the resident on 5/27/2024 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) and heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/31/2024, indicated the resident had the ability to make self-understood and the ability to understand others. The MDS also indicated the resident required maximal assistance with toileting, shower, and dressing. During a concurrent observation and interview on 6/10/2024 at 9:44 a.m., with the Infection Preventionist (IP), observed Resident 2 in bed with Resident 2's call light on the floor and not within reach. The IP stated that if the resident is unable to reach for the call light, then they won't be able to call for assistance or help. The IP stated that the resident can possibly have an accident and sustain a fall if they attempt to go the bathroom unassisted if their call light is not within reach when they need help. A review of the facility's policy and procedure titled, Answering the Call Light, last reviewed 7/2023, indicated that the purpose of the procedure was to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower, or bathing facility and from the floor. 38549 b. A review of Resident 7's Admission Record indicated the facility originally admitted the resident on 4/24/2024 and readmitted the resident on 6/1/2024 with diagnoses including spinal stenosis (a narrowing of the spinal canal, which can put pressure on the spinal cord and nerves) of the cervical region, difficulty in walking, and need for assistance with personal care. A review of Resident 7's MDS, dated [DATE], indicated the resident had modified independence with cognitive skills for daily decision making and required maximal assistance from staff for most activities of daily living (ADLs - the fundamental skills that allow a person to care for themselves independently). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's care plan (a document that outlines a resident's health information, care services, treatments, and goals) for risk for falls, initiated on 4/24/2024, indicated the goal that the resident will have no falls with injury until the next review date. Among some of the interventions listed included to place the call light within reach while in bed or close proximity to the bed. During an observation on 6/10/2024 at 9:31 a.m., observed Resident 7 asleep in bed with Resident 7's call light hanging off the back of his bed. During a concurrent observation and interview on 6/10/2024 at 9:58 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 verified the observation by stating that Resident 7's call light was not within the resident's reach. During an interview on 6/12/2024 at 4:15 p.m., with the Director of Nursing (DON), the DON stated she frequently provided in-services (training intended for those actively engaged in a profession) to staff regarding call lights. The DON stated she teaches staff to ensure that call lights are within residents' reach before leaving the room. The DON stated it was important for the resident's call light to be within reach because, in the event of an emergency, staff would be able to respond timely. The DON stated if the resident was unable to call for help, then the resident could have an accident. A review of the facility's policy and procedure titled, Answering the Call Light, last reviewed 7/2023, indicated that the purpose of the procedure was to ensure timely response to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 48142 c. A review of Resident 70's Admission Record indicated the facility admitted the resident on 5/27/2023 with diagnoses of attention to tracheostomy (a surgical procedure that creates an opening in the neck and into the windpipe to allow air to reach the lungs) and acute (sudden onset) and chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues). A review of Resident 70's MDS dated [DATE], indicated that Resident 70 was totally dependent on bed mobility, transfer, locomotion on and off the unit, toilet use, and personal hygiene with one to two-persons assistance. During a concurrent observation and interview on 6/10/2024 at 10:28 a.m., with Registered Nurse (RN 1) and Certified Nursing Assistant (CNA 2), observed Resident 70 waving. RN 1 and CNA 2 entered Resident 70's room and stated Resident 70 needed to be changed. RN 1 and CNA 2 observed and stated Resident 70's call light was not within reach and was wrapped around the side rails. During an interview on 6/10/2024 at 10:29 a.m., with RN 1, RN 1 stated it is important that the call light is within reach at all times so Resident 70 can easily ask for assistance and if the resident needed to be changed because if not, this could lead to a skin problem if left soiled for a long time. RN 1 stated this can lead to the resident being frustrated. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure titled, Answering the Call Light, last reviewed 7/2023, indicated, ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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** 48142 Based on interview and record review, the facility failed to ensure the resident's clinical records were updated with an advance directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to healthcare providers) for four of nine sampled residents (Resident 26, 58, 29 and 82) by failing to maintain current copies of the residents' advance directives in their medical records. This deficient practice had the potential to result in confusion in the care and services for Resident 26, 58, 29, and 82 and placed the residents at risk of receiving unwanted treatments and/or not receiving appropriate care based on their wishes. Findings: a. A review of Resident 26's Admission Record indicated the facility admitted the resident on 5/29/2024 with diagnosis of sepsis (a life-threatening complication of an infection). A review of Resident 26's Minimum Data Set (MDS- standardized assessment and care planning tool), dated 6/2/2024, indicated that Resident 26 had moderate cognitive (mental process) impairment. A review of Resident 26's Advance Directive Acknowledgement form, dated 5/31/2024, indicated Resident 26 had executed an advance directive and a copy was requested, with resident signature and social service signature noted. During a concurrent interview and record review on 6/11/2024 at 3:09 p.m., with the Social Service Director (SSD), reviewed Resident 26's Advance Directive Acknowledgement form, dated 5/31/2024. The SSD stated the facility is still waiting for Resident 26's family to provide a copy of the advance directive, which was requested on 5/31/2024. The SSD stated they had not followed up with Resident 26's family. The SSD stated that advance directives are very important for honoring residents' wishes when they cannot speak for themselves and that without an advance directive, Resident 26 would automatically receive full life-saving measures. A review of facility's policy and procedure title, Advance Directive, last reviewed on 7/2023, indicated, a copy of the advance directive is maintained as part of the resident's medical record. A copy of the Advance Directive is provided to emergency personnel if the resident is transferred from the facility via ambulance or in case of another emergency. b. A review of Resident 58's Admission Record indicated the facility admitted the resident on 5/20/2024 with diagnoses of multiple sclerosis (a condition that happens when the immune system attacks the brain and spinal cord) and benign prostatic hyperplasia (prostate gland [gland in the male reproductive system] enlargement that can cause urination difficulty). A review of Resident 58's History and Physical dated 5/23/2024, indicated the resident had the capacity to make decision. (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 58's MDS, dated [DATE], indicated that Resident 58's cognition (mental process) is intact. A review of Resident 58's Advance Directive Acknowledgement form, dated 5/22/2024, indicated Resident 58 had executed an advance directive and a copy was requested, with resident signature and social service signature noted. During a concurrent interview and record review on 6/11/2024 at 3:09 p.m., with the SSD, reviewed Resident 58's Advance Directive Acknowledgement form, dated 5/22/2024. The SSD stated the facility was still waiting for Resident 58's family to provide a copy of the advance directive, which was requested on 5/22/2024. The SSD stated they had not followed up with the family. The SSD stated that advance directives are very important for honoring residents' wishes when they cannot speak for themselves and that without an advance directive, Residents 58 would automatically receive full life-saving measures. A review of facility's policy and procedure titled, Advance Directive, last reviewed date on 7/2023, indicated, a copy of the advance directive is maintained as part of the resident's medical record. A copy of the Advance Directive is provided to emergency personnel if the resident is transferred from the facility via ambulance or in case of another emergency. 49252 c. A review of Resident 29's Admission Record indicated the facility readmitted the resident on 2/14/2024 with diagnoses that included rhabdomyolysis (a breakdown of muscle tissue in the body that can cause kidney injury), bipolar disorder (a mental illness that causes severe changes in mood, energy, and activity levels), and dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). A review of Resident 29's MDS, dated [DATE], indicated Resident 29 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 29's Advance Directive Acknowledgement form, dated 4/29/2024, indicated Resident 29's surrogate decision maker (a trusted individual who is involved in the resident's medical decision-making) had executed an Advance Directive for Resident 29, but the advance directive was not in Resident 29's medical chart. During a concurrent interview and record review on 6/11/2024 at 9:24 a.m., with the Medical Records Director (MRD), reviewed Advance Directive Acknowledgement form, dated 4/29/2024. The MRD stated Resident 29 had an advance directive, but it was not present in the medical record. During an interview on 6/11/2024 at 3:09 p.m., with the SSD, the SSD stated the facility did not have Resident 29's Advance Directive in Resident 29's medical record. The SSD further stated, without the records, it's a dignity issue and you want to make sure the resident's wishes are honored because that's important. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Advance Directive, last reviewed 7/2023, indicated, the purpose was to provide residents with the opportunity to make decisions regarding their health care. A copy of the advance directive is maintained as part of the resident's medical record and a copy should be provided to emergency personnel if the resident is transferred from the facility via ambulance or in case of another emergency. d. A review of Resident 82's Admission Record indicated the facility admitted the resident on 5/16/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease causing restricted airflow and breathing problems). A review of Resident 82's MDS, dated [DATE], indicated Resident 82 had intact cognition. A review of Resident 82's Advance Directive Acknowledgement form, dated 5/16/2024, indicated Resident 82 had decision making capacity and executed an advance directive, but the advance directive was not in Resident 82's medical chart. During an interview on 6/11/2024 at 3:09 p.m., with the SSD, the SSD stated the facility did not have Resident 82's Advance Directive in Resident 82's medical record. The SSD further stated, without the records, it's a dignity issue and you want to make sure the resident's wishes are honored because that's important. During a review of the facility's policy and procedure titled, Advance Directive, last reviewed 7/2023, indicated, the purpose was to provide residents with the opportunity to make decisions regarding their health care. A copy of the advance directive is maintained as part of the resident's medical record and a copy should be provided to emergency personnel if the resident is transferred from the facility via ambulance or in case of another emergency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a written document that summarizes a patient's needs, goals, and care/treatment) for three of 24 sampled residents (Residents 82, 30, 32) as evidenced by: 1. Resident 82 did not have a care plan in place for antibiotic-use that the resident was receiving for a urinary tract infection (UTI- an infection in any part of the urinary system). 2. Resident 30 did not have a care plan in place for Restorative Nursing Assistant (RNA, a program designed to ensure each resident maintains their physical and functional abilities) exercises that accurately reflected the physician's orders. 3. Resident 32 did not have a care plan in place for obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow). These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: a. A review of Resident 82's Admission Record indicated the facility admitted the resident on 5/16/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease causing restricted airflow and breathing problems). A review of Resident 82's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 5/20/2024, indicated Resident 82 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 6/10/2024 at 10:22 a.m., with Resident 82, Resident 82 stated they had a UTI and was experiencing urinary frequency, pain when urinating, and achiness in the lower abdomen. A review of Resident 82's Intravenous Administration Record, dated 6/1/2024 through 6/30/2024, indicated Resident 82 received ceftriaxone sodium solution (an antibiotic used to treat infections) one gram (gm, a unit of measurement) to treat a UTI from 6/7/2024 to 6/13/2024. (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 6/13/2024 at 11:10 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 82's care plans dated 5/16/2024 to 6/13/2024. RN 2 stated there was no care plan for Resident 82's antibiotic use of ceftriaxone. RN 2 stated there should be a care plan in place for the antibiotic that Resident 82 was being administered to specify the goals for the problem, the interventions that are necessary for nursing staff to carry out, and to provide a way to monitor the interventions for a specific time period. RN 2 further stated without a care plan, the nursing staff would not have a guide to show them if interventions were effective and appropriate for the specific problem in a that time frame and if interventions needed re-evaluation. RN 2 stated this could delay healing for the resident because there would be no way to monitor whether the interventions are working. During an interview on 6/11/2024 at 3:09 p.m., with the Director of Nursing (DON), the DON stated a care plan identifies how the nursing staff can properly take care of a resident and prevent a delay in the recovery process. The DON stated a resident on an antibiotic should have a care plan documented for the use of the antibiotic and if they don't, there's a risk of the resident not being cared for properly, which could negatively impact the quality of care. A review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed 7/2023, indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident . Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas, h. aid in preventing or reducing declines in the resident's functional status and/or functional levels . Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident's condition change. 38549 b. A review of Resident 30's Admission Record indicated the facility originally admitted the resident on 12/3/2023 and readmitted the resident on 12/18/2023 with diagnoses including abnormalities of gait and mobility and difficulty in walking. A review of Resident 30's MDS, dated [DATE], indicated the resident had moderately impaired cognition (thought processes) and required maximum assistance from staff for most activities of daily living (ADLs - basic skills that allow people to care for themselves independently). During a concurrent interview and record review on 6/12/2024 at 9:33 a.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 30's physician's orders and care plans dated 3/1/2024 to 6/12/2024. MDS Nurse 1 stated Resident 30 had the following physician's orders: - RNA to provide active range of motion (AROM - the extent to which a body part can move when muscles are used without assistance) exercises to the left lower extremity (LLE) every day (QD) seven times a week as tolerated, every day shift, ordered on 1/13/2024. - RNA to provide AROM exercises to the left upper extremity (LUE) QD seven times a week as tolerated, every day shift, ordered on 3/1/2024. - RNA to provide AROM exercises to the right lower extremity (RLE) QD seven times a week as tolerated, every day shift, ordered on 1/12/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- RNA to provide AROM exercises to the right upper extremity (RUE) QD seven times a week as tolerated, every day shift, ordered on 3/1/2024. When asked if Resident 30's physician's order for RNA exercises was reflected in the care plan, MDS Nurse 1 stated there was a care plan for Resident 30's AROM exercises for BLE. MDS Nurse 1 stated the care plan did not include Resident 30's AROM exercises for BUE. MDS Nurse 1 stated it was important for the resident's care plan to accurately reflect the physician's orders in order for the interdisciplinary team (IDT - a group of people with different functional expertise working toward a common goal) to provide the correct care to the resident. MDS Nurse 1 stated that if the care plan is different from the physician's orders, and the IDT is following the care plan, then some interventions may be missed. During an interview on 6/12/2024 at 4:24 p.m., with the Director of Nursing (DON), the DON stated it was important for a resident's care plan to match the physician's orders because it was how staff identified how to properly care for the resident. The DON stated if the care plan was inaccurate, then staff could potentially be performing the wrong interventions, and there was a risk of functional decline for the resident. A review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed on 7/2023, indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. Each resident's comprehensive care plan is designed to aid in preventing or reducing declines in the resident's functional status and/or functional levels. The comprehensive care plan includes the following-the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 34659 c. A review of Resident 32's Admission Record indicated the facility admitted the resident on 5/17/2024 with diagnoses that included obstructive and reflux uropathy. A review of Resident 32's MDS, dated [DATE], indicated the resident was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated that Resident 32 required maximal assistance (helper does more than half the effort) with toileting, showering, and personal hygiene. A review of Resident 32's physician's orders indicated the following: - Tamsulosin oral capsule (medication used for urinary retention [difficulty urinating and completely emptying the bladder]) give one capsule by mouth one time a day for urinary retention, clarified diagnosis, dated 6/11/2024 During a concurrent interview and record review on 6/11/2024 at 8:07 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 32's care plans from 5/17/2024 to 6/11/2024. RN 2 stated Resident 32 has urinary retention and has had that diagnosis since admission from the general acute care hospital (GACH, or simply hospital) on 5/17/2024. When asked if there was a care plan for urinary retention, RN 2 stated they were unable to locate one. (continued on next page)

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	555716	A. Building B. Wing	06/13/2024

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West Valley Subacute and Nursing Center	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/2024 at 2:15 p.m., with Resident 32, Resident 32 stated she took the medication Tamsulosin. During a concurrent interview and record review on 6/11/2024 at 2:19 p.m., with MDS Nurse 1, reviewed Resident 32's care plans from 5/17/2024 to 6/11/2024. MDS Nurse 1 confirmed by stating that Resident 32 did not have a care plan for urinary retention but should have one. MDS Nurse 1 stated it was important to monitor for urinary retention as well as keeping skin intact since Tamsulosin can cause frequent urination. During an interview on 6/11/2024 at 4:31 p.m., with the DON, the DON stated Resident 32 should have a care plan for urinary retention to ensure Resident 32 does not have any urinary obstruction and has normal urination. A review of the facility's policy and procedure titled, Care Plan Comprehensive, last reviewed 7/2023, indicated each resident's comprehensive care plan is designed to: incorporate identified problem areas and reflect treatment goals, timetables, and objectives in measurable outcomes. The policy and procedure indicated a resident's comprehensive care plan is to be developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 38469 Based on interview and record review, the facility failed to: 1. Ensure a STAT (immediately) specimen for Fecal Occult Blood Test (a lab test used to check stool samples for hidden blood) was collected timely when one of one sampled resident (Resident 25) had a bowel movement. 2. Ensure the result of the FOBT was followed up with the laboratory and the result relayed to the provider promptly for one of one sampled resident (Resident 25). This deficient practice had the potential to delay the necessary intervention for a positive occult blood test which could lead to complications such as anemia (low levels of health red blood cells [delivers oxygen to tissues in your body]). Findings: A review of Resident 25's Admission Record indicated the facility originally admitted the resident on 5/22/2024 with diagnoses including Guillain-Barre syndrome (a condition in which the body's immune system attacks the nerves) and myasthenia gravis (a rare long-term condition that causes muscle weakness). A review of Resident 25's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/26/2024, indicated the resident had the ability to sometimes makes self-understood and the ability to sometimes understand others. The MDS also indicated the resident required maximal assistance with eating, oral hygiene, dressing and totally dependent on staff for toileting and shower. A review of Resident 25's physician's order on 6/5/2024 at 1:44 p.m., included Stat complete blood count (CBC, a test that counts the cells that make up your blood), basic metabolic panel (BMP, blood test that checks the body's fluid balance and levels of electrolytes [minerals in your blood and other body fluids that carry an electric charge]), and stool for fecal occult blood. A review of Resident 25's Change in Condition Evaluation (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) dated 6/5/2024 at 1:50 p.m., indicated, Family reported that patient has soft black stool on the previous shift, but no sample was taken . The COC was reported to the primary clinician. A review of Resident 25's Personal Hygiene: Toileting report dated 6/5/2024, indicated that Resident 25 had a bowel movement at 9:32 p.m. No specimen was collected at this time. A review of Resident 25's Order Summary dated 6/6/2024 indicated an order for Fecal Occult Blood with a notation of Incomplete. A review of Resident 25's Patient Order History on 6/6/2024, indicated that the FOBT status was incomplete and not dispatched, order was rescheduled to 6/7/2024. On 6/7/2024, the order history indicated that CBC . FOBT . was drawn at 9:05 a.m. and drop off time of 10:10 a.m. at the laboratory. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 25's Hematology (the study of blood and blood disorders) Report for Hemoglobin (Hgb- a protein containing iron that facilitates the transport of oxygen in red blood cells. The normal Hgb level for males is 14 to 18 grams per deciliter [g/dl]; that for females is 12 to 16 g/dl) are as follows: - 6/3/2024 Hgb 11.8 g/dl - 6/6/2024 Hgb 9.5 g/dl - 6/7/2024 Hgb 9.2 g/dl - 6/10/2024 Hgb 3.7 g/dl A review of Resident 25's COC dated 6/7/2024 at 3:26 p.m., indicated Patient noted to have abnormal labs . awaiting FOBT result. A review of Resident 25's COC dated 6/10/2024 at 12:36 p.m., indicated that the resident had a positive FOBT. The COC indicated, Patient noted to have black stool, tarry (caused by internal bleeding), and clinician notified on 6/10/2024 at 9:00 a.m. A review of Resident 25's COC dated 6/10/2024 at 2:30 p.m., indicated that resident had abnormal lab result and that at 1:50 p.m. received a call about critically low Hgb of 3.7 g/dl, and physician was notified with order to transfer to hospital via 911 (911 is the nationwide emergency number). During a concurrent interview and record review on 6/12/2024 at 10:10 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 25's records including the COC's dated 6/5/2024, 6/7/2024, and 6/10/2024, physician's orders, Hygiene and Toileting records, laboratory orders and results. RN 2 stated that she wrote the COC dated 6/5/2024 indicating the family observation that Resident 25 passed a soft black stool. RN 2 stated that she notified the primary clinician. RN 2 stated that the primary clinician ordered a CBC, BMP, and FOBT tests on 6/5/2024 at 1:44 p.m. RN 2 stated that it was a STAT order and explained that an FOBT test will determine if Resident 25 has internal bleeding. RN 2 stated that during her shift from 7 a.m. to 3p.m., Resident 25 did not have a bowel movement. RN 2 stated that she endorsed the order to the evening shift. RN 2 stated that based on the Personal Hygiene Toileting Report dated 6/5/2024, wherein it was noted that Resident 25 had a bowel movement on 6/5/2024 at 9:32 p.m., the evening shift should have collected the stool specimen to carry out the STAT order. RN 2 stated she do not know why the stool specimen was not collected. RN 2 stated that it is crucial to immediately collect a stool specimen because a resident may have an internal bleeding which could result to loss of blood and the resident could go into a hypovolemic shock (a dangerous condition that happens when you suddenly lose a lot of blood or fluids from your body). RN 2 stated that the Order Summary dated 6/6/2024, indicated a note stating Incomplete, other not Dispatched, order rescheduled to 6/7/2024. RN 2 stated that the stool specimen was picked up on 6/7/2024 at 9:05 a.m. RN 2 stated that between the time the stool specimen was picked up on 6/7/2024 until 6/10/2024, there was no documentation that facility staff followed up on the result of the FOBT. RN 2 stated that she only knew of the result of the FOBT when she came in on 6/10/2024 when she saw Resident 25's primary provider who then ordered to continue monitoring laboratory tests and symptoms that morning. RN 2 stated that the primary provider was then notified on 6/10/2024 at 1:50 p.m. of the laboratory result of the CBC and BMP obtained at 9:15 a.m. which indicated a low Hgb of 3.7 g/dl. RN 2 stated that the primary provider then ordered to transfer Resident 25 to hospital via 911. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2024 at 8:18 a.m., with the Director of Nursing (DON), the DON stated that all laboratory STAT orders have to be done right away and the nurses must immediately call the laboratory provider. The DON stated that right away means under four hours, but they want the laboratory to pick up the specimen sooner than four hours. The DON explained that a fecal occult blood test is to see if there's abnormality in the gastrointestinal tract (GI system. The GI tract includes the mouth, throat, esophagus, stomach, small intestine, large intestine, rectum, and anus). The DON stated that GI tract bleeding could result to hypovolemic shock which in the worst-case scenario and can lead to death. The DON stated that the stool specimen should have been collected on the first opportunity when Resident 25 had a bowel movement on the night of 6/5/2024. The DON stated that it is also important for the nurses to follow up the result of the fecal occult blood test so that there won't be a delay in providing interventions to ensure a better outcome in terms of management of the disease condition. A review of the facility's policy and procedure titled, Policy on Laboratory Stat Orders, last reviewed on 7/2023, indicated, Laboratory will prioritize and expedite all qualified stat orders. It is our goal to complete STAT orders promptly within 4 to 6-hour timeframe. Results are automatically faxed to the facility fax number and uploaded in electronic medical record (EMR) as appropriate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on observation, interview and record review, the facility failed to ensure the low air loss mattress (LAL - a specialty bed that alternates pressure to help heal and prevent pressure ulcers [an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure]) was set correctly for three of five sample residents (Resident 29, 48, and 62). This deficient practice had the potential to increase the resident's risk of skin breakdown. Findings: a. A review of Resident 29's Admission Record indicated the facility readmitted the resident on 2/14/2024 with diagnoses that included rhabdomyolysis (a breakdown of muscle tissue in the body that can cause kidney injury), bipolar disorder (a mental illness that causes severe changes in mood, energy, and activity levels), and dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). A review of Resident 29's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 4/9/2024, indicated Resident 29 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), needed partial/moderate assistance (helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with moving in bed. The MDS indicated Resident 29 had three pressure ulcers. A review of Resident 29's Order Summary Report, dated 2/14/2024, indicated an order for a LAL mattress for wound management with settings based on comfort of the resident. A review of Resident 29's Care Plan (a written document that summarizes a patient's needs, goals, and care/treatment), last revised 6/10/2024, indicated Resident 29's sacral (triangular-shaped bone at the base of the back) pressure ulcer was clarified to a stage four (4) (a category indicating full thickness skin loss with exposed bone, tendon, or muscle) on 5/30/2024 and a listed an intervention for a LAL mattress for pressure reduction and for skin integrity. During an observation on 6/10/2024 at 9:10 a.m., in Resident 29's room, observed Resident 29 in bed with the LAL mattress on the static mode (a setting that creates a firm surface). During a concurrent observation and interview on 6/10/2024 at 9:23 a.m., with Certified Nursing Assistant 3 (CNA 3), in Resident 29's room, CNA 3 confirmed by stating the LAL mattress setting displayed normal pressure and was switched on the static mode. CNA 3 stated she was unaware of what the settings should be since Resident 29 was not her patient. (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 6/10/2024 at 9:31 a.m., with Treatment Nurse 1 (TN 1), in Resident 29's room, observed Resident 29's LAL mattress was set to the static mode and the pressure adjustment knob (weight setting knob that controlled the air pressure in the mattress) was at 240 pounds (lbs. - a unit of weight). TN 1 stated Resident 29's LAL mattress should be set according to her weight and comfort and should be on alternating mode (alternating air cells in the mattress are partially deflated and inflated, avoiding prolonged pressure on any single point) because it helps the wound and prevents other wounds from occurring. TN 1 adjusted the pressure adjustment knob down to approximately 150 lbs. and changed the setting from static to alternating mode. TN I further stated, if the setting is on static mode all the time, it creates pressure and prevents the wounds Resident 29 has from healing. During a concurrent observation and interview on 6/12/2024 at 10:24 a.m., with Treatment Nurse 2 (TN 2), in Resident 29's room, observed Resident 29's LAL mattress pressure adjustment knob was set to approximately 158 lbs. TN 2 stated the LAL mattress should be set to her weight because Resident 29 was very confused, alert and oriented to self and had poor judgment. TN 2 verified by stating that Resident 29's last weight was 118 lbs. on 6/9/2024. TN 2 further stated, LAL mattresses are needed for people with pressure ulcers, like Resident 29. During an interview on 6/12/2024 at 4:21 p.m., with the Director of Staff Development (DSD), the DSD stated proper settings for a LAL mattress are based on a resident's weight and if a resident can make decisions for themselves and are at least alert and oriented to person, place, and time, then the settings could be adjusted to comfort. The DSD stated if a resident is alert and oriented to self only, their weight should be used as the setting for the pressure adjustment knob. The DSD further stated, if the settings are incorrect and are too high, the mattress will be too hard and the firmness will cause more pressure on the wound, which is harmful to wound healing. A review of the facility-provided Medline LAL manual titled, A20: Alternating Pressure Therapy Pump Overlay/Replacement Mattress System, undated, indicated the product is intended to help and reduce the incidence of pressure ulcers while optimizing patient comfort, for long term home care of patients suffering from pressure ulcers .With alternate pressure mode, alternating air cells are partially deflated and inflated, avoiding prolonged pressure on any single point beneath the patient; this is to prevent pressure ulcers. Static Pressure mode, all of the air cells are equally inflated. A review of the facility's policy and procedure titled, Skin Integrity Management, last reviewed 7/2023, indicated the purpose was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds . Implement pressure ulcer prevention for identified risk factors. b. A review of Resident 48's Admission Record indicated the facility admitted the resident on 6/25/2021 with diagnoses that included tracheostomy (incision made in the windpipe to relieve an obstruction to breathing) and traumatic brain injury (a blow or jolt to the head or a penetrating head injury that disrupts brain function). A review of Resident 48's MDS, dated [DATE], indicated Resident 48 was rarely or never understood, was dependent (helper does all of the effort, resident does none of the effort to complete the activity or needs two or more helpers to complete the activity) on staff for self-care and mobility (moving in bed or transferring), and was at risk of developing a pressure ulcer. (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 Resident 48's Order Summary Report indicated an active order for a LAL mattress to set the LAL mattress mode to alternating and settings based on comfort and/or weight of resident. Check settings and functionality every shift, order date of 11/9/2021. During an observation on 6/11/2024 at 8:03 a.m., in Resident 48's room, observed Resident 48 was asleep in bed with the LAL mattress settings on normal pressure, alternating pressure mode, and at the pressure adjustment knob was at MAX (maximum - 400 lbs.) weight. During a concurrent observation and interview on 6/11/2024 at 8:37 a.m., with Treatment Nurse 3 (TN 3), TN 3 confirmed the observation by stating Resident 48's LAL mattress pressure adjustment knob was set at the MAX weight setting of 400 lbs. TN 3 stated the LAL mattress should be set to Resident 48's weight since the resident is unable to speak. TN 3 stated Resident 48's last weight was 181 lbs. and adjusted the knob down to approximately 170 lbs. to 180 lbs. TN 3 further stated the LAL mattress was set at the wrong weight which defeated the purpose of using it and increased the chances of Resident 48 acquiring pressure ulcers because the mattress was very firm. During an interview on 6/12/2024 at 4:21 p.m., with the DSD, the DSD stated proper settings for a LAL mattress are based on a resident's weight. The DSD stated if a resident is alert and oriented to self only, their weight should be used as the setting. The DSD further stated if the settings are incorrect and are too high, the mattress will be too hard. The DSD stated the firmness will cause more pressure on the wound, which is harmful to wound healing. A review of the facility-provided Medline LAL manual titled, A20: Alternating Pressure Therapy Pump Overlay/Replacement Mattress System, undated, indicated, This product is intended: to help and reduce the incidence of pressure ulcers while optimizing patient comfort .The pressure adjustment knob controls the air pressure in the mattress. Turning the knob clockwise will increase the pressure .Higher pressures will support heavier patients. The pressure should be adjusted according to individual comfort preferences. A review of the facility's policy and procedure titled, Skin Integrity Management, last reviewed 7/2023, indicated the purpose was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds . Implement pressure ulcer prevention for identified risk factors. 38549 c. A review of Resident 62's Admission Record indicated the facility originally admitted the resident on 11/30/2022 and readmitted the resident on 5/1/2024 with diagnoses that included surgical aftercare and gastrostomy (a surgical procedure that involves inserting a tube through the abdomen and into the stomach) status. A review of Resident 62's MDS, dated [DATE], indicated the resident had severely impaired cognition (thought processes) and was dependent on staff for all activities of daily living (ADLs - basic skills that allow a person to care for themselves independently). The MDS also indicated the resident was at risk of developing pressure ulcers. (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 Resident 62's Braden Scale for Predicting Pressure Sore Risk (a standardized tool used to assess a patient's risk of developing pressure ulcers), dated 5/28/2024, indicated the resident was at severe risk of developing a pressure ulcer. A review of Resident 62's care plan (a document that outlines a patient's care needs, the services he/she will receive, and who will provide those services) for risk for skin breakdown, initiated on 1/23/2024, indicated to use a pressure redistribution surface to bed as per guideline. During an observation on 6/10/2024 at 8:42 a.m., observed Resident 62 asleep in bed and their LAL mattress set to 265 lbs. A sticker indicated to set the LAL mattress to 137 lbs. During a concurrent observation and interview on 6/10/2024 at 8:48 a.m., with Registered Nurse 1 (RN 1), RN 1 confirmed the observation by stating that Resident 62's LAL mattress was currently set to 265 lbs. RN 1 stated it should have been set to 137 lbs., which was Resident 62's current weight. During an interview on 6/12/2024 at 4:27 p.m., with the Director of Nursing (DON), the DON stated that if the resident was unable to verbalize his/her comfort level, then the LAL mattress would be set according to the resident's weight. The DON stated if the resident's LAL mattress was set incorrectly, then it defeats the purpose of the LAL mattress, which was to prevent pressure injuries. A review of the Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operator's Manual, undated, indicated the mattress was indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. The manual indicated to determine the patient's weight and set the control knob to that weight setting on the control unit. A review of the facility's policy and procedure titled, Skin Integrity Management, last reviewed on 7/2023, indicated the purpose of the policy was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds . Implement pressure ulcer prevention for identified risk factors.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 38549 Based on interview and record review, the facility failed to ensure licensed nurses attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (prn) opioid pain medication (medication used to treat moderate to severe pain) on multiple dates for one of 24 sampled residents (Resident 30). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from opioid pain medication. Findings: A review of Resident 30's Admission Record indicated the facility originally admitted the resident on 12/3/2023 and readmitted the resident on 12/18/2023 with diagnoses that included acute respiratory failure (a condition that occurs when the lungs can't properly oxygenate the blood), tracheostomy (a surgical procedure that creates a temporary or permanent opening in the neck and into the windpipe to help a patient breathe) status, and gastrostomy (a surgical procedure that creates an opening in the abdomen and into the stomach) status. A review of Resident 30's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/8/2024, indicated the resident had moderately impaired cognition (thought processes) and required maximum assistance from staff for most activities of daily living (ADLs - basic skills that allow people to care for themselves independently). During a concurrent interview and record review on 6/12/2024 at 9:19 a.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 30's physician's orders and Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional) dated 4/2024 and 5/2024. MDS Nurse 1 stated the resident had a physician's order for hydrocodone-acetaminophen (medication used to treat moderate to severe pain) 10-325 milligrams (mg - unit of measurement) via gastrostomy tube (GT - a surgically inserted tube that provides direct access to the stomach to deliver nutrition, fluids, and medication) every six (6) hours as needed for severe pain 8-10/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered from 12/18/2023 to 5/30/2024. Reviewed Resident 30's MAR dated 4/2024 with MDS Nurse 1. MDS Nurse 1 verified by stating she could not find any documentation indicating that licensed nurses provided non-pharmacological interventions prior to administering hydrocodone-acetaminophen 10-325 mg on the following dates: 4/4/2024, 4/5/2024, 4/10/2024, and 4/13/2024. Reviewed Resident 30's MAR dated 5/2024 with MDS Nurse 1. MDS Nurse 1 verified she could not find any documentation indicating that licensed nurses provided non-pharmacological interventions prior to administering hydrocodone-acetaminophen 10-325 mg on the following dates: 5/3/2024, 5/6/2024, 5/15/2024, 5/23/2024, 5/25/2024, and 5/29/2024. MDS Nurse 1 stated that nurses should provide non-pharmacological interventions prior to administering prn pain medication in order to possibly avoid medication interventions. MDS Nurse 1 stated that, with medications, the resident can possibly experience adverse side effects. (continued on next page)

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	555716	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Subacute and Nursing Center	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2024 at 4:21 p.m., with the Director of Nursing (DON), the DON stated it was important for the nurses to attempt non-pharmacological interventions prior to administering prn pain medication in order to avoid giving the resident unnecessary medication. The DON stated the resident can potentially experience adverse side effects from taking medications. A review of the facility's policy and procedure titled, Pain Management, last reviewed 7/2023, indicated the purpose of the policy was to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with resident directed goals. An individualized, interdisciplinary care plan will be developed and include non-pharmacological and pharmacological approaches. Residents receiving interventions for pain will be monitored for the effectiveness and side effects (e.g. constipation, sedation) in providing pain relief. Document non-pharmacological interventions and effectiveness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to: 1. Ensure there was documented evidence that multiple doses of Zosyn (an antibiotic [medicine that fights bacterial infections]) intravenous solution (IV- a medical technique that administers fluids, medications, and nutrients directly into a person's vein) were administered per physician's order for one of two sampled residents (Resident 2). This deficient practice had the potential for the resident to develop antibiotic-resistant bacteria (when bacteria change to resist antibiotics that used to effectively treat them) due to misuse which could lead to infections taking longer to heal. 2. Ensure the Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR, a report detailing the drugs administered to a patient by the licensed nurses) for four of six sampled residents (Resident 387, 15, 39, and 44). These deficient practices had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). Findings: 1. A review of Resident 2's Admission Record indicated the facility originally admitted the resident on 5/27/2024 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), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and cellulitis (a deep infection of the skin caused by bacteria) of left lower limb. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/31/2024, indicated the resident had the ability to make self-understood and the ability to understand others. The MDS also indicated the resident required maximal assistance with toileting, shower, and dressing. A review of Resident 2's physician's orders indicated an order to administer Zosyn intravenous solution 3-0. 375 grams (gm, a unit of measurement) per 50 milliliters (ml, a unit of measurement), one gram intravenously every eight (8) hours (6:00 a.m., 4:00 p.m., and 10:00 p.m.) for cellulitis for seven (7) days with start date on 5/28/2024 and end date of 6/4/2024. A review of Resident 2's Care Plan (a written document that summarizes a resident's health, care needs, and current treatments) titled Resident 2 is admitted with bilateral lower extremities cellulitis, dated 5/28/2024, indicated that Resident 2 is on IV antibiotic for bilateral lower extremity cellulitis. Among some of the interventions listed was to ensure IV medication(s) is administered as ordered. (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 Resident 2's Medication Administration Record (MAR- includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time), indicated that there was no documentation on the MAR indicating that Zosyn was administered on the following dates and time: - 5/28/2024 at 6:00 a.m. - 5/29/2024 at 6:00 a.m. - 5/31/2024 at 6:00 a.m. - 6/1/2024 at 10:00 p.m. - 6/2/2024 at 10:00 p.m. - 6/3/2024 at 6:00 a.m. During a concurrent interview and record review on 6/12/2024 at 8:37 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 2's physician's order and MAR dated 5/2024 and 6/2024. RN 2 verified and confirmed by stating that on multiple days and administration times, Zosyn was not signed off as given on the MAR. RN 2 stated the MAR will serve as the record of what medications are administered and if the dates are blank, either scenarios are possible, such as that the medication was not given, or the resident refused. RN 2 stated that for medications that are refused by the resident, there is a corresponding legend to document the refusal and, in this case, there was also no documentation that Resident 2 refused Zosyn. RN 2 stated that if the antibiotic is not correctly administered, the resident could develop tolerance to the medication and will result to untreated infection. RN 2 stated that untreated infection can result to the infection going to the blood or sepsis which could lead to death. RN 2 stated that a resident could also develop multi-drug resistance organism [MDRO- bacteria that have become resistant to certain antibiotics] due to misuse of antibiotic. During an interview on 6/13/2024 at 9:14 a.m., with the Director of Nursing (DON), the DON stated that if the MAR is blank, it means that the medication is not given. The DON stated antibiotics are prescribed to treat an infection and all doses have to be administered to ensure the infection is properly treated. The DON stated that a resident can develop antibiotic resistance if the entire course of the antibiotic order is not administered. A review of the facility's policy and procedure titled, Antibiotic Stewardship, last reviewed on 7/2023, indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 34659 2.a. A review of Resident 387's Admission Record indicated the facility admitted the resident on 11/29/2022 and readmitted the resident on 6/6/2024 with diagnoses that included epileptic seizures (a brain condition that causes reoccurring seizures [temporary abnormalities in muscle tone or movements]). (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 Resident 387's MDS, dated [DATE], indicated Resident 387 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 387 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. A review of Resident 387's physician's orders indicated an order for laconsamide oral solution 10 milligrams per milliliter (mg/ml, a unit of measurement), give 10 ml via percutaneous endoscopic gastrostomy tube (PEG-Tube, a plastic tube inserted into the stomach to deliver medications for those with swallowing problems) two times a day for seizure, dated 6/6/2024. During a concurrent interview and record review on 6/10/2024 at 11 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 387's MAR dated 6/2024 and CDR for laconsamide 10mg/ml. Resident 387's MAR indicated laconsamide was given on 6/10/2024 at 9 a.m. Reviewed Resident 387's CDR for laconsamide that indicated there was no signature for 6/10/2024. RN 1 stated the process when giving a controlled medication is to remove the medication from the medication cart, sign the CDR, give the medication, and then sign the MAR. RN 1 stated Licensed Vocational Nurse 2 (LVN 2) who gave the medication earlier that day should have signed Resident 387's CDR in addition to signing the MAR. During an interview on 6/10/2024 at 11:21 a.m., with LVN 2, LVN 2 stated she forgot to sign Resident 387's CDR for laconsamide but should have signed it at 10 a.m. when she gave the medication. LVN 2 stated this was important to sign both at the time of occurrence to ensure the records were accurately accounted for. During a concurrent interview and record review on 6/11/2024 at 3:49 p.m., with the DON, reviewed Resident 387's MAR dated 6/2024 and CDR for laconsamide 10mg/ml. The DON verified by stating that there was a discrepancy between Resident 387's MAR dated 6/2024 and CDR for laconsamide 10mg/ml. The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the CDR, give the medication to the resident, and then sign the MAR which is the pour, pass, and sign procedure. The DON stated it is important to do this to decrease the chance of a medication error. The DON stated these residents could be at risk for receiving a medication twice since a second nurse may not see that it was given since it was not signed on the MAR. 2.b. A review of Resident 15's Admission Record indicated the facility admitted the resident on 7/18/2016 and readmitted the resident on 1/11/2023 with diagnoses that included systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs). A review of Resident 15's MDS, dated [DATE], indicated Resident 15 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 15 required partial assistance (helper does less than half the effort) with toileting and personal and oral hygiene. A review of Resident 15's physician's orders indicated an order for Norco 5-325 mg, give one tablet by gastrostomy tube (G-Tube, a plastic tube inserted into the stomach to deliver medications for those with swallowing problems) every six hours as needed for severe pain 7-10 (on the numeric scale with zero being no pain and 10 being the most excruciating pain imaginable), dated 10/25/2023. A review of Resident 15's CDR for Norco 5-325 mg indicated the medication was removed from the bubble pack (a package that contains multiple sealed compartments with medication/s) on 5/31/2024 at 2 a.m., but there is no corresponding entry in Resident 15's MAR dated 5/2024. (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 6/10/2024 at 11:45 a.m., with LVN 3, reviewed Resident 15's MAR dated 5/2024 and CDR for Norco 5-325 mg. LVN 3 stated Resident 15's MAR did not correspond to the entry made on 5/31/2024 at 2 a.m. in Resident 15's CDR for Norco 5-325 mg. LVN 3 stated the process when giving a controlled medication is to remove the medication from the medication cart, sign the CDR, give the medication, and then sign the MAR. LVN 3 stated the licensed nurse who gave the Norco 5-325 mg to Resident 15 should have signed both the MAR and the CDR. LVN 3 stated the medication should be given to Resident 15 right after removing from the bubble pack to avoid medication misplacement or loss. During a concurrent interview and record review on 6/11/2024 at 3:49 p.m., with the DON, reviewed Resident 15's MAR dated 5/2024 and CDR for Norco 5-325 mg. The DON verified by stating that there was a discrepancy between Resident 15's MAR dated 5/2024 and CDR for Norco 5-325 mg. The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the CDR, give the medication to the resident, and then sign the MAR which is the pour, pass, and sign procedure. The DON stated it is important to do this to decrease the chance of a medication error. The DON stated these residents could be at risk for receiving a medication twice since a second nurse may not see that it was given since it was not signed on the MAR. 2.c. A review of Resident 39's Admission Record indicated the facility admitted the resident on 9/29/2020 and readmitted the resident on 1/21/2024 with diagnoses that included osteoarthritis (degeneration of the joints causing stiffness and pain). A review of Resident 39's MDS, dated [DATE], indicated Resident 39 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 39 required maximal assistance (helper more than half the effort) with toileting and personal and oral hygiene. A review of Resident 39's physician's orders indicated an order for morphine sulfate (medication used to treat moderate to severe pain) tablet 30 mg, give one tablet by mouth every four hours as needed for moderate pain (5 - 7/10 numeric pain scale), dated 5/30/2024. A review of Resident 39's Controlled Drug Record for morphine sulfate 30 mg indicated the medication was removed from the bubble pack on 6/9/2024 at 12:29 a.m., but there was no corresponding entry in Resident 39's MAR. During a concurrent interview and record review on 6/10/2024 at 11:45 a.m., with LVN 3, reviewed Resident 39's MAR dated 6/2024 and CDR for morphine sulfate 30 mg. LVN 3 stated Resident 39's MAR did not correspond to the entry made on 6/9/2024 at 12:29 a.m. in Resident 39's CDR for morphine sulfate 30 mg. LVN 3 stated the process when giving a controlled medication is to remove the medication from the medication cart, sign the CDR, give the medication, and then sign the MAR. LVN 3 stated the licensed nurse who gave the morphine sulfate 30 mg to Resident 39 should have signed both the MAR and CDR. LVN 3 stated the medication should be given to Resident 39 right after removing from the bubble pack to avoid medication misplacement or loss. (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 6/11/2024 at 3:49 p.m., with the DON, reviewed Resident 39's MAR dated 6/2024 and CDR for morphine sulfate 30 mg. The DON verified by stating that there was a discrepancy between Resident 39's MAR dated 6/2024 and CDR for morphine sulfate 30 mg. The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the CDR, give the medication to the resident, and then sign the MAR which is the pour, pass, and sign procedure. The DON stated it is important to do this to decrease the chance of a medication error. The DON stated these residents could be at risk for receiving a medication twice since a second nurse may not see that it was given since it was not signed on the MAR. 2.d. A review of Resident 44's Admission Record indicated the facility admitted the resident on 2/15/2024 with diagnoses that included left knee fracture (broken bone). A review of Resident 44's MDS, dated [DATE], indicated Resident 44 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 44 required setup help (helper sets up) with eating, and oral and personal hygiene. A review of Resident 44's physician's orders indicated the following: - Tramadol tablet (medication used to treat moderate to severe pain) 100 mg, give 100 mg by mouth every six hours as needed for severe pain (7 - 10/10), dated 3/8/2024 and discontinued 5/30/2024. - Tramadol tablet 100 mg, give 100 mg by mouth ever six hours as needed for severe pain (8 - 10/10), dated 5/30/2024. A review of Resident 44's Care Plan for Pain, initiated 2/15/2024, indicated a goal that Resident 44 will achieve an acceptable level of pain control for 90 days. The care plan indicated an intervention to give pain medication as ordered for pain. A review of Resident 44's CDR for tramadol 100 mg indicated the following dates and times that the medication was removed from the bubble pack but with no corresponding MAR entry: - 5/20/2024 at 9 p.m. - 5/22/2024 at 8 p.m. - 5/24/2024 at 8 p.m. - 5/25/2024 at 9:45 p.m. - 6/1/2024 at 8 p.m. - 6/2/2024 at 8 p.m. - 6/8/2024 at 8 p.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 6/10/2024 at 4 p.m., with LVN 4, reviewed Resident 44's MARs dated 5/2024 and 6/2024. LVN 4 stated Resident 44's MARs did not correspond to the entries made on 5/20/2024, 5/22/2024, 5/24/2024, 5/25/2024, 6/1/2024, 6/2/2024, and 6/8/2024 in Resident 44's CDR for tramadol 100 mg. LVN 3 stated the process when giving a controlled medication is to remove the medication from the medication cart, sign the CDR, give the medication, and then sign the MAR. LVN 4 stated he gave Resident 44 the tramadol 100 mg on 5/22/2024 and 5/24/2024, signed the CDR for tramadol 100 mg but did not sign the MAR but should have. LVN 4 stated the licensed nurse who gave the medication on the other dates and times should have signed both the MAR and CDR. During a concurrent interview and record review on 6/11/2024 at 3:49 p.m., with the DON, reviewed Resident 44's MARs dated 5/2024 and 6/2024 and CDR for tramadol 100 mg. The DON verified by stating that there was a discrepancy between Resident 44's MARs and CDR for tramadol 100 mg. The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the CDR, give the medication to the resident, and then sign the MAR which is the pour, pass, and sign procedure. The DON stated it is important to do this to decrease the chance of a medication error. The DON stated these residents could be at risk for receiving a medication twice since a second nurse may not see that it was given since it was not signed on the MAR. A review of the facility's policy and procedure titled, Controlled Drug Medications, last reviewed, 7/2023, indicated when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record: Date and time of administration. Amount administered. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. Initials of the nurse administering the dose on the MAR after the medication is administered.

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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** 34659 Based on observation, interview, and record review, the facility failed to: 1. Ensure resident's insulin (a hormone that lowers the level of glucose [sugar] in the blood) was dated when opened for two of two sampled residents (Resident 12 and 387). 2. Ensure an eye drop medication was not used past the expiration date for one of one sampled resident (Resident 33). These deficient practices had the potential to diminish the effectiveness of the medications. 3. Ensure only authorized personnel had access to one of two medication rooms (Medication room [ROOM NUMBER]). This deficient practice resulted in unauthorized personnel having access to resident medications and had the potential for drug diversion (illegal distribution or abuse of prescription drug). Findings: 1.a. A review of Resident 12's Admission Record indicated the facility admitted the resident on 3/25/2014 with diagnoses that included diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). A review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/7/2024, indicated Resident 12 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 12 required supervision (helper provides verbal cues and/or touching assistance when completing the activity) for eating and dressing. A review of Resident 12's physician's orders indicated the following: - Lantus insulin solution (long-acting insulin), 100 units per milliliter (Unit/ml, a unit of measure for insulin), inject 50 units subcutaneously (into the fat beneath the skin) in the morning for diabetes mellitus; hold for blood sugar less than 100 milligrams per deciliter (mg/dL, a unit of measure for blood sugar monitoring), dated 11/19/2022. - Lantus insulin solution, inject 50 units subcutaneously in the morning for diabetes mellitus; hold for blood sugar less than 100 mg/dL, dated 3/2/2022. A review of Resident 12's Care Plan for Diabetes Mellitus, initiated 2/26/2023, indicated a goal that the resident will be free from any signs or symptoms of hyperglycemia (high blood sugar) through the review date. The care plan indicated an intervention to give diabetic medication as ordered by the doctor. (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 observation and interview on 6/10/2024 at 11:00 a.m., with Registered Nurse 1 (RN 1), observed in Medication Cart 1, Resident 12's Lantus solution injector pen (a device to inject insulin into the subcutaneous fat through the skin), without an open date (a date that licensed nurses write on the medication indicating when it was first opened for use). RN 1 stated once a medication is first opened it should have an open date written on the medication container. RN 1 stated this was important to place an open date on the insulin pen so that the medication will not be kept after 28 days. RN 1 stated this was important to label to ensure the medications are still effective in treating a resident's condition. During an interview on 6/11/2024 at 4:31 p.m., with the Director of Nursing (DON), the DON stated insulin should be labeled with an open date to ensure they are discarded after the 28th day of being opened. The DON stated this was important to ensure the medications are effective in treating a resident's condition. A review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 7/2023, indicated multi-dose (medication used more than one time from a container) vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A review of the facility's policy and procedure titled, Guide for Special Handling of Medications, last reviewed 1/2024, indicated insulin Lantus - after opening the medication is to be discarded after 28 days. 1.b. A review of Resident 387's Admission Record indicated the facility admitted the resident on 11/29/2022 with diagnoses that included diabetes mellitus. A review of Resident 387's MDS, dated [DATE], indicated Resident 387 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 387 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. A review of Resident 387's physician's orders indicated an order for insulin lispro injection solution 100 unit/ml, inject as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges): if 71 - 150 mg/dL give zero units; 151 - 200 mg/dL give one unit; 201 - 250 mg/dL give two units, 251 - 300 give three units; 301 - 350 mg/dL give four units; 351 - 400 give six units; 401 and greater give eight units, subcutaneously every four hours for diabetes mellitus, dated 6/7/2024. During a concurrent observation and interview on 6/10/2024 at 11:00 a.m., with RN 1, observed in Medication Cart 1, Resident 387's lispro insulin vial (glass container) without an open date. RN 1 stated once a medication is first opened it should have an open date written on the medication container. RN 1 stated this was important to place an open date on the insulin vial so that the medication will not be kept after 28 days. RN 1 stated this was important to label to ensure the medications are still effective in treating a resident's condition. During an interview on 6/11/2024 at 4:31 p.m., with the DON, the DON stated insulin should be labeled with an open date to ensure they are discarded after the 28th day of being opened. The DON stated this was important to ensure the medications are effective in treating a resident's condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 7/2023, indicated multi-dose (medication used more than one time from a container) vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A review of the facility's policy and procedure titled, Guide for Special Handling of Medications, last reviewed 1/2024, indicated insulin lispro - after opening the medication is to be discarded after 28 days. 2. A review of Resident 33's Admission Record indicated the facility admitted the resident on 4/25/2024 with diagnoses that included diabetes mellitus. A review of Resident 33's MDS, dated [DATE], indicated Resident 33 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 33 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. A review of Resident 33's physician's orders indicated an order for latanoprost ophthalmic solution (an eye medication) 0.005%, instill one drop in both eyes at bedtime for glaucoma (group of eye conditions that can cause blindness), dated 4/25/2024. During a concurrent observation and interview on 6/10/2024 at 11:00 a.m., with RN 1, observed in Medication Cart 1, Resident 33's latanoprost eye drops with an open date of 4/28/2024. RN 1 stated she thought eye drops can be used up until 30 days after first opened. During an interview on 6/11/2024 at 4:31 p.m., with the DON, the DON stated any eye drop medications should be labeled with an open date to ensure they are discarded after the 28th day of being opened. The DON stated this was important to ensure the medications are effective in treating a resident's condition. A review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 7/2023, indicated multi-dose (medication used more than one time from a container) vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A review of the facility's policy and procedure titled, Guide for Special Handling of Medications, last reviewed 1/2024, indicated latanoprost ophthalmic solution - date when opened and discard after 28 days. 38549 3. During an observation on 6/10/2024 at 7:42 a.m., observed the Dietary Supervisor (DS) type in the access code to the locked Medication room [ROOM NUMBER] in the in order to gain access to the designated resident refrigerator inside Medication room [ROOM NUMBER]. Observed signs on Medication room [ROOM NUMBER] door indicating that only licensed nurses or facility staff accompanied by licensed nurses may enter the med (medication) room. (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 observation and interview on 6/12/2024 at 10:45 a.m., with Registered Nurse 2 (RN 2), RN 2 stated that only licensed nurses had access to the room. Observed the following medications inside Medication room [ROOM NUMBER]: - House supply medications (over-the counter medications) - Emergency kit (e-kit - a small supply of medications that can be used when pharmacy services are unavailable) containing oral medications, such as antibiotics (medicines that treat and prevent bacterial infections) - E-kit containing intramuscular (IM) medications (medications that are injected into a muscle), such as Haldol (an antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) and Thorazine (an antipsychotic medication) - E-kit containing intravascular (IV - into or by means of a vein or veins) medications During an interview on 6/12/2024 at 10:55 a.m., with the DS, the DS confirmed by stating she had the access code to Medication room [ROOM NUMBER] and went in there every day to check the status of the designated resident refrigerator. During an interview on 6/12/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON stated that authorized personnel, or licensed nurses, are the only ones who have access to the medication room. The DON stated if any other staff needed to get into the room, they needed to be supervised by a licensed nurse. The DON stated it was important that only authorized personnel had access to the room because, if not, there was an increased risk that unauthorized personnel would have access to medications they should not have access to. A review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed on 7/2023, indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. A review of the facility's policy and procedure titled, Storage of Medications, last reviewed on 7/2023, indicated that only persons authorized to prepare and administer medications have access to locked medications.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48678 Based on interview and record review, the facility failed to promote and facilitate resident's self-determination through support of choice, by denying two out of two residents (Resident 44 and 57) their preferred meal at dinner time. This deficient practice violated the residents' rights in food preferences and had the potential to affect the residents' sense of self-worth and self-esteem. Findings: a. A review of Resident 44's Admission Record indicated the facility admitted the resident on 2/15/2024 for orthopedic aftercare following left knee surgery. A review of Resident 44's History and Physical (H&P - a formal assessment of a patient and their problem) indicated Resident 44 had the capacity to make decisions. A review of Resident 44's physician's orders indicated an order for consistent carbohydrate diet regular texture, ordered on 2/15/2014. During an interview on 6/11/2024 at 11:09 a.m., during the Resident Council meeting (a meeting held at the facility with residents who reside in the facility to discuss concerns residents have), Resident 44 stated she wanted to have cereal for dinner on one particular occasion, but [NAME] 1 told her he didn't serve cereal for dinner because he only serves cereal in the morning. Resident 44 stated she just wanted a bowl of cereal because she did not have a big appetite, especially after she underwent gastric bypass surgery (a weight-loss procedure that changes how the stomach and small intestine process food). Resident 44 stated she was mad that [NAME] 1 told her that because she knows the facility has cereal and it was such a simple request. Resident 44 stated she did not eat that night because she did not like the dinner they were serving and when she requested an alternative, she was denied that request. During an interview on 6/11/2024 at 3 p.m., with [NAME] 1, [NAME] 1 stated he recalled Resident 44 wanting cereal for dinner but that at the time, he didn't look for the cereal boxes in the kitchen because he thought they had run out. [NAME] 1 stated he did not look in the back where there were more cereal boxes and he didn't see it, therefore, he told Resident 44 he did not have cereal. b. A review of Resident 57's Admission Record indicated the facility admitted the resident on 8/1/2022 for diagnosis of acute kidney failure (when your kidneys suddenly become unable to filter waste products from your blood). A review of Resident 57's History and Physical indicated Resident 57 had the capacity to make decisions. A review of Resident 57's physician orders indicated an order for regular, no salt on tray, regular texture diet, ordered on 11/30/2022. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 11:24 a.m., during the Resident Council meeting, Resident 57 stated on one occasion, she requested hard boiled eggs from the kitchen, and [NAME] 1 responded stating there were no eggs in the facility. Resident 57 stated she was upset and could not believe the facility did not have eggs. Resident 57 stated she likes to eat small dinners like eggs, so she doesn't feel extra full before going to bed because it's uncomfortable. During an interview on 6/11/2024 at 3:04 p.m., with [NAME] 1, [NAME] 1 stated on that particular occasion when Resident 57 had requested for hard boiled eggs, he remembers running out of the boxed premade hard boiled eggs the facility has in the kitchen. [NAME] 1 stated he could have grabbed regular eggs from the fridge, boiled them on the stove for about 20-30 minutes and offered those to Resident 57. [NAME] 1 stated instead he offered Resident 57 a different item from the alternate menu, like a hamburger, but Resident 57 denied the alternate menu. During an interview 6/11/2024 at 3:11 p.m., with the Dietary Supervisor (DS), the DS stated it is the responsibility of [NAME] 1 to ensure that resident's preferences are honored. The DS stated if the residents want a food choice item that is appropriate for their dietary needs, and residents have no restrictions, then [NAME] 1 should honor those requests. The DS stated the facility always has eggs and cereal and there was no reason why [NAME] 1 could not have provided those for Resident 44 and Resident 57. The DS stated the process for serving food to residents starts by Certified Nursing Assistants filling out a request form, turning it in to the charge nurse so it can be reviewed, and approved based on physician's orders, and then it goes to the kitchen for the cooks to fulfill the request. During an interview on 6/12/2024 at 10:05 a.m., with the Director of Nursing (DON), the DON stated the facility has to accommodate resident's preferences and maintain certain guidelines. The DON stated, if the cook is here, then he should accommodate resident's preferences, if the cook is not here at night, then as long as the resident gives notice of their preferences in the morning, we can arrange to have those food preferences prepared for them. A review of the facility's policy and procedures titled, Resident Rights, dated 6/2024, indicated employees shall treat all residents with kindness, respect, and dignity by honoring basic rights of residents such as self-determination, and exercising resident's rights without staff interference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of five sampled residents (Resident 82) by failing to ensure the Physician's Order for Life-Sustaining Treatment (POLST - a written medical order that helps give residents with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness) form was complete for Resident 82. This deficient practice had the potential to result in Resident 82 receiving treatments that were undesired during the event of a medical crisis in which Resident 82 could no longer communicate Resident 82's wishes. Findings: A review of Resident 82's Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - lung disease causing restricted airflow and breathing problems). A review of Resident 82's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated [DATE], indicated Resident 82 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a concurrent interview and record review on [DATE] at 9:28 a.m., with the Medical Records Director (MRD), reviewed Resident 82's POLST, dated [DATE]. Resident 82's POLST indicated, it was signed by Resident 82 with wishes for cardiopulmonary resuscitation (CPR -an emergency life-saving procedure performed when the heart stops beating, by delivering artificial breaths and manual chest compressions), full treatment of medical interventions, and no wishes for artificially administered nutrition. The MRD stated Resident 82's POLST was lacking a date of when the POLST was signed by Resident 82 or relationship of the signee (self) and the physician's documentation of discussion with the resident and the physician's signature. The MRD stated it was the admitting nurse that helps the resident fill it out and if Resident 82 signed it, the form should be completed with the missing information. During an interview on [DATE] at 11:19 a.m., with Registered Nurse 2 (RN 2), RN 2 stated if a POLST is filled out by the resident but is not dated and not signed by the physician, then it is incomplete. RN 2 stated the resident's rights and preferences on treatment would be violated because the POLST would be deemed invalid, and the resident would be treated as full code status (all medical measures will be taken to bring the resident back to life) during an emergency situation. During an interview on [DATE] at 2:43 p.m., with the Director of Nursing (DON), the DON stated Resident 82's POLST documentation was incomplete. The DON further stated if something is missing such as the date and the physician's signature, the healthcare staff would have to treat the resident as a full code until the POLST was properly filled out. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Charting and Documentation, last reviewed ,d+[DATE], indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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** 38549 Based on observation, interview, and record review, the facility failed to maintain infection control practices for three of 24 sampled residents (Residents 337, 187, 188) by failing to: 1. Ensure a resident's nasal cannula (a medical device that provides supplemental oxygen or increased airflow to people who need respiratory help) was not touching the floor for Resident 187. 2. Ensure the urinals (a container used to collect urine) of Residents 187 and 188 were labeled with a resident identifier. These deficient practices had the potential to place the residents at increased risk of contracting an infection. 3. Label the intravenous (IV - into or by means of a vein or veins) administration set (medical device used to deliver IV fluids or medications) used to administer an antibiotic (medication that inhibits the growth of or destroys bacteria in the body) for Resident 337. This deficient practice had the potential to result in contamination of Resident 337's IV tubing and risked transmitting bacteria that could lead to further infection. Findings: 1. A review of Resident 187's Admission Record indicated the facility admitted the resident on 5/30/2024 with diagnoses including pneumonia (an infection that affects one or both lungs), acute (short-term) and chronic (long-term) respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that make it difficult to breathe and restrict airflow), and shortness of breath. A review of Resident 187's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/3/2024, indicated the resident had intact cognition (thought processes) and required maximum assistance from staff for some activities of daily living (ADLs - basic skills that allow someone to care for themselves independently). During a concurrent observation and interview on 6/10/2024 at 9:12 a.m., with Certified Nursing Assistant 4 (CNA 4), observed Resident 187 awake in bed with a nasal cannula on and the oxygen tubing touching the floor. CNA 4 confirmed by stating that Resident 187's oxygen tubing was touching the floor and immediately took it off the floor. CNA 4 stated it should not have been touching the floor. During an interview on 6/12/2024 at 4:10 p.m., with the Infection Preventionist (IP), the IP stated that residents' oxygen tubing should be kept off the floor because you wouldn't want anything that goes on the resident's body to be contaminated with bacteria. The IP stated there was a potential for the resident to get an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2024 at 4:19 p.m., with the Director of Nursing (DON), the DON stated that oxygen tubing should be kept off the floor for infection control reasons. The DON stated there was an increased risk for infection to the resident if the oxygen tubing was not kept off the floor. A review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated that floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/2023, indicated that an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards. Important facets of infection prevention include-instituting measures to avoid complications or dissemination and following established general and disease-specific guidelines such as those of the CDC. 2.a. A review of Resident 187's Admission Record indicated the facility admitted the resident on 5/30/2024 with diagnoses including pneumonia, acute and chronic respiratory failure, and chronic obstructive pulmonary disease. A review of Resident 187's MDS, dated [DATE], indicated the resident had intact cognition and required maximum assistance from staff for some activities of daily living. During a concurrent observation and interview on 6/10/2024 at 9:12 a.m., with CNA 4, observed Resident 187 awake in bed and was holding an unlabeled urinal. CNA 4 stated the urinal should have been labeled with the resident's name and the date of when it was given to him. During an interview on 6/12/2024 at 4:10 p.m., with the IP, the IP stated that resident equipment, such as urinals, should be labeled with the resident's room number, so staff knew to whom it belonged. The IP stated that, if not labeled, then there is a potential of cross-contamination, especially if the resident has a roommate. During an interview on 6/12/2024 at 4:19 p.m., with the DON, the DON stated that urinals should be labeled with the resident's name for infection control, so that staff could identify whom it belonged to, and it is not accidentally used for different residents. The DON stated there was an increased risk for residents to contract an infection if urinals are not labeled with a resident identifier. During an interview on 6/13/2024 at 10 a.m., with the Administrator (ADM), the ADM stated she could not find a specific policy addressing the labeling of urinals or resident equipment. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/2023, indicated that an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards. Important facets of infection prevention include-instituting measures to avoid complications or dissemination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.b. A review of Resident 188's Admission Record indicated the facility admitted the resident on 6/3/2024 with diagnoses including urinary tract infection (a common infection that occurs when bacteria enter the urinary tract and multiply). During a concurrent observation and interview on 6/10/2024 at 9:22 a.m., with the IP, observed Resident 188 asleep in bed with an unlabeled urinal at his bedside. The IP confirmed the observation by stating that Resident 188's urinal was not labeled and stated it should have been labeled with the resident's initials, so staff knew to whom it belonged. The IP stated doing so would lessen the risk of cross-contamination between residents. During an interview on 6/12/2024 at 4:19 p.m., with the DON, the DON stated that urinals should be labeled with the resident's name for infection control, so that staff could identify whom it belonged to, and it is not accidentally used for different residents. The DON stated there was an increased risk for residents to contract an infection if urinals are not labeled with a resident identifier. During an interview on 6/13/2024 at 10 a.m., with the Administrator (ADM), the ADM stated she could not find a specific policy addressing the labeling of urinals or resident equipment. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, last reviewed on 7/2023, indicated that an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program is based on accepted national infection prevention and control standards. Important facets of infection prevention include-instituting measures to avoid complications or dissemination. 49252 3. A review of Resident 337's Admission Record dated 6/13/2024, indicated the facility admitted the resident on 6/4/2024 with diagnoses that included lower leg osteomyelitis (a serious condition in which there's an infection of the bone caused by a bacteria or fungus) and diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). A review of Resident 337's MDS, dated [DATE], indicated Resident 337 had intact cognition. During an observation on 6/10/2024 at 10:08 a.m., in Resident 337's room, with Registered Nurse 2 (RN 2), observed RN 2 administer vancomycin (an antibiotic used to treat bacterial infections) 1500 milligrams (mg, a unit of measurement) intravenously to Resident 337 through the peripherally inserted central catheter line (PICC line - a long, thin tube inserted through a vein in the arm and passed through to the larger veins into the heart and is used to give medications, IV fluids [liquids or medications that are infused into the bloodstream] or draw blood) with an unlabeled intravenous administration tubing that was connected to the vancomycin bag. During a concurrent observation and interview on 6/10/2024 at 12:45 p.m., with RN 2, in Resident 337's room, observed Resident 337's vancomycin tubing administration set was unlabeled. RN 2 stated it should be labeled with a sticker of the date and time it was given and initials of the individual who administered the medication. RN 2 stated labeling is done for infection control, so the IV set (medication bag and tubing) can be changed as scheduled. RN 2 further stated they dropped the IV tubing label on the floor and didn't replace it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/2024 at 10:05 a.m., with the IP, the IP stated the IV administration set should be labeled by the nurse that prepares the medication for administration. The IP stated the label should contain the nurse's name, date, time, dose, and rate. The IP further stated nursing staff won't know how long ago it was prepared if the set is unlabeled. The IP stated there's a potential for the resident to get an infection or bacteria from it. The IP stated the best practice is to label the IV tubing that connects to the medication bag. A review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed 7/2023, indicated, For medications that are prepared or compounded for intravenous infusion, the label contains: .g. date and time of administration; h. initials of the person administering medication; and i. date after which the mixture cannot be used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Subacute and Nursing Center	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48678 Based on observation, interview, and record review, the facility failed to prevent the presence of insects and flies and seal off possible entryway for pests for one of one sampled resident (Resident 3). This deficient practice had the potential to cause an infection to 89 residents residing in the facility. Findings: A review of Resident 3's Admission Record indicated the facility admitted the resident on 12/12/2022 with diagnosis including cerebral infarction (disruption of blood flow to the brain due to problematic vessels that cause lack of blood supply and oxygen to the brain), hemiplegia, (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) affecting her right dominant side. A review of Resident 3's History and Physical (H&P- a term used to describe a physician's examination of a resident) indicated Resident 3 did not have the capacity to understand and make decisions. A review of Resident 3's Minimum Data Set (MDS- a standardized resident assessment and care screening tool) dated 5/31/2024, indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, toileting, getting dressed, rolling left and right, sitting up, standing up, lying down, and transferring from the bed to a chair. During an interview on 6/12/2024 at 12:45 p.m., with Resident 3's Family Member 2 (FM 2), FM 2 stated during his visit on 6/3/2024 at around 7:30 p.m., he noted there were three insects crawling out from small cracks in the walls in Resident 3's room and noted one insect crawling up the bathroom door in Resident 3's room. FM 2 stated he reported this to the registered nurse (RN) in charge that night. During a concurrent observation and interview on 6/12/2024 at 1:03 p.m., with RN 3 in Resident 3's room, a fly was observed flying over Resident 3's head, and RN 3 tried to swat it away while the Respiratory Therapist (RT) tried to suction (used to clear the airway of blood, saliva, or other secretions so that a patient may breathe). Resident 3's tracheostomy (trach-a tube placed in the windpipe to help someone breathe). RN 3 stated that a fly in the room increases the risk of infection for Resident 3 especially if the fly lands on Resident 3's trach because Resident 3 cannot move independently and cannot try to swat the fly away. During an interview on 6/12/2024 at 3:16 p.m., with the Infection Preventionist (IP), the IP stated that a fly in Resident 3's room could cause infection because flies carry bacteria, and if it were to land on Resident 3's trach, it could transfer bacteria or lay eggs, which would cause an infection to Resident 3. (continued on next page)

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2024 at 1:17 p.m., with the Maintenance Supervisor (MS), the MS stated windows should be screened, however there were rooms that had bent and broken screens from which insects and flies could easily enter residents' rooms. The MS stated window screens should be replaced or repaired to reduce the number of insects and flies that come inside the facility, because even if the facility is treated for pests, the treatment will not prevent insects from entering the facility through the gaps where the windows are not screened, or screens are broken. The MS stated the company who treats the facility noted a door that had a gap where flies and other insects could enter the facility, and recommended he cover the gap. A review of the facility's policy and procedure dated 6/2024, indicated the facility should maintain an on-going pest control program to ensure that the building is free of insects, and windows are always screened.