STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Crest Health Care Center	11834 Inglewood Avenue Hawthorne, CA 90250

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51634 Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 52) had a call light (call bell) device within easy reach. This deficient practice had the potential to result in the resident being unable to alert health care workers for assistance for activities of daily living and care needs. Findings: During a review of Resident 52's Admission Record (Face Sheet), indicated the facility readmitted the resident on 3/29/2025 with diagnoses including functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and unspecified dementia (a progressive state of decline in mental abilities). During a review of the Minimum Data Set (MDS - (a resident assessment tool), dated 2/7/2025 indicated Resident 52 had functional limitation in range of motion in both upper extremities. During a review of Resident 52's care plan report, initiated on 3/31/2025 indicated the following goals: assistance in calling for help, in being kept clean, dry, and odor free by placing the call light device within easy reach. The care plan report indicated interventions including: call light should be within easy reach of the resident for staff to know when to assist the resident with activities of daily living/self-care and to notify staff of hygienic needs. During an observation on 4/1/2025 at 10:24 a.m., Resident 52 was not able to access the call light device, which had fallen between the bed mattress and the upper left side rail. During a concurrent observation and interview, on 4/1/2025 at 10:31 a.m., there was no visible call light device within the resident's reach. The Director of Nursing (DON) and Licensed Vocational Nurse (LVN) 4 entered Resident 52' room and found the call bell device between the bed mattress and the upper left side rail. During an observation on 4/2/2025 at 2:21 p.m., in Resident 52's room, the call light device was pinned to the upper right side of the resident's pillow. Resident 52 stated the call light device was not within reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation on 4/2/2025 at 2:27 p.m., Licensed Vocational Nurse (LVN) 2 stated Resident 52 could not reach the call light device. LVN 2 stated when the call light was not within reach, the resident will not be able to contact staff for help when needed. During a review of the facility's policy and procedure (P&P), Answering the Call Light, undated, indicated Ensure that the call light is accessible to the resident when in bed or wheelchair in room, from the toilet or shower room if necessary.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to ensure the use of an anti-psychotic (a class of drug used to treat mental health conditions) medication was accurately documented in the Minimum Data Set ([MDS] a resident assessment tool) for one of eight sampled residents (Resident 38). This deficient practice resulted in Resident 38's inaccurate medical condition submitted to the Centers for Medicare/Medicaid Services (CMS). Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 38's diagnoses included bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 38's History and Physical (H&P), dated 1/10/2025, the H&P indicated Resident 38 had the capacity to make decisions for activities of daily living. During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38 was dependent on staff for toileting and bathing. The MDS indicated Resident 38 was not taking any anti-psychotic medication. During a review of Resident 38's Order Summary Report for April 2025, the order summary report dated 11/15/2024, indicated Risperdal (an anti-psychotic medication) to be given for schizoaffective disorder. During a concurrent interview and record review on 4/3/2025 at 12:26 p.m. with the Minimum Data Set Nurse (MDSN), Resident 38's MDS was reviewed. The MDSN stated the MDS did not indicate Resident 38 was taking any anti-psychotic medication. The MDSN stated Risperdal is an anti-psychotic. The MDSN stated it was important to document an accurate MDS assessments because this information goes to CMS and the MDS assessment drives the resident's plan of care and quality of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to ensure weekly weight order was conducted weekly for one of 4 sampled residents (Resident 149). This deficient practice had the potential to result in the facility not knowing the resident had excessive weight loss or weight gain which could lead to delay in providing interventions needed for the resident. Findings: During a review of Resident 149's Admission Record, the Admission Record indicated Resident 149 was admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought) and hyperlipidemia (a condition characterized by elevated levels of fats in the blood). During a review of Resident 149's history and physical (H&P), dated 3/14/2025, the H&P indicated Resident 149 did not have the capacity to make decisions . During a review of Resident 149's Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2025, the MDS also indicated Resident 149 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 149's physician orders, dated 4/3/2025, the physician order indicated to weigh Resident 149 every Saturday until 4/11/2025. During a concurrent interview and record review, on 4/3/2025, at 11:30 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated the CNAs were responsible for weighing residents. CNA 2 stated Resident 149 was only weighed on 3/17/2025. CNA 2 stated Resident 149 was missing weekly weights as per order. CNA 2 stated the risk of not monitoring the resident's weight as ordered could result in not knowing if the resident lost or gained too much weight. During a concurrent interview and record review, on 4/3/2025, at 11:40 a.m., with Registered Nurse 2 (RN 2), RN 2 stated newly admitted residents should be weighed weekly for 30 days then monthly. RN 2 stated Resident 149 had a physician order for monitoring weights weekly until 4/11/2025. RN 2 stated Resident 149 was not weighed weekly as ordered. RN 2 stated the risk of not monitoring a resident's weight could result in weight loss or weight gain and/or ineffectiveness of medications. During a review of the facility's policy and procedures (P&P), titled Weight Assessment and Intervention, dated 3/2022, the P&P indicated residents should be weighed at intervals established by the interdisciplinary team.

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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** 49131 Based on observation, interview and record review the facility failed to place the low air loss mattress (LALM- a pressure relieving mattress for the management of pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence]) at the proper setting, according to the manufacturer's recommendation, for one of five sampled residents (Resident 58). This deficient practice had the potential to cause discomfort, new pressure injuries, poor wound healing and deterioration of the current pressure ulcers for Resident 58. Findings: During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included pressure ulcer of the sacrum (a large, triangular bone at the base of the spine), left and right buttock, and cellulitis (a skin infection that causes swelling and redness). During a review of Resident 58's History and Physical (H&P) dated 12/14/2024, the H&P indicated Resident 58 had the ability to understand and make decisions. During a review of Resident 58's Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 58 was cognitively intact (ability to think and reason). The MDS indicated Resident 58 was dependent on staff for Activities of Daily Living (ADLs) such as toileting and bathing. The MDS indicated Resident 58 was at risk for developing pressure ulcers and used a pressure reducing device in bed. During a review of Resident 58's Monthly Weight Report dated 3/6/2025, the Weight Report indicated Resident 58 weighed 214 pounds (lbs.). During a review of Resident 58's Wound Management Care Plan dated 3/10/2025, the Wound Management Care Plan intervention included to provide a LALM for Resident 58 to maximize the outcome and enhance the wound healing process. During an observation on 4/3/2025 at 1:12 p.m., in Resident 58's room, Resident 58 was observed lying in bed on a LALM with a setting of 340 pounds. During a concurrent observation and interview on 4/3/2025 at 1:35 p.m. with the Treatment Nurse (TN), TN stated the LALM should be set at the appropriate setting according to the weight of the resident. TN stated it was important to ensure the LALM was at the correct weight setting for the LALM to be at the appropriate level of firmness to effectively offload (reduce pressure) the resident's bony prominences (areas where bones are close to the skin's surface, with minimal cushioning, making them more likely to develop pressure ulcers). TN stated Resident 58's LALM was set at 340 lbs., however the resident weighed 214 pounds. TN stated the appropriate setting for Resident 58 should have been 200 or 240 pounds for optimal pressure relief and was unsure why the LALM was set at 340 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the undated manufacturer's operation manual for the LALM, the manual indicated the user adjusts the air mattress to a desired firmness according to the resident's weight or the suggestion from a health care professional. During a review of the facility's policy and procedure (P&P), titled Support Surface Guidelines, dated 9/2023, the P&P indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface and the support surfaces are modifiable and individual needs differ.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure residents on tube feeding received treatment and care in accordance with professional standards of practice, by failing to: 1. Ensure the head part of Geri-chair (a fully reclining chair designed for individuals with limited mobility, offering multiple positions for comfort and support) was elevated while one of three residents, (Resident 10), was lying in and received gastrostomy tube ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feedings. This deficient practice placed the resident at risk of aspiration (inhalation of foreign materials) that can lead to pneumonia (lung infection), hospitalization and death. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated, Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), GT placement, and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 10's History and Physical (H&P), dated 2/18/2025, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/28/2025, the MDS indicated, Resident 10's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 10 was totally dependent (helper does all of the effort) from staff with oral hygiene, lower body dressing, and personal hygiene. During a review of Resident 10's Order Summary Report, dated 4/3/2025, the Order Summary Report indicated a tube feeding order of Jevity (type of tube feeding formula) 1.2 kilocalorie (]kcal] - unit of measurement) at 65 cubic centimeter ([cc] - unit of volume) per hour for 20 hours (turn on at 12 p.m., off at 8:00 a.m.) to provide 1300 cc/1560 kcal per day. The Order Summary Report indicated to observe aspiration precaution and elevate head of bed 30 to 45 degrees at all times during GT feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/1/2025 at 12:49 p.m., with Licensed Vocational Nurse 3 (LVN 3), in Resident 10's room, Resident 10 was observed lying on Geri-chair receiving continuous GT feeding of Jevity 1.2 at 65 cc/hour. LVN 3 stated Resident 10 was not sitting in upright position and the head of Ger-chair was approximately 10 degrees. LVN 3 stated the head of Geri-chair should be elevated at least 30 to 45 degrees to prevent aspiration. LVN 3 stated Resident 10 was at risk for aspiration pneumonia, shortness of breath, vomiting, and choking since the head of Ger-chair was at lowest position. During a review of the facility's policy and procedure (P&P), titled Enteral Feedings - Safety Precautions, dated 3/2023, the P&P indicated, the facility should remain current and follow accepted best practices in enteral nutrition.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 42) was evaluated by a physician every 60 days and document his visit in resident's clinical records. This deficient practice had the potential for Resident 42's current medical condition not timely assessed by a physician that can lead to delay in necessary care and treatment. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated, Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included liver cirrhosis (a condition in which the liver is scarred and permanently damaged), hypertension ([HTN] - high blood pressure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 42's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/20/2025, the MDS indicated, Resident 42's cognitive (ability to think and reason) skills for daily decision making was consistent and reasonable. The MDS indicated Resident 42 was independent (Resident completes the activity by himself with no assistance from a helper) with oral hygiene, toileting hygiene, and personal hygiene. During an interview on 4/1/2025 at 9:51 a.m., with Resident 42, Resident 42 stated he had not met and seen his physician in the facility since he was admitted . Resident 42 stated he would be happy to see his physician so he could ask questions about his medical conditions. During a concurrent interview and record review on 4/2/2025 at 12:45 p.m., with the Director of Nursing (DON), Resident 42's clinical records were reviewed. The DON stated Resident 42 was visited by a Nurse Practitioner ([NP] - a nurse who has advanced clinical education and training,) on 3/22/2024, 4/18/2024, 5/7/2024, 6/6/2024, 7/31/2024, 8/15/2024, 9/13/2024, 10/24/2024, 11/14/2024, 12//11/2024, 1/25/2025, 2/14/2025, and 3/13/2025. The DON stated Resident 42 was not visited by his physician in the facility for over a year. The DON stated residents in the facility should be visited by a physician and document his finding in the progress notes at least once a month to comply with the regulation and to assess and evaluate treatment plan. During a review of the facility's policy and procedure (P&P), titled Physician Visits, dated 4/2013, the P&P indicated, the attending physician must visit his/her patients at least once every 30 days for the first 90 days, following the resident's admission, and then at least every 60 days thereafter.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 42) was evaluated by a physician every 60 days and document his visit in resident's clinical records. This deficient practice had the potential for Resident 42's current medical condition not timely assessed by a physician that can lead to delay in necessary care and treatment. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated, Resident 42 was admitted to the facility on [DATE]. Resident 42's diagnoses included liver cirrhosis (a condition in which the liver is scarred and permanently damaged), hypertension ([HTN] - high blood pressure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 42's Minimum Data Set ([MDS] - a resident assessment tool), dated [DATE], the MDS indicated, Resident 42's cognitive (ability to think and reason) skills for daily decision making was consistent and reasonable. The MDS indicated Resident 42 was independent (Resident completes the activity by himself with no assistance from a helper) with oral hygiene, toileting hygiene, and personal hygiene. During an interview on [DATE] at 9:51 a.m., with Resident 42, Resident 42 stated he had not met and seen his physician in the facility since he was admitted . Resident 42 stated he would be happy to see his physician so he could ask questions about his medical conditions. During a concurrent interview and record review on [DATE] at 12:45 p.m., with the Director of Nursing (DON), Resident 42's clinical records were reviewed. The DON stated Resident 42 was visited by a Nurse Practitioner ([NP] - a nurse who has advanced clinical education and training,) on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], 12//,d+[DATE], [DATE], [DATE], and [DATE]. The DON stated Resident 42 was not visited by his physician in the facility for over a year. The DON stated residents in the facility should be visited by a physician and document his finding in the progress notes at least once a month to comply with the regulation and to assess and evaluate treatment plan. During a review of the facility's policy and procedure (P&P), titled Physician Visits, dated ,d+[DATE], the P&P indicated, the attending physician must visit his/her patients at least once every 30 days for the first 90 days, following the resident's admission, and then at least every 60 days thereafter. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2). During a review of Resident 57's Admission Record, the Admission record indicated Resident 57 was originally admitted to the facility [DATE] and readmitted on [DATE] with diagnoses including spinal stenosis (a condition where the spinal canal becomes narrow), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), cervicalgia (neck pain), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 57's History and Physical (H&P), dated [DATE], the H&P indicated Resident 57 had the capacity to make his own decisions . During a review of Resident 57's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 57 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview, on [DATE], at 10:06 a.m., with Resident 57, Resident 57 stated his driver's license had expired in 2022. Resident 57 stated he informed the Social Services Director (SSD) ,d+[DATE] weeks ago that he would like to renew his driver's license. Resident 57 stated he needed an unexpired driver's license for identification to his medical appointments. Resident 57 stated he felt frustrated for not having his driver's license renewed. During an interview, on [DATE], at 9:30 a.m., with the SSD, the SSD stated the protocol for renewing a resident's driver license was to escort the resident to the Department of Motor Vehicles (DMV) or if a resident was bedbound, the DMV would report to the facility. The SSD stated she had been aware for 2 weeks that Resident 57 needed assistance to renew his driver's license. The SSD stated she did not have documentation to show she attempted to contact the DMV for Resident 57. The SSD stated the risk of not following up with DMV to get the resident's driver's license renewed could result in long delay causing the resident to feel frustrated. During a review of facility's Social Worker Job Description, dated [DATE], the Social Worker job description indicated, the Social Worker was to assist in the provision of the medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The Social Worker job description also indicated to work with the patient, family and other team members to outline goals of stay at admission and the plan to meet those goals and discharge as appropriate. The Social Worker job description indicated, social services should assist residents or responsible parties in processing forms or applications in the effort to obtain outside services. The P&P indicated, the outside services included but is not limited to Social Security, Medi-aid, SSI or any other services to which the resident may be entitled. 47923

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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** 47923 Based on observation, interview and record review, the facility failed to administer accurate amount of medication, to one of 29 residents (Resident 10), according to the physician's order. This failure had the potential for the medication to provide ineffective effect to the resident. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated, Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), gastrostomy ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 10's History and Physical (H&P), dated 2/18/2025, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/28/2025, the MDS indicated, Resident 10's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 10 was totally dependent (helper does all of the effort) from staff with oral hygiene, lower body dressing, and personal hygiene. During a review of Resident 10's Order Summary Report, dated 4/3/2025, the Order Summary Report indicated an order of ferrous sulfate ([FeSo4] - a drug supplement used to prevent and treat anemia) 220 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount)/5 milliliter ([ml] - unit of volume), to give 7.5 ml (330 mg) via GT daily (9 a.m.) for anemia. During morning medication administration (med pass) observation, at station two on 4/3/2025 from 9:17 a.m. to 10:00 a.m., for Resident 10, Licensed Vocational Nurse 3 (LVN 3), administered FeSo4 5 ml via GT to Resident 10. During an interview on 4/3/2025 at 10:06 a.m., with LVN 3, LVN 3 stated she did not administer the correct dose of FeSo4 to Resident 10. LVN 3 stated the physician order was to give FeSo4 7.5 ml (330 mg), but she administered only 5 ml (220 mg) to Resident 10. LVN 3 stated it was an oversight on her part for not giving the correct dose of FeSo4 to Resident 10. LVN 3 stated the risk for not administering the correct dose of FeSo4 to Resident 10 could lead to her anemia getting worst and might have serious complication on her medical condition. During a review of the facility's policy and procedure (P&P), titled Administering Medication, dated 3/2023, the P&P indicated, medications should be administered in accordance with prescriber orders.

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	555719	A. Building B. Wing	04/04/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1). Ensure expired one opened bottle of vitamin B1 (one of the B vitamins) medication was not kept in the medication cart 1. This deficient practice had the potential to result in administering expired medication to the residents with orders. 2). Label with an opened date, the Ipratropium with Albuterol Solution (a combined inhalation solution to treat and prevent shortness of breath) pouch in medication cart 1 for Resident 33, that had a pharmacy fill date of 7/3/2024. 3). Ensure expired one pouch of Ipratropium with Albuterol Solution for Resident 83 was not kept in medication cart 1. These failures had the potential for the affected residents to receive expired medications. These failures placed the medications at risk of bacterial growth and less potent, which can fail to treat shortness of breath and chest congestion for Resident 33 and Resident 83's shortness of breath or wheezing, when needed. Findings: 1). During a concurrent observation and interview on 4/2/2025 at 11:08 a.m., of the medication cart one with Licensed Vocational Nurse 2 (LVN 2), found one opened bottle of expired vitamin B1. LVN 2 stated the vitamin B1 was labeled with an opened date on 3/23/2025 and the expiration date printed on the bottle was 2/25/2025. LVN 2 stated it was the responsibility of the licensed nursing staff to check the expiration date of all the medications in medication cart 1. LVN 2 stated giving expired medication to residents could cause poison and untoward side-effects (an effect of the drug beyond its desired effect). 2). During a review of Resident 33's Admission Record, the Admission Record indicated, Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included respiratory failure (a medical condition that makes it difficult to breathe on your own), dysphagia (difficulty of swallowing), and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement. During a review of Resident 33's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/23/2025, the MDS indicated, Resident 33's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was totally dependent (helper does all of the effort) from staff with toileting hygiene, upper/lower body dressing, and personal hygiene. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's Order Summary Report, dated 4/2/2025, the Order Summary Report indicated an order of Ipratropium with Albuterol Solution 0.5-2.5 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount)/ 3 milliliter ([ml] - unit of volume), inhale orally every 4 hours as needed for shortness of breath and chest congestion. During a concurrent observation and interview on 4/2/2025 at 11:09 a.m., of the medication cart 1 with LVN 2, observed one opened and expired ipratropium with albuterol inhalation foil pack for Resident 33 stored at room temperature. The opened foil pack was not labeled with a date. LVN 2 stated the ipratropium with albuterol solution for Resident 33 indicated a pharmacy fill date of 7/3/2024. LVN 2 stated it was unknown at this time when the ipratropium with albuterol solution foil pack for Resident 33 was opened since it was unlabeled. LVN 2 stated each medication has a specific date on how long it would be effective. LVN 2 stated she will dispose immediately the unlabeled ipratropium with albuterol solution for Resident 33. 3). During a review of Resident 83's Admission Record, the Admission Record indicated, Resident 83 was admitted to the facility on [DATE]. Resident 83's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), hypertension ([HTN] - high blood pressure) obstructive sleep apnea (a sleep disorder where the airway collapses during sleep, leading to pauses in breathing), and muscle weakness. During a review of Resident 83's MDS, dated [DATE], the MDS indicated, Resident 83's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 83 required substantial assistance (helper does more than half the effort) from staff with oral hygiene and personal hygiene. During a review of Resident 83's Order Summary Report, dated 4/2/2025, the Order Summary Report indicated an order of Ipratropium with Albuterol Solution 0.5-2.5 mg/3 ml to inhale orally every 6 hours as needed for shortness of breath or wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs). During a concurrent observation and interview on 4/2/2025 at 11:14 a.m., of the medication cart 1 with LVN 2, observed one opened and expired ipratropium with albuterol inhalation foil pack for Resident 83 stored at room temperature. LVN 2 stated the ipratropium with albuterol solution for Resident 83 indicated a pharmacy fill date of 1/17/2025. LVN 2 stated the ipratropium with albuterol inhalation foil pack for Resident 83 was opened on 2/25/2025. LVN 2 stated giving expired medication would affect the potency of the medication and no longer be effective to the resident. During a review of the facility's policy and procedure (P&P), titled Labeling of Medication Containers, dated 4/2019, the P&P indicated, all medications maintained in the facility should be properly labeled in accordance with current and federal guidelines and regulations. During a review of the facility's P&P, titled Storage of Medications, dated 3/2023, the P&P indicated, the facility should store all drugs and biologicals in a safe, secure, and orderly manner. The P&P indicated, discontinued, outdated, or deteriorated drugs or biologicals should be returned to the dispensing pharmacy or destructed as indicated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the ipratropium with albuterol inhalation solutions manufacturer's instructions for storage and labeling, indicated that opened foil packs of ipratropium with albuterol inhalation solutions should be stored at room temperature between 36 and 77 degrees Fahrenheit and used or discarded within two weeks of opening the foil cover.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to ensure, one of eight sampled residents' (Resident 16), Complete Blood Count ([CBC]- a blood test that measures the number and type of cells in your blood) and Albumin (a blood test to check the level of protein in the blood) orders were implemented, as ordered by the physician on 12/11/2024. This deficient practice resulted in inadequate monitoring of Resident 16's health status. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnoses included diabetes (DM-a disorder characterized by difficulty in blood sugar control, dysphagia (difficulty swallowing) and quadriplegia (the loss of muscle function in all limbs). During a review of Resident 16's History and Physical (H&P), dated 1/9/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set ([MDS] a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 16 was dependent on staff for toileting, bathing, and dressing. During a review of Resident 16's Order Summary Report, for 4/2025, the report indicated a physician order for CBC/Albumin due to resident with pressure ulcer, dated 12/11/2024. During a concurrent interview and record review on 4/3/2025 at 11:35 a.m. with Registered Nurse (RN) 1, Resident 16's lab results were reviewed. There was no laboratory result for the CBC/Albumin ordered on 12/11/2024. RN 1 stated Resident 16's CBC/Albumin lab tests orders was not done on 12/11/2024. RN 1 stated, if the laboratory tests were not done, the facility won't know why Resident 16 was getting pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results, dated 3/2023, the P&P indicated staff should process test requisitions and arrange for tests.

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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 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. 48712 Based on observation and interview, the facility failed to ensure the juice connectors for the apple, grape, and pineapple juice was free of sticky residue. This deficient practice had the potential to result in cross contamination (movement of bacteria from one place to another) in the kitchen. Findings: During a concurrent observation and interview on 4/2/2025 at 9:20 a.m. with the Dietary Supervisor (DS), the connectors for the apple, grape, and pineapple juice was observed with a sticky substance. The DS stated the connectors contained dust and sticky residue that can cause cross contamination resulting in infection. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated 11/2022, the P&P indicated food services staff should maintain clean food storage areas. Non-refrigerated foods should be kept clean.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 48712 Based on observation and interview, the facility failed to ensure three dumpsters (trash container) were kept closed. This deficient practice had the potential to result in rodents and insects being attracted to the facility and cause contaminations and infections. Findings: During a concurrent observation and interview on 4/1/2025 at 8:41 a.m. with the [NAME] in the parking lot, three dumpsters were noted with the lids off. The [NAME] stated the dumpsters should be closed to prevent possible contamination. The [NAME] stated if there were food inside it could attract animals. During a review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, the P&P indicated dumpsters should be kept closed and free of surrounding litter. Dumpsters must be kept covered when stored or not in continuous use.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview and record review, the facility failed to ensure the foley catheter (a thin, flexible tube inserted into the bladder to drain urine) removal for one of one sampled resident (Resident 85) was documented, according to the facility's policy and procedure (P&P). This deficient practice had the potential to result in the lack of communication between staff and a delay in the provision of care or interventions for Resident 85. Findings: During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of the sacrum (a large, triangular bone at the base of the spine), left and right buttock, and cellulitis (a skin infection that causes swelling and redness). During a review of Resident 58's History and Physical (H&P), dated 12/14/2024, the H&P indicated Resident 58 had the ability to understand and make decisions. During a review of Resident 58's Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 58 was cognitively intact (ability to reason, understand, remember, judge, and learn) and was dependent on staff for Activities of Daily Living (ADLs) such toileting and bathing. The MDS indicated Resident 58 had an indwelling (foley) catheter. During a review of Resident 58's Progress Notes dated 3/26/2025, the Progress Notes indicated Resident 58 requested to have her foley catheter removed and the physician's order was obtained to remove the resident's foley catheter. The Progress notes did not indicate when the resident's foley catheter was removed, what happened during the removal process and how the resident tolerated the procedure. During a review of Resident 58's Order Summary Report dated 3/2025, the Order Summary indicated on 3/26/2025, the physician ordered to remove Resident 58's foley catheter. During an interview on 4/1/2025 at 9:33 a.m. with Resident 58, Resident 58 stated she recently (date unknown) had her foley catheter removed because it was bothering her. During an interview on 4/3/2025 at 2:54 p.m. with the Treatment Nurse (TN), TN stated she removed Resident 58's foley catheter on 3/26/2025. TN stated she did not document notes about the removal of the foley catheter because she felt it was not necessary because nothing eventful happened during the removal. TN stated it was important to document notes about the removal of the foley catheter to communicate with other staff members what happened during the procedure. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Charting and Documentation, dated 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals or changes in the resident's medical, or physical condition should be documented in the resident's medical record. The P&P also indicated treatments or services performed, and changes in the resident's condition should be documented on and should be objective, complete, and accurate. The P&P further indicated documentation of procedures and treatments should include how the resident tolerated the procedure/treatment, and assessment data and/or any unusual findings obtained during the procedure/treatment. During a review of the facility's P&P titled, Indwelling (Foley) Catheter Removal, dated 8/2022, the P&P indicated to document the date and time the foley catheter removal was performed, any abnormal findings from the removal, if they refused the procedure and the name title of the person who performed the procedure in the resident's medical record after the foley catheter was removed.

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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. 51634 Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices for one of two residents (Resident 52) who was on enhanced barrier precautions [EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs)]. This deficient practice had the potential to result in spread of infectious disease. Findings: During an observation on 4/1/2025 at 10:31 a.m., The Director of Nursing (DON) and Licensed Vocational Nurse (LVN) 4 entered Resident 52's room from the hallway, and were observed not performing hand hygiene before entering the resident's room, before touching the resident's linen, after assisting the resident, and before leaving the resident's room. During an interview on 4/1/2025 at 10:39 a.m. with the DON, the DON stated hand hygiene should be performed before touching the residents. During an interview on 4/1/2025 at 12:05 p.m., at the nurse's station, Licensed Vocational Nurse (LVN) 4 stated staff were to wash hands between each resident especially when transitioning from resident to resident who are on EBP. LVN 4 stated staff should wear a gown and gloves and immediately wash hands before and after care, because infections can arise if hand hygiene was not performed, and to prevent spread of disease as much as possible. During a review of Resident 52's care plan report indicated Resident 52 was at high risk for infection based on a medical history of previous infections. The goal of the care plan was to reduce the risk for active infection by using interventions including hand hygiene during care to reduce the potential for the resident acquiring an infection. During a review of the facility policy and procedure (P&P) titled Handwashing/Hand Hygiene, dated 4/2023 indicated to use an alcohol-based hand rub before and after direct contact with residents, and after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation and record review, the facility failed to meet the required 80 square feet for each resident in rooms [ROOM NUMBER]. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for residents in rooms [ROOM NUMBER]. Findings: A review of the Request for Waiver Variation Letter completed by the facility, on 4/2/2024 at 9:30 a.m., dated on 4/1/2025, indicated room [ROOM NUMBER], 111 and 117 did not meet the requirement of 80 square feet (sq ft) per resident as follows: a. room [ROOM NUMBER] had three resident beds, which measured 236.4 square feet; b. room [ROOM NUMBER] had three resident beds, which measured 236.4 square feet; c. room [ROOM NUMBER] had three resident beds, which measured 231.6 square feet; During an interview, on 4/4/2024 at 9:40 a.m., with the Administrator (ADMIN), the ADMIN stated residents had not complained of inadequate nursing care due to lack of required square footage. The ADMIN stated the inadequate square footage did not affect the ability of the staff members to provide care. During a multiple observations made to Rooms 109, 111 and 117 through 4/1/2025 to 4/4/2025, the room sizes of the above rooms did not adversely affect the residents' health and or safety. Recommend room waiver.