STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555718	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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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 - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, and medical record review, the facility failed to promote the dignity and respect for one of 13 final sampled residents (Resident 3). * Resident 3 was observed waiting for someone to assist him to eat his meals and CNA 3 was standing over Resident 3 while assisting the resident to eat his meal. This failure posed the risk of not treating the resident with respect. Findings: Medical record review for Resident 3 was initiated on 10/22/24. Resident 3 was admitted to the facility on [DATE]. Review of the resident's H&P examination dated 3/12/24, showed the resident had no capacity to understand and make decisions. Review of Resident 3's care plan initiated on 3/11/24, showed a care plan problem addressing the risk for altered nutritional status, weight fluctuation, and skin breakdown due to variable oral intake, with approaches in the plan of care to assist with set up trays during meals and assist with eating as needed. Review of Resident 3's MDS Significant Change in Status assessment dated [DATE], showed in section GG, functional abilities and goals, the resident had limitation in range of motion to both upper and lower extremities. Resident 3 required substantial or maximal assistance (helper does more than half the effort) when eating. On 9/3/24 at 0927 hours, an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed lying in bed with a breakfast tray on the overbed table in front of him. Resident 3 stated no one assisted him to eat breakfast and asked the surveyor to feed him. On 10/22/24 at 0930 hours, an interview was conducted with CNA 2. CNA 2 was informed of Resident 3 looking for someone to assist him to eat. CNA 2 stated there was an assigned staff to assist the resident to eat. CNA 2 further stated she would find out who was assigned to help the resident. (continued on next page)

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

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/22/24 at 0940 hours, an interview and concurrent observation with Resident 3 was conducted. Resident 3 stated he was hungry because he did not have his breakfast yet. The meal tray was observed in front of the resident. Resident 3 asked the surveyor to feed him. On 10/22/24 at 0945 hours, CNA 2 was observed assisting Resident 3 to eat. On 10/22/24 at 1206 hours, an observation with Resident 3 was conducted. The lunch meal tray was served to Resident 3. On 10/22/24 at 1212 hours, an observation with CNA 3 was conducted. CNA 3 was observed setting up the lunch meal tray, removing the plate cover, and placing the overbed table in front of the Resident 3. CNA 3 informed Resident 3 to wait for someone to assist the resident to eat. Resident 3 was observed looking at his food in front of him. Resident 3 asked CNA 3 when someone would come in to feed him. On 10/22/24 at 1215 hours, an interview with CNA 3 was conducted. CNA 3 stated he was assigned to another resident and could not start assisting the resident because he would need to stop when the lunch tray of his assigned residents arrived. On 10/22/24 at 1218 hours, an observation with Resident 3 was conducted. Resident 3 was observed asking CNA 3 who would be coming to feed him. CNA 3 responded to the resident, Someone is coming to help you. On 10/22/24 at 1220 hours, an observation with CNA 3 was conducted. CNA 3 was observed standing at Resident 3's bedside while assisting the resident who was lying on the bed to eat. On 10/22/24 at 1221 hours, an interview with CNA 3 was conducted. CNA 3 verified he was standing up while feeding the resident. CNA 3 was asked if he would like to sit down while feeding the resident. CNA 3 pulled a chair and sat. CNA 3 stated he needed to sit to be in the same level with the resident. On 10/29/24 at 1420 hours, an interview with the DON was conducted. The DON was informed and acknowledged the findings.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs for one nonsampled residents (Resident 545). * The facility failed to ensure the call light was within reach and accessible for Resident 545. This failure had the potential to negatively impact the resident's psychosocial well-being or result in a delay to receive care. Findings: Review of the facility's P&P titled Answering the Call Light revised September 2022 showed the following: - Upon admission and periodically as needed, explain and demonstrate the use of call light to the resident; - Ask the resident to return and demonstration; and - Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor; On 10/22/24 at 0953 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 545. Resident 545 was observed awake and lying in bed in her room. Resident 545 was observed with a blue sling wrapped on her right arm. Resident 545 stated she fell at home. When asked if she had any concerns, Resident 545 stated when she needed help going to the restroom, no one came every time she called using the call light. The call light was observed clipped to the outer side of the left upper bed rail. Resident 545 showed how she used the call light; however, Resident 545 was observed pressing the bed remote and stated it was the call light. Resident 545 was informed the call light was the one clipped to the outer side of left upper bed rail. When asked if she was able to reach the call light, Resident 545 stated she could not reach the call light. Medical record review for Resident 545 was initiated on 10/22/24. Resident 545 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 545's H&P examination dated 10/20/24, showed Resident 545 had fluctuating capacity to understand and make decisions. Review of Resident 545's MDS dated [DATE], showed Resident 545 had a BIMS score of 14 (cognitively intact) and needed substantial to maximal assistance with toileting hygiene (including how the resident maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) and with mobility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 1000 hours, an interview was conducted with LVN 1. LVN 1 verified the call light for Resident 545 was not within the resident's reach. LVN 1 stated the call light should always be placed within the resident's reach. LVN 1 was observed placing the call light within Resident 545's reach and started teaching and reminding Resident 545 on how to use the call light. On 10/29/24 at 1559 hours, an interview was conducted with the DON. The DON stated the expectations for the call light were to be placed within the resident's reach; and it should be always be working and answered as soon as possible. The DON was informed and acknowledged the above findings.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility document review, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 to one nonsampled resident (Resident 22) reviewed for beneficiary notification. The SNF ABN Form CMS-10055 was used to inform the residents of their potential financial liability and appeal rights and protections should they wish to receive care and services that may not be covered by Medicare. This failure had the potential for not allowing Resident 22 to make an informed decision regarding their Medicare services. Findings: Medical record review for Resident 22 was initiated on 10/29/24. Resident 22 was admitted to the facility on [DATE]. On 10/29/24 at 0940 hours, an interview and concurrent facility document review was conducted with the SSD. The SSD was asked to provide documentation of the SNF ABN Form CMS-10055 for Resident 22. The SSD stated Resident 22 had skilled days remaining but was discharged from Medicare Part A services and continued to live in the facility. The SSD further stated he missed to provide the SNF ABN form to Resident 22. The SSD verified the facility was not able to provide the SNF ABN form to Resident 22 or her representative. On 10/29/24 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48853 Based on interview, medical record, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for one of 13 final sampled resident (Resident 35) and one nonsampled resident (Resident 37). * The facility failed to develop a care plan problem to address Resident 35's use of antibiotic for UTI. * The facility failed to ensure a care plan problem was developed to address the risk of infection prevention and control related to education for Resident 37 and family member to provide the PureWick catheter supplies in a timely manner and cleaning of the collection canister, collector, and pump tubing. These failures posed the risk of not providing appropriate, consistent, and individualized care to the residents. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. Review of Resident 35's medical record was initiated on 10/22/24. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 9/17/24, showed Resident 35 had fluctuating capacity to understand and make decisions. Review of Resident 35's Order Summary Report dated 10/22/24, showed a physician's order dated 10/20/24, for Levaquin (an antibiotic medication that treats bacterial infections) 500 mg one tablet by mouth one time a day for abnormal urinalysis (a medical test that examines urine to check for urinary tract infections, kidney problems, or diabetes) for seven days. Review of Resident 35's MAR showed Levaquin 500 mg one tablet by mouth one time a day was administered to the resident on 10/20 and 10/21/24. Review of Resident 35's Plan of Care failed to show documented evidence of a care plan problem developed to address Resident 35's use of Levaquin for UTI. On 10/25/24 at 1050 hours, an interview and concurrent record review was conducted with LVN 4. LVN 4 verified Resident 35's plan of care failed to show a care plan problem was developed for the use of Levaquin medication for UTI. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 1054 hours, an interview and concurrent record review was conducted with the ADON. The ADON verified there was no care plan developed for Resident 35 for the use of Levaquin medication for UTI. On 10/29/24 at 1424 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. 49324 2. According to the BD manufacturer's recommendation on cleaning the PureWick's collection canister, the collection canister, canister lid, collector tubing, pump tubing, and PureWick Urine Collection System base should be cleaned and disinfected at the time of each use, or at a minimum daily. The power cord should be cleaned and disinfected at the time of each use, or at a minimum daily. Gloves should be worn when handling soiled or dirty accessories. The manufacturer's guidelines also showed specific procedure or steps to clean the Purewick's collection canister. Medical record review for Resident 37 was initiated on 10/22/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed a physician's order dated 6/20/24, for PureWick catheter attached to canister- may drain every shift and PRN when the resident is in bed. Another physician's order dated 6/20/24, showed may remove the PureWick catheter when out of bed, in the wheelchair per the resident's request. Review of Resident 37's H&P examination dated 6/21/24, showed Resident 37 had the capacity to understand and make decisions. Review of Resident 37's MDS dated [DATE], showed the BIMS score of 15 (a person's cognition is intact:). Review of Resident 37's MDS dated [DATE], under Section H, showed the use of external catheter appliance. Under the section for urinary incontinence showed Resident 37 was occasionally incontinent. Review of Resident 37's last change in condition evaluation was dated 10/6/24, showed the resident had an open skin to the right lateral lower thigh. Review of Resident 37's care plan showed no care plan to address the risk of infection control related to education Resident 37 and family member on providing PureWick catheter supplies in a timely manner. There was no care plan developed to address the cleaning of the collection canister, collector, and pump tubing. On 10/22/24 at 1021 hours, an observation was conducted in Resident 37's room. Resident 37's PureWick collection canister was observed to have dry, dark green residue. There was no label and date shown when the PureWick canister, collector, and pump tubing were last cleaned or changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 1032 hours, a concurrent room observation and interview was conducted with LVN 2. LVN 2 acknowledged the PureWick collection canister had a dry, dark green residue. When asked about the PureWick canister, collector, and tubing were last changed or cleaned, LVN 2 stated Resident 37's family member brought the PureWick catheter supplies to the facility. LVN 2 further stated he was not familiar with the PureWick catheter care. LVN 2 added LVN 3 would know more for further details. On 10/22/24 at 1045 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the PureWick collection canister had a dry dark green residue. When LVN 3 was asked when the PureWick canister, collector and tubing were last changed or cleaned, LVN 3 stated she was not informed nor could provide any documentation when the PureWick canister, collector and tubing were last changed and could not provide any information or documentation on when Resident 37's family member had last brought any PureWick catheter supplies. LVN 3 also acknowledged no care plan problem was developed to address the risk of infection control related to education for Resident 37 and the resident's family member regarding the provision of PureWick catheter care and supplies that were needed in a timely manner. On 10/22/24 at 1105 hours, an interview was conducted with Resident 37. Resident 37 stated she could not recall when the new PureWick canister and other supplies were brought by her family member. Resident 37 stated she and her family member were not provided with an education on the importance or reason for bringing the PureWick catheter supplies in a timely manner and not aware how her PureWick canister, collector, and tubing should have been cleaned by the facility staff. Resident 37 stated a new PureWick canister and other supplies would be provided by her family member. On 10/22/24 at 1101 hours, a concurrent observation and interview was conducted with the ADON. The ADON stated the PureWick canister should not have a dry, dark green residue and should have been checked by the staff every shift. The ADON acknowledged the staff were unable to determine when the PureWick canister was last changed nor cleaned. The ADON also verified there was no care plan problem developed to address the risk of infection prevention and control related to education for Resident 37 and resident's family member regarding the provision of PureWick catheter care and supplies that were needed in a timely manner. On 10/29/24 at 1635 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure injury and promote healing of existing pressure ulcer for one of one final sampled resident (Resident 41) reviewed for pressure injury. * Resident 41 developed a Stage 3 pressure injury to the coccyx after admission to the facility. The facility failed to ensure Resident 41 was provided with high protein snacks at bedtime as recommended by the RD. In addition, LVN 3 failed to provide protective barrier to protect the wound during wound care per facility P&P. These failures posed Residents 41 at risk for developing new pressure ulcers and worsening of the existing pressure ulcer. Findings: Review of the facility's P&P titled Wound Care undated showed the purpose of this procedure is to provide guidelines for the care of wound to promote healing. The procedure section includes to position the resident and place disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Medical record review for Resident 41 was initiated on 10/22/24. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's Admit/Screener 3.0 dated 8/16/24, showed an assessment of the resident's skin integrity with no pressure injury identified. Review of the physician's order dated 8/16/24, showed an order for enhanced barrier precaution related to use of medical device, indwelling urinary catheter. Review of Resident 41's H&P examination dated 8/19/24, showed the resident had capacity to understand and make decisions. Review of the physician's order dated 8/23/24, showed an order to give HS snack. Review of Resident 41's care plan revised on 8/29/24, showed a care plan problem addressing the risk for altered nutritional status, and weight fluctuation, skin breakdown, with an approach to provide HS snack daily. Review of Resident 41's Weekly Observation Tool dated 9/20/24, showed the resident acquired Stage 2 pressure injury to the coccyx area, measuring 1.0 cm (length) x 1.5 cm (width) x 0.1 cm (depth). Review of Resident 41's Nutrition/Dietary Note dated 10/2/24, showed appropriate high protein HS snacks continuing in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 41's care plan updated 10/7/24, showed a care plan problem addressing altered skin integrity related to Stage 3 pressure injury with the intervention including to give nutritional/dietary supplements as ordered. However, the care plan was not revised to show the high protein HS snacks as per the RD's note. Further review of Resident 41's Weekly Observation Tool dated 10/8/24, showed worsening of the pressure injury of the coccyx, SDTI, measuring 3.0 cm x 2.5 cm x 0.1 cm, with a 100% slough wound bed. Review of the physician's order dated 10/11/24, showed an order to perform wound care to the coccyx (tailbone) pressure injury sore as follows: to cleanse with NSS, pat and dry, apply a collagen dressing, cover with an optifoam dressing daily for 21 days. Review of Resident 41's TAR for 10/1/24 -10/31/24, showed an entry to provide dated 10/12/24, treatment to the coccyx pressure injury sore, to cleanse with NSS, pat and dry, apply collagen, cover with an optifoam dressing daily for 21 days. On 10/24/24 at 0855 hours, a wound care observation for Resident 41's coccyx was conducted with LVN 3. LVN 3 was observed to remove the dressing from the wound and exposed the wound bed to the resident's diaper. LVN 3 cleansed the coccyx pressure injury with NSS, applied a collagen dressing, and covered with an optifoam dressing. On 10/24/24 at 0910 hours, an interview was conducted with the LVN 3. LVN 3 verified she did not use protective barriers to protect the wound base when doing the treatment for the resident and exposed the wound to the resident's diaper. On 10/25/24 at 1007 hours, an interview with LVN 3 was conducted. LVN 3 verified Resident 41's Stage 3 pressure injury in the coccyx developed in the facility. On 10/25/24 at 1034 hours, an interview with the DON was conducted. The DON verified Resident 41's Stage 3 pressure injury in the coccyx was developed in the facility. The DON verified Resident 41's HS snack was ordered on 8/23/24, and should have been high protein snacks. On 10/29/24 at 1323 hours, an interview with the RD was conducted. The RD stated she recommended high protein snacks which should include cottage cheese and yogurt for the Resident 41. The RD verified Resident 41's current order was HS snacks. On 10/29/24 at 1425 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to prevent urinary tract infections for two of three sampled residents (one final sampled resident, Resident 41; and one nonsample resident, Resident 37) reviewed for urinary catheter care. * The staff failed to ensure proper monitoring and care for Resident 37's Pure Wick collection canister. Resident 37's Pure Wick collection canister was observed to have dry, dark green residue. * The facility failed to ensure Resident 41's indwelling urinary catheter drainage bag was positioned below the resident's bladder and prevent tugging of the catheter for adequate urinary drainage and resident discomfort. Resident 41's indwelling urinary catheter tubing was observed on the floor under the resident's bed. These failure posed the risk for Residents 37 and 41 to develop catheter-associated urinary tract infections. Findings: 1. According to the BD manufacturer's recommendation for cleaning the PureWick's collection canister, the collection canister, canister lid, collector tubing, pump tubing, and PureWick Urine Collection System base should be cleaned and disinfected at the time of each use, or at a minimum daily. The power cord should be cleaned and disinfected at the time of each use, or at a minimum daily. Note: Gloves should be worn when handling soiled or dirty accessories. The manufacturer's guidelines showed the following: Cleaning: Prepare a soapy solution by mixing one teaspoon (approximately 5 ml) of dish soap with 1 gallon (approximately 4 liters) of cool tap water. Fully submerge canister and lid in the solution. Allow it to sit for a minimum of ten minutes. While submerged, use of a toothbrush to brush all accessible areas of the canister and lid for a minimum of one minute to remove any visible signs of debris or dirt. Rinsing: Rinse the canister and the lid thoroughly with cool tap water until there is no visible signs of the cleaning solution. Visual Inspection: Inspect the canister and the lid to ensure that all debris and dirt have been removed. If there is any sign of debris or dirt, repeat steps above until there is no sign of debris or dirt remaining on the canister and lid. Disinfection: Fully submerge the canister and lid in 70% isopropyl alcohol (IPA). Allow it to sit for a minimum of ten minutes. Rinse: Rinse the canister and the lid thoroughly with cool tap water. Drying: Dry the canister and lid with clean low tint towel or cloth. Cleaning the Collector and Pump Tubing. Instructions for cleaning the collector tubing with elbow connector and pump tubing showed the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Initial Rinse: Disconnect the connector and disconnect the elbow connector from the lid. Rinse the disconnected tubing thoroughly by running cool tap water through the inside of the tubing. While rinsing, remove any excess dirt by wiping the outside of the tubing and elbow connector with low lint disposable wipes. While rinsing, flush the tubing with cool tap water to remove any excess dirt. - Cleaning: Prepare a soapy solution by mixing one teaspoon (approximately 5 ml) of dish soap with one gallon of cool tap water. Completely submerge the tubing and elbow connector in the solution and allow it to soak for a minimum of ten minutes. At the beginning of the soak time, flush the inside of the tubing with the prepared solution. While submerged, use a soft toothbrush to brush all accessible areas of the tubing and elbow connector for a minimum of one minute to remove any visible signs of debris or dirt. - Rinsing: Rinse the tubing and elbow connector thoroughly with cool tap water until there is no visible sign of soap cleaning solution. While rinsing, flush the inside of the tubing with tap water. - Visual Inspection: Inspect the tubing to ensure that all debris and dirt have been removed. If there is any sign of debris or dirt, repeat the steps above until there is no sign of debris or dirt remaining on or inside the tubing. - Disinfection: Fully submerge the tubing and elbow connector in 70% isopropyl alcohol (IPA). Allow it to soak for a minimum of ten minutes. Flush the IPA through the tubing, prior to starting the ten-minute time. - Rinse: Rinse the tubing and elbow connector thoroughly with cool tap water, ensuring that the inside of the tubing is flushed with water. - Drying: Dry the tubing and elbow connector outer surface with a clean low lint towel or cloth and allow the inside of the tubing to air dry for a minimum of thirty minutes at room temperature. Medical record review for Resident 37 was initiated on 10/22/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed a physician's order dated 6/20/24, for PureWick catheter attached to canister, may drain every shift and PRN when the resident is in bed. Another physician's order dated 6/20/24, showed may remove the PureWick catheter when out of bed in the wheelchair per the resident's request. Review of Resident 37's H&P examination dated 6/21/24, showed Resident 37 had the capacity to understand and make decisions. Review of Resident 37's MDS dated [DATE], showed the BIMS score of 15 (a person's cognition is intact:). Review of Resident 37's MDS dated [DATE], under Section H, showed the use of an external catheter appliance. The section for urinary incontinence showed Resident 37 was occasionally incontinent. Review of Resident 37's last change in condition evaluation was dated 10/6/24, showed the resident with an open skin to the right lateral lower thigh. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Cleaning and Maintenance of PureWick In-services dated 2/16, 2/24, and 2/25/24, provided by the IP showed not all staff had attended the in-service. The in-services sign in sheet showed no attendance of LVNs 2 and 3. On 10/22/24 at 1021 hours, an observation was conducted in Resident 37's room. Resident 37's PureWick collection canister was observed to have dry, dark green residue. There was no label and date shown when the PureWick canister, collector and pump tubing were last cleaned or changed. On 10/22/24 at 1032 hours, a concurrent room observation and interview was conducted with LVN 2. LVN 2 acknowledged the PureWick collection canister had a dry, dark green residue. When asked when the PureWick canister, collector, and tubing were last changed or cleaned, LVN 2 stated Resident 37's family member was bringing the PureWick catheter supplies to the facility. LVN 2 further stated he was not familiar with the PureWick catheter care. LVN 2 added LVN 3 would know more for further details. On 10/22/24 at 1045 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the PureWick collection canister had a dry dark green residue. When LVN 3 was asked when the PureWick canister, collector, and tubing were last changed or cleaned, LVN 3 stated she was not informed nor could provide any documentation when the PureWick canister, collector, and tubing were last changed and could not provide any information or documentation on when Resident 37's family member had last brought any PureWick catheter supplies. LVN 3 also acknowledged PureWick catheter care was something new to her. On 10/22/24 at 1101 hours, a concurrent observation and interview was conducted with the ADON. The ADON stated the PureWick canister should not have a dry, dark green residue and should have been checked by the staff every shift. The ADON acknowledged the staff were unable to determine when the PureWick canister was last changed nor cleaned. The ADON also verified the PureWick canister was something new to the staff. On 10/24/24 at 0853 hours, an interview was conducted with the DSD/Acting IP. The DSD/Acting IP acknowledged the PureWick Catheter care was something new and it was her first time to encounter a resident with PureWick catheter. The DSD/Acting IP also verified not all the staff attended the in-service about the PureWick catheter care and the in-service should have been provided to all the facility staff. On 10/29/24 at 1635 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 48853 2. Medical record review for Resident 41 was initiated on 10/22/24. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 8/19/24, showed the resident had capacity to understand and make decisions. Review of Resident 41's Order Summary Report dated 10/25/24 showed the following physician's orders: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order dated 10/10/24, may insert Foley catheter (20 Fr/30 ml) as needed. - an order dated 8/16/24, to provide Foley catheter care every shift. Review of Resident 41's care plan initiated on 8/17/24, and revised on 8/28/24, showed a care plan problem addressing at risk for infection due to use of the Foley catheter with approach to plan of care to avoid and check for kinks in tubing, keep drainage system closed, and to ensure collection unit positioned below the resident's bladder. On 10/29/24 at 0851 hours, an interview with Resident 41 was conducted. Resident 41 stated it felt the catheter was tight. Resident 41's indwelling urinary catheter drainage bag was observed on the floor under the resident's bed. On 10/29/24 at 0900 hours, an interview with the ADON was conducted. The ADON verified the resident's indwelling urinary catheter drainage bag was on the floor. The ADON stated the indwelling urinary catheter drainage bag was not supposed to be on the floor. The ADON hanged the indwelling catheter drainage bag on the resident's bed frame.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, and medical record review, the facility failed to ensure one of seven final sampled residents (Residents 38) reviewed for respiratory care was provided the appropriate respiratory care. * The facility failed to ensure Resident 38's storage bag for the Yankauer suction tip was changed weekly. This failure had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Medical record review for Resident 38 was initiated on 10/22/24. Resident 38 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 38's H&P examination dated 5/7/24, showed Resident 38 did not have the capacity to understand and make decisions. Review of Resident 38's Order Summary Report for October 2024, showed a physician's order dated 5/27/24, to suction oral secretions as needed for excessive secretions. On 10/22/24 at 0935 hours, a concurrent observation and interview was conducted with LVN 5 in Resident 38's room. LVN 5 verified Resident 38's storage bag for theYankauer suction tip was dated 10/4/24. LVN 5 stated the respiratory storage bags including the bag for the Yankauer suction tip which was to be changed weekly on Thursdays and should have been changed. LVN 5 stated changing the storage bags weekly was to ensure infection control would be maintained and limited bacteria build up. On 10/29/24 at 1625 hours, and interview with the DON was conducted. The DON stated the respiratory supplies and storage bags were expected to be replaced weekly or as needed, and Resident 38's storage bag for the Yankauer suction tip should have been replaced. The DON acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure 13 of 13 final sampled residents reviewed for side rail use (Residents 6, 8, 10, 14, 15, 23, 30, 35, 37, 38, 41, 545, and 602) were assessed to ensure the safety use of side rails. * The facility failed to ensure the risks of entrapment assessments were completed prior to the use of side rails and failed to ensure the bed dimensions appropriate for the residents' sizes and weights for Residents 6, 8, 10, 14, 15, 23, 30, 35, 37, 38, 41, 545, and 602. This failure had the potential to put the residents at risk for entrapment and serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Entrapment/Bed Assessment revised 10/2018 showed the following: - The resident is assessed for the use of bed rails, which includes a review of risks including entrapment; - The facility must ensure the bed is appropriate for the resident and that the bed rails are properly installed and maintained. - Assess the resident for risk of entrapment from bed rails prior to installation; and - Ensure that the bed's dimensions are appropriate for the resident's size and weight. Review of the facility's P&P titled Proper Use of Side Rails revised 10/2018 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using the side rails on admission, bed change, quarterly, and as needed. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility, ability to change positions, transfer to and from bed or chair, and to stand and toilet, risk of entrapment from the use of side rails, and the bed's dimensions are appropriate for the resident's size and weight. 1. Review of Resident 35's medical record was initiated on 10/22/24. Resident 35 was admitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 35's H&P examination dated 9/17/24, showed Resident 35 had fluctuating capacity to understand and make decisions. Review of Resident 35's Admission MDS assessment dated [DATE], showed the resident's BIMS Summary Score of 9 (indicates moderate cognitive impairment). The resident was able to make self-understood and understand others. Resident 35's functional abilities showed impairment on one side of the resident's upper extremity and no functional limitation impairment of both sides of lower extremity. Review of Resident 35's Order Summary Report dated 9/17/24, showed a physician's order for the use of bilateral 1/4 side rails while in bed as enabler for bed mobility. Review of Resident 35's Side Rails Screening Tool dated 9/17/24, showed the IDT had recommended the use of the bilateral 1/4 side rails due to generalized weakness and decreased mobility and requiring assistance with bed mobility resident will be able to use side rails as grab device for bed mobility and assistance. However, further review of Resident 35's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/23/24 at 0833 hours, Resident 35 was observed lying in bed with bilateral upper 1/4 bed rails elevated. On 10/25/25 at 1548 hours, an interview with the RA was conducted. The RA fail to provide the measurement of assessment for Resident 35's bed. The RA stated he generally measured the bed but did not measure the bed dimensions for the resident's height or body size. On 10/29/24 at 1422 hours, an interview with the DON was conducted. The DON made aware of the findings. 2. Medical record review for Resident 41 was initiated on 10/22/24. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 8/19/24, showed the resident had capacity to understand and make decisions. Review of Resident 41's Admission MDS assessment dated [DATE], showed the resident's BIMS Summary Score of 14 (indicates that a person's cognition is intact). The resident was able to make self-understood and understand others. Resident 41's functional abilities assessment showed no functional limitation impairment of both sides of upper and lower extremities. Review of Resident 41's Order Summary Report for October 2024 showed a physician's order for the use of bilateral 1/4 side rails while in bed as enabler for bed mobility. Review of Resident 41's Side Rails Screening Tool dated 8/18/24, showed the IDT had recommended use of bilateral 1/4 side rails due to decreased mobility and generalized weakness requiring assistance with bed mobility and transfers to use as positioning device for bed mobility and assistance. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, further review of Resident 41's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/24/24 at 0800 hours, Resident 41 was observed lying in bed with bilateral upper 1/4 bed rails elevated. On 10/24/24 at 0801 hours, an interview with Resident 41 was conducted. Resident 41 stated he used the side rails to pull himself up. On 10/25/25 at 1548 hours, an interview with the RA was conducted. The RA fail to provide the measurement of assessment for Resident 41's bed. The RA stated he generally measured the bed but did not measure the bed dimensions for the resident's height or body size. On 10/29/24 at 1422 hours, an interview with the DON was conducted. The DON made aware of the findings. 47474 3. Medical record review for Resident 10 was initiated on 10/22/24. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 9/12/24, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Order Summary Report dated October 2024 showed a physician's order dated 9/11/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Further review of Resident 10's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/22/24 at 0907 hours, Resident 10 was observed laying in bed with bilateral upper 1/4 side rails elevated. 4. Medical record review for Resident 23 was initiated on 10/22/24. Resident 23 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 23's H&P examination dated 9/26/24, showed Resident 23 had capacity to understand and make decisions. Review of Resident 23's Order Summary Report dated September 2024, showed a physician's order dated 9/26/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Further review of Resident 23's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/22/24 at 0905 hours, Resident 23's bed was observed with bilateral upper 1/4 side rails elevated. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Medical record review for Resident 38 was initiated on 10/22/24. Resident 38 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 5/7/24, showed Resident 38 had no capacity to understand and make decisions. Review of Resident 38's Order Summary Report dated October 2024, showed a physician's order dated 5/6/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Further review of Resident 38's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/22/24 at 0929 hours, Resident 38 was observed laying in bed with bilateral upper 1/4 side rails elevated. 6. Medical record review for Resident 602 was initiated on 10/22/24. Resident 602 was admitted to the facility on [DATE]. Review of Resident 602's H&P examination dated 10/21/24, showed Resident 602 had capacity to understand and make decisions. Review of Resident 602's Order Summary Report dated October 2024, showed a physician's order dated 10/21/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Further review of Resident 602's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/24/24 at 0909 hours, Resident 602 was observed laying in bed with bilateral upper 1/4 side rails elevated. On 10/25/25 at 1547 hours, a concurrent interview and facility document review with the RA was conducted. The RA was not able to show documented evidence the risk for entrapment assessment conducted for Residents 10, 23, 38, and 602. The RA verified he did not measure the zones of entrapment specific to each resident's body weight and height. The RA stated he should have accurate conducted the entrapment assessments to ensure the residents would be free from entrapment and injuries with the use of the side rails. On 10/29/24 at 1625 hours, and interview with the DON was conducted. The DON acknowledged the above findings. 49258 7. On 10/22/24 at 0950 hours, 10/23/24 at 1545 hours, and 10/25/24 at 1445 hours, Resident 6 was observed in bed with bilateral upper side rails elevated. Medical record review for Resident 6 was initiated on 10/25/24. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's H&P examination dated 2/25/24, showed Resident 6 had fluctuating capacity to understand and make decisions. Review of Resident 6's MDS dated [DATE], showed Resident 6 had moderate cognitive impairment, with no impairment to the upper extremities, with impairment to both lower extremities, and dependent with mobility. Review of Resident 6's Order Summary Report showed a physician's order dated 2/25/24, for bilateral 1/4 (quarter) side rails up when in bed as enabler for bed mobility. Review of the Side Rails Screening Tool dated 8/20/24, showed the reason for the use of the side rails were to support self during care (holding rail to stay positioned while caregiver is providing care), to place bed control where resident can easily reach, and to give the resident the sense of security and comfort by managing the fear of rolling out of bed when turning. The form further showed the potential risks of the side rails use were strangling, suffocating, bodily injury, or death where residents or part of their body get caught between the rails or between the bed rails and mattress. However, further review of Resident 6's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/25/24 at 1456 hours, an interview was conducted with LVN 4. When asked about Resident 6's use of bed rails, LVN 4 stated Resident 6 used the bed rails when turning on her side during personal care. LVN 4 further stated Resident 6 had been using the bed rails for a long time. 8. On 10/22/24 at 1157 hours, 10/23/24 at 1540 hours, and 10/25/24 at 1440 hours, Resident 14 was observed in bed with bilateral upper side rails elevated. Medical record review for Resident 14 was initiated on 10/25/24. Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 14's H&P examination dated 3/4/24, showed Resident 14 had fluctuating capacity to understand and make decisions. Review of Resident 14's MDS dated [DATE], showed Resident 14 had moderate cognitive impairment, with impairment to both sides of upper and lower extremities, and dependent with mobility. Review of Resident 14's Order Summary Report showed a physician's order dated 4/15/22, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Review of the Side Rails Screening Tool dated 9/3/24, showed the reason for the use of the side rails were to support self during care (holding rail to stay positioned while caregiver is providing care), to place bed control where resident can easily reach, and to give the resident the sense of security and comfort by managing the fear of rolling out of bed when turning. The form further showed the potential risks of the side rails use were strangling, suffocating, bodily injury, or death where residents or part of their body get caught between the rails or between the bed rails and mattress. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, further review of Resident 14's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/25/24 at 1456 hours, an interview was conducted with LVN 4. When asked about Resident 14's use of bed rails, LVN 4 stated Resident 14 used the bed rails during repositioning and Resident 14 held on the bed rails during personal care when being turned on one side. LVN 4 further stated Resident 14 had been using the bed rails for a long time. 9. On 10/23/24 at 0953 hours, 10/24/24 at 1100 hours, and 10/25/24 at 1430 hours, Resident 15 was observed in bed with bilateral upper side rails elevated. Medical record review for Resident 15 was initiated on 10/25/24. Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 15's H&P examination dated 11/10/23, showed Resident 15 had no capacity to understand and make decisions. Review of Resident 15's MDS dated [DATE], showed Resident 15 had severe cognitive impairment, with impairment to both sides of upper and lower extremities, and dependent with mobility. Review of Resident 15's Order Summary Report showed a physician's order dated 11/13/23, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Review of the Side Rails Screening Tool dated 8/1/24, showed the reason for the use of the side rails were to get in and out of bed safely, to transfer from bed to wheelchair or vice versa, support self during care (holding rail to stay positioned while caregiver is providing care), to scoot self-up in bed to maintain proper positioning, to place bed control where resident can easily reach, and to give the resident the sense of security and comfort by managing the fear of rolling out of bed when turning. The form further showed the potential risks of the side rails use were strangling, suffocating, bodily injury, or death where residents or part of their body get caught between the rails or between the bed rails and mattress. However, further review of Resident 15's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/25/24 at 1448 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 15's used of the bilateral 1/4 bed rails. CNA 4 stated Resident 15 had been using the bed rails for assistance with bed mobility and turning. 10. On 10/22/24 at 1004 hours, 10/23/24 at 0800 hours, and 10/25/24 at 1400 hours, Resident 30 was observed in bed with bilateral upper side rails elevated. Medical record review for Resident 30 was initiated on 10/25/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's H&P examination dated 10/2/24, showed Resident 30 had no capacity to understand and make decisions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 30's MDS dated [DATE], showed Resident 30 was cognitive intact, with impairment to both sides of upper and lower extremities, and needed substantial assistance to partial and moderate assistance with mobility. Review of Resident 30's Order Summary Report showed a physician's order dated 10/1/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Review of the Side Rails Screening Tool dated 9/30/24, showed the reason for the use of the side rails were to support self during care (holding rail to stay positioned while caregiver is providing care) and to place bed control where resident can easily reach. The form further showed the potential risks of the side rails use were strangling, suffocating, bodily injury, or death where residents or part of their body get caught between the rails or between the bed rails and mattress. However, further review of Resident 30's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. On 10/25/24 at 1448 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 30's used of the bilateral 1/4 bed rails. CNA 4 stated Resident 30 would hold on to the bed rails during repositioning and when being provided with personal care. 11. On 10/22/24 at 1056 hours, 10/23/24 at 0830 hours, and 10/25/24 at 0850 hours, Resident 545 was observed in bed with bilateral upper side rails elevated. Medical record review for Resident 545 was initiated on 10/25/24. Resident 545 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 545's H&P examination dated 10/20/24, showed Resident 545 had fluctuating capacity to understand and make decisions. Review of Resident 545's MDS dated [DATE], showed Resident 545 was cognitively intact and needed substantial to maximal assistance with mobility. Review of Resident 545's Order Summary Report showed a physician's order dated 10/21/24, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Review of the Side Rails Screening Tool dated 10/18/24, showed the reason for the use of the side rails were to transfer from bed to wheelchair or vice versa, to transfer from bed to the bedside commode, to hold on to the side rail when standing up from bed, support self during care (holding rail to stay positioned while caregiver is providing care), to scoot self-up in bed to maintain proper positioning, when changing from lying to sitting position, and to place bed control where resident can easily reach, and to give the resident the sense of security and . The form further showed the potential risks of the side rails use were strangling, suffocating, bodily injury, or death where residents or part of their body get caught between the rails or between the bed rails and mattress. However, further review of Resident 545's medical record failed to show documented evidence of the side rail entrapment assessment was completed and documented prior to the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/24 at 1456 hours, an interview was conducted with LVN 4. When asked about Resident 545's use of bed rails, LVN 4 stated Resident 545 used the bed rails when turning, repositioning, and for transfer. On 10/25/25 at 1548 hours, a concurrent interview and facility record review was conducted with the RA. The RA failed to provide the bed inspection and side rail risk and entrapment assessments conducted for Residents 6, 14, 15, 30, and 545. when asked, the RA stated he generally conducted the bed zone measurements but did not inspect or measure the bed's dimensions per the resident's size, weight, and height. On 10/29/24 at 1559 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 6, 14, 15, 30, and 545. 49324 12. Medical record review for Resident 8 was initiated on 10/22/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident s H&P examination dated 11/12/23, showed Resident 8 had the capacity to understand and make decisions. Review of Resident 8's MDS dated [DATE], showed the resident's BIMS score of 15 (a person's cognition is intact). Review of Resident 8 's Order Summary Report showed a physician's order dated 11/3/22, for bilateral 1/4 side rails up when in bed as enabler for bed mobility. Further review of Resident 8's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/22/24 at 1034 hours, an observation was conducted on Resident 8's room. Resident 8's bed had bilateral upper 1/4 side rails. On 10/25/25 at 1547 hours, a concurrent facility record review and interview was conducted with the RA. When the RA was asked if he had any documentation showing the risk of entrapment assessment on Resident 8, the RA was not able to provide the documentation for the risk for entrapment assessment conducted for Resident 8. The RA verified he did not measure the zones of entrapment specific to each resident's body weight and height. On 10/29/24 at 1625 hours, and interview with the DON was conducted. The DON acknowledged the above findings. 13. Medical record review for Resident 37 was initiated on 10/22/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 6/21/24, showed Resident 37 had the capacity to understand and make decisions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 37's MDS dated [DATE], showed the resident's BIMS score of 15 (a person's cognition is intact). Review of Resident 37's Order Summary Report showed a physician's order dated 6/21/24, for bilateral side rails up when in bed as enabler for bed mobility. However, further review of Resident 37's medical record showed no documented evidence the side rail entrapment assessment was completed prior to the use of side rails. On 10/22/24 at 1021 hours, an observation was conducted on Resident 37's room. Resident 37's bed had the bilateral upper 1/4 side rails elevated. On 10/25/25 at 1547 hours, a concurrent facility record review and interview was conducted with the RA. When the RA was asked if he had any documentation for the risk of entrapment assessment on Resident 37, the RA was not able to provide the documentation for the risk of entrapment assessment conducted for Resident 37. The RA verified he did not measure the zones of entrapment specific to each resident's body weight and height. On 10/29/24 at 1625 hours, an interview with the DON was conducted. The DON acknowledged the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the specific competencies and skill sets necessary to care for the residents' needs. * The facility failed to ensure the Certification of Infection Preventionist Training Course was updated for the DSD/Acting IP. * The facility failed to ensure the nursing staff' competency on how to care for Resident 37's pure wick canister, collector and tubing. These failures had the potential to negatively impact the resident's well-being. Findings: 1. Review of the facility's P&P titled Infection Preventionist revised 2001 showed the infection preventionist is responsible for coordinating the implementation and updating of the infection prevention and control program. Qualifications: 1. The infection preventionist is qualified by education, training, experience and/or certification and has sufficient knowledge to perform the role. 2. The infection preventionist remains current with infection prevention and control issues and is aware of national organizations' guidelines as well as those from national/state/local public health authorities. On 10/28/24 at 0955 hours, a concurrent certification record review and interview was conducted with the DSD/Acting IP. The DSD/Acting IP's Certification of Nursing Home Infection Preventionist Training Course was on 9/11/22. When the DSD/Acting IP was asked if it was overdue, the Acting IP stated it should be due. On 10/29/24 at 1635 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 2. According to the BD manufacturer's recommendation on cleaning the PureWick's collection canister, the collection canister, canister lid, collector tubing, pump tubing, and PureWick Urine Collection System base should be cleaned and disinfected at the time of each use, or at a minimum daily. The power cord should be cleaned and disinfected at the time of each use, or at a minimum daily. Note: Gloves should be worn when handling soiled or dirty accessories. The manufacturer's guidelines also showed the specific procedures and steps for cleaning and how to care for them. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled In- Service Training showed all staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation included all staff are required in regular in-service education. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. Required training topics include the following: - Effective communication with residents and family (direct care staff). - The infection prevention and control program standards, policies and procedures. Medical record review for Resident 37 was initiated on 10/22/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed a physician's order dated 6/20/24, for PureWick catheter attached to canister- may drain every shift and PRN when the resident is in bed. Another physician's order dated 6/20/24, showed may remove the PureWick catheter when out of bed, in the wheelchair per the resident's request. Review on Cleaning and Maintenance of Pure Wick In-services dated 2/16, 2/24, and 2/25/24 provided by the IP showed not all staff attended the in-service. The in-services document showed no attendance of LVNs 2 and 3. On 10/22/24 at 1032 hours, a concurrent room observation and interview was conducted with LVN 2. LVN 2 acknowledged the PureWick collection canister had a dry, dark green residue. When asked when the PureWick canister, collector, and tubing were last changed or cleaned, LVN 2 stated Resident 37's family member was bringing the PureWick catheter supplies to the facility. LVN 2 further stated he was not familiar with the PureWick catheter care. LVN 2 added LVN 3 would know more for further details. On 10/22/24 at 1045 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the PureWick collection canister had a dry dark green residue. When LVN 3 was asked when the PureWick canister, collector, and tubing were last changed or cleaned, LVN 3 stated she was not informed nor could provide any documentation when the PureWick canister, collector, and tubing were last changed and could not provide any information or documentation on when Resident 37's family member had last brought the PureWick catheter supplies. LVN 3 also acknowledged the PureWick catheter care was something new to her. On 10/22/24 at 1101 hours, a concurrent observation and interview was conducted with ADON. The ADON stated the PureWick canister should not have a dry, dark green residue and should have been checked by the staff every shift. The ADON acknowledged the staff were unable to determine when the PureWick canister was last changed nor cleaned. The ADON also verified the PureWick canister was something new to the staff. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 0853 hours, an interview was conducted with the DSD/Acting IP. The DSD/Acting IP acknowledged the PureWick catheter care was something new to most staff and it was her first time as well to encounter a resident with Pure Wick catheter. The DSD/Acting IP also verified not all staff had attended the in-service about the PureWick catheter care and the in-service should have been provided to all the facility staff. On 10/29/24 at 1635 hours, an interview was conducted with the DON. The DON acknowledged the above findings. Cross reference F690, example #1.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure accurate reconciliation and administration as evidenced by: * The facility failed to ensure administration of the controlled medications for one nonsampled resident (Resident 42) was accurately documented to ensure accurate reconciliation and to prevent the medication administration errors. This failure had the potential for medication administration error, inaccurate reconciliation, and drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes). Findings: 1. Review of facility's P&P titled Controlled Substance revised November 2022 showed controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss or diversion and detection follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. On 10/23/24 at 0942 hours, review of the controlled medications was conducted. Review of the Controlled Medication Count Sheet for Resident 42's hydrocodone/acetaminophen (an opioid pain medication) 5-325 mg showed the medication was removed on 9/28/24 at 0600 hours, signed by a nurse; however, there was no documentation in the MAR or in Medication Administration Notes showing the medication was administered to the resident. Medical record review for Resident 42 was initiated on 10/23/24. Resident 42 was admitted on [DATE]. Review of Resident 42's H&P examination dated 8/19/24, showed the resident had fluctuating capacity to understand and make decisions. Review of the Order Summary Report dated 10/23/24, showed a physician's order dated 8/17/24, for hydrocodone/ acetaminophen 5-325 mg one tablet by mouth every four hours as needed for moderate to severe pain (pain levels of 4 - 10) (using a pain scale level of 0 to 10, with 0 = no pain and 10 = worst pain) not to exceed acetaminophen 3 grams in 24 hrs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 42's MAR for 9/1/24 - 9/30/24, showed an entry for hydrocodone/acetaminophen 5-325 mg one tablet by mouth every four hours as needed for moderate to severe pain (pain levels of 4 - 10), not to exceed acetaminophen 3 grams in 24 hrs. Further review of Resident 42's MAR failed to show documentation for the administration of hydrocodone/acetaminophen 5-325 on 9/28/24 at 0600 hours. On 10/23/24 at 0945 hours, an interview, and a concurrent record review was conducted with LVN 2. LVN 2 verified the MAR failed to show documentation the hydrocodone/acetaminophen 5-325 mg was administered to the resident on 9/28/24 at 0600 hours. On 10/24/24 at 1145 hours, an interview with the ADON was conducted. The ADON verified the Controlled Medication Count Sheet for Resident 42's hydrocodone/acetaminophen 5-325 mg tablet record showed a nurse signature on 9/28/24 at 0600 hours, however, the MAR failed to show documentation the hydrocodone/ acetaminophen 5-325 mg tablet was administered to the resident on 9/28/24 at 0600 hours. On 10/29/24 at 1430 hours, an interview with the DON was conducted. The DON was informed and acknowledged the findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility's P&P, the facility failed to ensure the medication error rate was below 5%. The facility's medication rate was 8%. One licensed nurses (LVN 1) observed administering the medications was found to have errors while administering the medications to two nonsampled residents (Residents 11 and 29). * The facility failed to ensure Resident 11 received the prescribed eye drops and in accordance with the facility's P&P. * The facility failed to ensure Resident 29 received the prescribed medication with food as ordered by the physician. These failures had the potential for the residents developing complications and ineffective therapeutic effects of the medications. Findings: 1. Review of the facility's P&P titled Specific Medication Administration Procedures: Eye Drop Administration Revised December 2019 showed to gently pull down lower eyelid to form a pouch, while instructing resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger and press gently to instill prescribed number of drops into pouch near outer corner of eye. Do not let tip of dropper touch the eye or any other surface. Medical record review for Resident 11 was initiated on 10/23/24. Resident 11 was admitted to the facility on [DATE]. On 10/23/24 at 0836 hours, a medication administration observation was conducted with LVN 1. LVN 1 administered one drop of dorzolamide hcl and timolol malate (eye drops used to treat increased pressure in the eye caused by glaucoma) ophthalmic solution directly on Resident 11's inner canthus (inner corner of the eyes). LVN 1 did not gently pull down the lower eyelid to form a pouch, while instructing the resident to look up and press gently to instill the prescribed number of drops into pouch near outer corner of eye per the facility's P&P. LVN 1 instilled more than one drop to the resident's left eye. LVN 1 had to get another unit dose vial of dorzolamide hcl and timolol malate to administer to the resident's right eye. Review or Resident 11's Order Summary Report for Octorber 2024 showed a physician's order dated 8/26/23, for dorzolamide hcl and timolol malate ophthalmic solution 2-0.5%, instill 1 drop in both eyes every 12 hours for glaucoma (a group of eye diseases that can damage the optic nerve and lead to vision loss or blindness); and give 5 (five) minutes apart from other eye drops. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 1455 hours, an interview with LVN 1 was conducted. LVN 1 verified she instilled the eye drops into Resident 11's inner corner of the eyes because it was hard for the resident to tilt his head back when in wheelchair and had put too much of a drop to the residents left eye. LVN 1 stated she had to get another vial to administer to the resident's right eye because there was no medication left to administer in the resident's right eye. On 10/29/24 at 1428 hours, an interview with the DON was conducted. The DON was informed and acknowledged the findings. 2. Review of the facility's P&P titled Preparation and Guidelines: Medication Administration Guidelines Revised December 2019 showed the medications are administered in accordance with written orders of the prescriber. Medications are administered within 60 minutes of scheduled time except before, with or after meal orders, which are administered based on mealtimes. Medical record review for Resident 29 was initiated on 10/23/24. Resident 29 was admitted to the facility on [DATE] and was readmitted on [DATE]. On 10/23/24 0843 hours, a medication administration observation was conducted with LVN 1. LVN 1 was observed to administered methenamine hippurate 1 gm one tablet by mouth to Resident 29 without any food. Review of Resident 29's Order Summary Report as of 10/23/24, showed a physician's order dated 9/18/24, for methenamine hippurate 1 gm one tablet by mouth two times a day for UTI prophylaxis (prevention); and to give with food. Review of Resident 29's MAR for October 2024 showed methenamine hippurate oral tablet 1 gm one tablet by mouth two times a day for UTI prophylaxis was scheduled to be administered at 0730 and 1730 hours. On 10/23/24 at 1455 hours, an interview with LVN 1 was conducted. LVN 1 verified she administered methenamine hippurate 1 gm one tablet by mouth to Resident 29 without any food. LVN 1 stated she was late in giving medication and was not able to give methenamine hippurate with food. On 10/29/24 at 1428 hours, an interview with the DON was conducted. The DON was informed and acknowledged the findings as above.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the medications were properly stored and labeled. * The facility failed to dispose of the prescription medications as nitroglycerine tablets in Medication Cart A. * The facility failed to store the external and internal medications separately. *The facility failed to accurately monitor the Glucose Quality Control of the glucometer in Medication Cart A. * The facility failed to disposed of the opened sterile dressings, expired dressings, indwelling catheters in the treatment cart. *The facility failed to appropriately label multiple ointments with open date. * The facility failed to ensure accuracy and complete records in the facility's Medication Room temperature log and Medication Refrigerator temperature log. These failures had the potential to negatively impact the residents' well-being. Findings: 1. Review of the facility's P&P titled Medication Labeling and Storage revised February 2023 showed if the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medications for external use as well as hazardous drugs, and biologicals, are clearly marked as such, and are stored separately from the other medications. Review of the facility's P&P titled Obtaining a Fingerstick Glucose Level revised [DATE] showed to ensure the equipment and devices are working properly by performing calibrations or checks as instructed by the manufacturer or the facility. Review of the facility's P&P titled Glucometer Cleaning and Control Testing dated [DATE] showed for glucose control test daily and as needed. a. On [DATE] at 0942 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 2. The following findings were identified and verified by LVN 2: - a nitroglycerine (a fast-acting medication that's used to prevent and treat angina or chest pain) 0.4 mg with a label to discard after [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- four diclofenac sodium (a medication that treats arthritis of the knee to decrease inflammation) topical gels, calcium citrate (a supplement for the bone), PreserVision (eye vitamin) and three lidocaine (a medicated patch to help relieve minor pain in the neck, arms, shoulders, and legs) patch boxes were stored together in the middle part of the bottom drawer of Medication Cart A. - two metamucil (fiber supplement) bottles and opened container of sanitizing wipes were stored together in the right side of the bottom drawer of Medication Cart A. b. Review of the Glucometer Evencare Diabetes Care System Quality Control Log Sheet for [DATE] showed an entry for ,d+[DATE] and [DATE], the lot strips number was 168240832002. However, the bottled of the Glucose test strip was labeled with date opened [DATE], showed the lot test strips number was 16823102016. c. On [DATE] at 1026 hours, an inspection of the medication storage and labeling of the treatment cart and concurrent interview was conducted with LVN 3 with the following findings: - three opened syringes - one iodoform packing strip (wound packing strips are continuous, one-piece strips of material used to fill empty space in a deep cavity or tunneling wounds.) with the expiration date of ,d+[DATE] - three Silicone-elastomer Coated Latex Foley Catheter (a urinary indwelling catheter) with the expiration date of [DATE] - an opened xeroform petroleum dressing (dressing is primarily used for wounds healing) - skin integrity hydrogel tube (a gel used to maintain a moist environment to dry or minimally exudating wounds) with no open date - two estradiol cream (is a hormone medication, used by women to help reduce vaginal symptoms of menopause such as vaginal dryness, burning or itching). 0.01% with no open date On [DATE] at 1428 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 49324 2. Review of the facility's P&P titled Medication Storage in the Facility revised ,d+[DATE] showed all the medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC). Medications requiring storage at room temperature are kept at temperatures ranging from 59 degrees Fahrenheit (15 degrees Celsius) degrees to 77 degrees Fahrenheit (25 degrees Celsius). Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees Fahrenheit (2 degrees Celcius) and 46 degrees Fahrenheit (8 degrees Celsius) with a thermometer to allow temperature monitoring. The facility should maintain a temperature log in the storage area to record temperatures at least once a day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Medication Room Temperature Log showed to keep the medication room temperature at 66 degrees - 77 degrees Fahrenheit. The Medication Room temperature Log showed the year, month, dates, medication temperature, and initials of the staff for documentation. Record review of the facility's Refrigerator Temperature Log showed to check the refrigerator temperature twice daily, ,d+[DATE] and ,d+[DATE] shifts and initial upon record. Medication Refrigeration Temperature was to be at 36 - 46 degrees, to clean every Friday and initial date when done. On [DATE] at 0808 hours, a concurrent observation of the Medication Storage Room, record review, and concurrent interview was conducted with the ADON. The Medication Room temperature was observed to be 70 degrees Fahrenheit and the Medication Refrigerator temperature was observed to be 42 degrees Fahrenheit. When the ADON provided the Medication Room Temperature Record Log, it was observed there were missing documentation on the following dates: - On ,d+[DATE], no documentation of the medication room temperature and initials. - On ,d+[DATE], no documentation of the medication room temperature and initials. - On ,d+[DATE], no documentation of the medication room temperature and initials. The ADON verified all the missing documentation in the Medication Room Temperature Log. The ADON was also asked to show the Refrigerator Temperature Record Log. The Refrigerator Temperature Record Log showed missing documentation on the following dates: - on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], 1500 - 2300 hours shift, no documentation of the refrigerator temperature and initials. - on [DATE], 1500 - 2300 hours shift, no documentation of the refrigerator temperature, initials and cleaning. - on [DATE], 2300 - 0700 hours shift, no documentation of the refrigerator temperature and initials. The ADON acknowledged all the missing documentation in the Refrigerator Temperature Log and stated the assigned staff should have checked and recorded, cleaned, and signed their initials. On [DATE] at 1645 hours, an interview was conducted with the DON. The DON verified the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and facility P&P review, the facility failed to follow the food preferences for one nonsampled resident (Resident 25) observed during the dining observation. * The facility failed to ensure Resident 25 received a chocolate shake as shown on the meal ticket as the preferred drink. This failure had the potential to affect the resident not receiving food as per their preference. Findings: Review of the facility's P&P titled Resident Food Preferences revised on 7/2017 showed the individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The modifications to the diet will only be ordered with the resident's or representative's consent. Upon the resident's admission (or within 24-hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences. Medical record review for Resident 25 was initiated on 10/22/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 7/22/24, showed Resident 25 had capacity to understand and make decisions. Review of Resident 25's Order Summary Report for October 2024 showed an order dated 8/12/24, for Resident 25 to be on a regular diet mechanical soft texture. Review of Resident 25's meal ticket dated 10/22/24, showed to provide one high calorie chocolate shake (four fluid ounces carton). On 10/22/24 at 1220 hours, a concurrent observation and interview was conducted with CNA 5 and Resident 25 during the dining observation. Resident 25's lunch tray was observed with four fluid ounces of strawberry shake. Resident 25's meal ticket showed to provide one four fluid ounces of high calorie chocolate shake. CNA 5 verified the findings and stated Resident 25 liked chocolate and usually received the chocolate shake; however, CNA 5 did not know why he got strawberry shake. When Resident 25 was asked if he preferred the strawberry shake or the chocolate shake, Resident 25 stated he preferred the chocolate shake. On 10/22/24 at 1229 hours, a concurrent observation and interview was conducted with the RD. The RD verified the findings and stated the meal ticket showed the residents' food preferences. The RD stated she would check in the kitchen for a chocolate shake. Upon return from the kitchen, the RD stated the facility had chocolate shake, but acknowledged the chocolate shake was not provided to Resident 25 at the time of meal preparation and stated she would provide the chocolate shake to the resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1625 hours, and interview with the DON was conducted. The DON acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the proper hand washing was performed when preparing food. * The facility failed to ensure proper labeling and dating of the opened food in the freezer. * The facility failed to ensure the expired food was discarded. * The facility failed to ensure a dry food storage container was properly sealed. * The facility failed to ensure the food preparation equipment were in good condition. * The facility failed to ensure the food preparation equipment were properly air dried prior to storage. * The ice machine was not clean. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen. Findings: Review of the facility's Resident Assessment Report (CMS-802) dated [DATE], showed 46 of 48 residents residing in the facility received food prepared in the kitchen. 1. Review of the facility's P&P titled Handwashing Facilities and Handwashing Procedure guidelines revised [DATE], showed the following: - Hands must be washed frequently and correctly: a. During food preparation, as often as necessary to remove soil and contamination when changing tasks; b. Before donning gloves to initiate a task that involves working with food; and c. After engaging in other activities that contaminate the hands. According to the USDA Food Code 2022 Section ,d+[DATE].14, food employees shall clean their hands before donning gloves to initiate a task that involves working with food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0938 hours, a concurrent observation and interview with [NAME] 1 was conducted. [NAME] 1 was observed preparing the pureed vegetables. [NAME] 1 was observed leaving the pureed meal preparation counter and touched several kitchen equipment, and returned to start the pureed vegetable preparation. [NAME] 1 was observed donning his gloves without performing handwashing prior. On [DATE] at 1010 hours, an interview was conducted with the Food Services Director. The Food Services Director was informed of the findings. The Food Services Director stated the staff should perform handwashing all the time before donning gloves. 2. Review of the facility's P&P titled Labeling and Dating dated ,d+[DATE] showed all foods are labeled, dated, and securely covered and use-by dates are monitored and followed. On [DATE] at 0800 hours, during the initial tour of kitchen with the Food Services Director, an observation of the freezer showed the following: a. The following food items had an opened and unsealed package and were not dated with an open date: - one bag of corn kernel, - one bag of lobsters, - one bag of pork sausage patties, - one bag of turkey sausage, - one bag of chicken fritters, - one container of basil pesto - one bag of plant-based chicken breast, and - one bag of plant-based ground beef In addition, the above food items appeared with freezer burned (a condition caused by reaching the surface of the food). b. Cooked pork shoulder with label used by [DATE] at 11:22 AM; prepared [DATE] at 11:22 AM still stored in the freezer. The Food Services Director verified and acknowledged the above findings. The Food Services Director stated she would discard the food items and would remind the staff to label all opened food packages and monitor the usage of food items. 3. Review of the facility's P&P titled Food Storage revised [DATE], showed food shall be protected from contamination by storing food in an area where it is not exposed to splash, dust, or other contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0818 hours, during the initial tour of the kitchen with the Food Services Director, a container of thickener was observed with the plastic cover not properly sealed near the sink area. The Food Services Director verified the findings. 4. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. According to the USDA Food Code 2022 Section ,d+[DATE].11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts ,d+[DATE] and ,d+[DATE] or shall be discarded. On [DATE] at 0818 hours, during the initial tour of kitchen with the Food Services Director, the following items were observed: - one large frying pan with thick black residue buildup on the cooking surface, and - five black and four purple scoops' rubber handles were worn out with heavy white residue. The Food Services Director verified the findings and stated she would discard the items and would replace with new ones. 5. According to the USDA Food Code 2022, Section ,d+[DATE].11, Equipment and Utensils, Air- Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility's P&P titled Sanitation and Infection Control, Subject: Dishwasher Storage revised , d+[DATE] showed the dishware will be air dried prior to storage after coming out of the dish machine. On [DATE] at 0820 hours, during the initial tour of the kitchen with the Food Services Director, one large, tall pot was observed to be stored with the inside still wet. The Food Services Director verified the findings and stated the equipment was not air dried properly. 6. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. Review of the facility's P&P titled Ice Machine Sanitation undated showed all ice shall be prepared and service in the most sanitary way. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1510 hours, an observation of the ice machine located in the main kitchen and concurrent interview was conducted with the Food Services Director. The ice machine was observed with a slimy yellow residue and black residue on the ice machine deflector (a device that directs ice from the machine into the ice storage bin), on the cover, and on the groove on top of deflector when wiped with white paper towel. The Food Services Director stated the ice machine was being cleaned by the dishwasher biweekly in both interior and exterior part of the ice machine. The Food Services Director stated a contracted company did the overall deep cleaning and sanitizing every six months.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's P&P for the resident's food brought by the visitors was followed. * The facility failed to show evidence of safe food handling instructions provided to the residents' family or visitors bringing food to the resident from outside. * The facility failed to ensure the resident refrigerator was clean. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: 1. Review of CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further showed the facility has the responsibility under the food safety regulation to help visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Further Review of the facility's P&P untitled and undated showed no documented evidence of safe food handling instructions were provided to the visitors or residents' family members bringing food from outside. On 10/24/24 at 1443 hours, an interview was conducted with LVN 1. LVN 1 stated they allowed the resident's family or visitor to bring food from outside for the resident. When asked if the staff provided the visitors information on safe food handling including proper hand hygiene, LVN 1 stated they would only instruct the resident's family member or visitor regarding the type and consistency of the resident's diet. LVN 1 further stated they did not provide specific instructions to the resident's family member or visitor regarding safe food handling. On 10/24/24 at 1509 hours, a concurrent interview and facility document review was conducted with the RD. The RD stated the resident's family members or visitors were educated regarding the type of diet when the food should be consumed or tossed. The RD stated the residents' family members or visitors were not educated specifically on the safe food handling including proper hygiene. 2. Review of the facility's P&P titled Deep Cleaning Refrigerators in a Skilled Nursing Facility undated showed environmental services will perform the deep cleaning of all the refrigerators within the facility to ensure optimal sanitation, prevent foodborne illnesses, and maintain a safe and hygienic environment for residents. On 10/23/24 at 1530 hours, an observation of the resident's refrigerator located in the kitchen of the nursing unit was conducted with the RD. The freezer door with shelves inside were observed dusty and with black residue all over which was verified by the RD. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 1545 hours, a concurrent interview and facility document review was conducted with the Facility Services Director. The Facility Services Director stated all of refrigerators' interior and exterior were being cleaned by the housekeeping staff daily and the deep cleaning was being done monthly. The Facility Services Director further stated the facility had no record documented for the deep cleaning of all the refrigerators. On 10/29/24 at 1559 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, and facility P&P review, the facility failed to ensure infection prevention and control program were maintained per facility's P&P as evidence by: * The facility failed to ensure the clean linen folding table in the laundry was free from personal items. * The facility failed to ensure LVN 2 completely wipe off the entire BP cuff, pulse oximeter, and thermometer prior obtaining one nonsampled resident's (Resident 595) vital signs who was on EBP observed during the medication administration. * The facility failed to ensure LVN 2 performed hand hygiene before and after removing gloves prior to changing to new pair of gloves during the medication administration for one final sampled resident (Resident 38), who was on EBP. These failures had the potential to cause safety hazards and the spread of infection to staff and residents. Findings: Review of the facility's P&P titled Procedures for Handling, Storage, Transportation, and Processing of Linens, undated showed clean linen storage is to be stored in designated areas that are clean, dry, and free from contamination. The P&P further showed to fold linens neatly and inspect them for cleanliness, stains, or damage before storing or delivering. Following these procedures ensures the safe and efficient handling, storage, transportation, and processing of lines, minimizing contamination risks and extending the life of the fabrics. 1. On 10/23/24 at 1537 hours, a concurrent observation and interview was conducted with the Facility Service Director. The Facility Service Director verified the clean linen folding table in the laundry room had one white portable fan and one black stationary storage container on top of the clean linen folding table. The Facility Service Director acknowledged the potential for contamination with the personal items and clean linens. On 10/29/24 at 1625 hours, an interview with the DON was conducted. The DON acknowledged the above findings. 48853 2. Medical record review for Resident 595 was initiated on 10/23/24. Resident 595 was admitted to the facility on [DATE]. Review of Resident 595's Order Summary Report dated 10/23/24, showed an order dated 10/7/24, for EBP (Enhanced Barrier Precautions) related to use of urinary indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 0858 hours, a medication administration observation for Resident 595 was conducted with LVN 2. LVN 2 wiped the inner part of the blood pressure cuff and stethoscope. LVN 2 failed to completely wipe off the entire BP cuff and did not clean pulse oximeter, and thermometer prior to obtaining the resident's vital signs. On 10/23/24 at 0859 hours, an interview was conducted with LVN 2. LVN 2 verified he did not clean the entire the blood pressure cuff, pulse oximeter, and thermometer. 3. On 10/23/24 at 1414 hours, a medication administration observation for Resident 38 was conducted with LVN 2. LVN 2 was observed donned the gloves prior administering medication through resident's GT without performing hand hygiene and after removing gloves to change to a new pair of gloves. Medical record review for Resident 38 was initiated on 10/23/24. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's Order Summary Report dated 10/23/24, showed an order dated 5/6/24, for EBP related to use of GT. On 10/23/24 at 1458 hours, an interview with LVN 2 was conducted. LVN 2 verified he did not perform hand hygiene before and after removing gloves prior changing to new pair of gloves. On 10/29/24 at 1428 hours, an interview with the DON was conducted. The DON was informed and acknowledged the findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their antibiotic stewardship program when the facility failed to conduct an assessment for the McGeer's criteria to determine the true infection for four sampled residents (two final sampled residents, Residents 23 and 30; and two nonsampled residents, Residents 9 and 397). * The facility failed to assess for the McGeer's criteria for Residents 9, 23, 30 and 397 with prescribed antibiotics in the month of September. This failure had the potential for inaccurately identifying for true infections and potentially inhibited the residents' physicians from discontinuing the unnecessary antimicrobials. Findings: Review of the facility's P&P titled Antibiotic Stewardship revised 12/2016 showed the antibiotics will be prescribed and administered to the residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. Review of the facility's P&P titled Antibiotic Stewardship - Review and Surveillance of Antibiotic and Outcomes revised 12/2016 showed the antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wife antibiotic stewardship. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist or designee. The P&P further showed all the residents antibiotic regimens will be documented on a facility-approved antibiotic surveillance tracking form. Review of the facility's document titled Monthly Infection Surveillance Report dated September 2024 showed four residents were admitted from the acute care hospital in September with antibiotics. However, the facility failed to show documentation the McGeer's form or an antibiotic surveillance tracking form was completed to assess for the true infection for the residents who were admitted from the acute care hospital with antibiotics. 1. Medical record review for Resident 9 was initiated on 10/25/24. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 10/1/24, showed Resident 9 had capacity to understand and make decisions. Review of Resident 9's Order Summary Report upon admitted d September 2024 showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order dated 9/26/24, to administer Doxycycline (antibiotic) 100 mg one tablet by mouth every 12 hours for BLE cellulitis (bacterial infection that affects the deep layers of the skin and underlying tissues) for two days. 2. Medical record review for Resident 23 was initiated on 10/22/24. Resident 23 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 23's H&P examination dated 9/26/24, showed Resident 23 had capacity to understand and make decisions. Review of Resident 23's Order Summary Report upon readmitted d September 2024 showed the following: - an order dated 9/25/24, to administer Meroenem (antibiotic) 1 gm IV every eight hours for ESBL urine for seven days. 3. Medical record review for Resident 30 was initiated on 10/22/24. Resident 30 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 30's H&P examination dated 10/2/24, showed Resident 30 had capacity to understand and make decisions. Review of Resident 30's Order Summary Report upon readmitted d September 2024 showed the following: - an order dated 9/30/24, to administer Ertapenem (antibiotic) 1 gm IV daily for anterior abdominal wall abscess. 4. Medical record review for Resident 397 was initiated on 10/25/24. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's H&P examination dated 9/19/24, showed Resident 397 had capacity to understand and make decisions. Review of Resident 397's Order Summary Report upon admitted d September 2024 showed the following: - an order dated 9/12/24, to administer Doxycycline 100 mg one tablet by mouth twice daily for H Pylori (type of infection) for seven days. On 10/25/24 at 1321 hours, a concurrent interview and facility document review was conducted with the DSD/Acting IP . The DSD/Acting IP verified the above findings. The DSD/Acting IP stated the facility did not complete a McGeer's form or an antibiotic surveillance tracking form for the residents who were admitted from the acute care hospital with antibiotics. The DSD/Acting IP stated the purpose of the antibiotic stewardship was to limit the excess use of antibiotics and to discuss the physicians if an antibiotic was still needed for the resident or if the antibiotic can be discontinued. The DSD/Acting IP further stated the purpose of identifying and completing an antibiotic surveillance form was to prevent the increase or overuse of antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555718	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1625 hours, and interview with the DON was conducted. The DON verified the facility did not assess the McGeer's criteria for the residents admitted from the acute care hospital with the antibiotic orders. The DON acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555718	A. Building B. Wing	10/29/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 49258 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were completed and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for 13 of 13 residents observed with bed rails (Residents 6, 8, 10, 14, 15, 23, 30, 35, 37, 38, 41, 545, and 602). These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: Review of the facility's P&P titled Entrapment/Bed Assessment revised 10/2018 showed the following: - The resident is assessed for the use of bed rails, which includes a review of risks including entrapment; - The facility must ensure the bed is appropriate for the resident and that the bed rails are properly installed and maintained. - Assess the resident for risk of entrapment from bed rails prior to installation; and - Ensure that the bed's dimensions are appropriate for the resident's size and weight. Review of the facility's P&P titled Proper Use of Side Rails revised 10/2018 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using the side rails on admission, bed change, quarterly, and as needed. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility, ability to change positions, transfer to and from bed or chair, and to stand and toilet, risk of entrapment from the use of side rails, and the bed's dimensions are appropriate for the resident's size and weight. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's document titled Bed Zone Measurements showed Zones 1, 2, 3, 4, 6, and 7 were inspected. Zone 5 showed, N/A. The document showed Zone 5 was not inspected for possible entrapment. Review of the medical records for Residents 6, 8, 10, 14, 15, 23, 30, 35, 37, 38, 41, 545, and 602 showed these residents used the side rails while in bed. However, the entrapment risk assessment was not completed prior to the use of side rails for these residents and no documented evidence the measurements of bed dimensions appropriated for the resident's size and weight. Cross reference to F700. In addition, there was no documented evidence of the routine bed inspection conducted to identify areas for possible entrapment. On 10/25/25 at 1548 hours, a concurrent interview and facility record review was conducted with the RA. When asked if he inspected the bed when there was a change of bed or mattress or a new resident to determine if any areas of possible entrapment were present based on the change of the bed, or mattress, or user, the RA stated he generally conducted the bed zone measurements but did not inspect or measure the bed's dimensions per the resident's size, weight and height or if there would be a change of bed or mattress.