

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Dept of State Hospitals - Metropolitan Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 11401 South Bloomfield Avenue Norwalk, CA 90650	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide ongoing assessment, monitoring and implementation of interventions for one of 21 sampled residents (Resident 10) when on 10/23/2025, Resident 10 was diagnosed with a blood clot in his arteriovenous fistula (AV fistula- surgical connection of an artery and a vein that allows for blood to flow directly to provide a long-term access point for filtering blood in patients with kidney disease) and the physician had an order to check the AV fistula for bruit and thrill (bruit is a swooshing sound heard over a blood vessel, while a thrill is the vibrating or buzzing sensation felt over the same vessel, both indicate a strong blood flow of an AV fistula), on the left upper arm every shift, since 11/24/2025. In addition, the facility failed to provide training and ensure staff competency for caring for residents that were dependent on renal dialysis (life-sustaining treatment that filters waste, extra salt, and fluid from the blood when the kidneys fails and are unable to) when four of four licensed nursing staff did not know how to properly assess and monitor for AV fistula complications - including how to assess for bruits and thrills. This failure resulted in Resident 10 experiencing pain, significant swelling with decreased mobility to the left arm. This failure had the potential to result in fistula failure, severe pain, limb ischemia (restricted blood flow to the arm), infection, deep vein thrombosis (DVT- serious condition when a blood clot forms in a deep vein), pulmonary embolism (fatal blockage in a lung artery caused from a blood clot that traveled), heart failure and/or death. Findings: During a review of Resident 10's Face sheet (demographics), the Face sheet indicated Resident 10 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease (ESRD- a medical condition that occurs when the kidneys permanently fail and cannot clean the blood or manage fluids anymore), dependence on renal dialysis, type 2 diabetes mellitus (condition when the body cannot use insulin correctly and sugar builds up in the blood), hypertension (high blood pressure) and heart failure. During a concurrent observation and interview on 12/2/2025 at 10:28 a.m., in Resident 10's room with Resident 10, Resident 10 was sitting on the edge of his bed with a visibly swollen left hand. Resident 10 removed his jacket and showed surveyor his AV fistula to the left upper arm with significant swelling to the entire left arm. Resident 10 had facial grimacing when attempting to make a fist with the left hand. Resident 10 stated he was informed about a month ago that he had a blood clot in the left arm near his AV fistula. Resident 10 stated the AV fistula is not being used at dialysis due to the blood clot and he had to undergo a procedure to have a new access site to the right side of the chest. Resident 10 further stated the swelling has made it very difficult to move his wrist and hand, and experiences pain constantly. During an interview on 12/2/2025 at 12:05 p.m. with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated he was unsure how to monitor an AV fistula site. LPT 1 further stated he has not received any training for caring for dialysis patients. During an interview on 12/3/2025 at 3:59 p.m. with Medical Doctor (MD) 1, MD 1 stated Resident 10 was admitted with swelling to the left arm in May 2025 but did not get evaluated by a vascular surgeon (doctor specialized in circulation and surgery) until 10/23/2025 due to MD 1 believing it was a Nephrologist's (doctor specialized in kidneys) concern and not a Primary Care Physician (PCP) concern. MD 1 was informed by facility management that it was the PCP's responsibility to oversee care of AV fistula complications. MD 1 stated he ordered a vein (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555731	Facility ID: 555731 If continuation sheet Page 1 of 23

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Signs/symptoms/complaints may include: a. diminishing, absent or change in character of pulse, thrill, or bruit. On 12/5/2025 at 1:36 p.m., the survey team called an Immediate Jeopardy situation (a situation in which the facility's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident), related to the lack of licensed nurse competency in assessing, monitoring and implementing physician's order for resident receiving dialysis treatment, at F 698 [CFR S 483.25(l)], in the presence of the Nurse Administrator. On 12/5/2025 at 7:50 p.m., the Standard and Compliance Director provided the survey team with a Plan of Action which included the following actions to be completed and/or started immediately: a.) Resident 10 was assessed at the time of the concern was identified by Unit Physician. b.) Unit Physician was notified, and new orders were received and implemented. c.) Pain was assessed and addressed per physician's orders. d.) Training was initiated with all licensed nursing staff on Nursing Policy and Procedure 408: Care of Vascular Access for Hemodialysis AV fistula, AV graft and Venous Catheter and were able to provide return demonstration on: how to assess for bruit and thrill, documentation and communication requirements. e.) Staff competency will be validated in assessment of AV fistula will be validated using the newly developed Vascular Access Assessment checklist. f.) Unit Supervisor/designee will review and verify the completion of 1147B form (Outside Facility Information form is to notify the facility of the treatment and recommendations provided by an outside facility) immediately following each patient dialysis appointment to ensure real time information and patient status. Medical Services Physician will maintain ongoing communication as need with the Dialysis center, including the Nephrologist as needed to ensure coordination of care and follow up. g.) Patients who could have been affected by this deficient practice who are receiving dialysis were assessed by nursing and physician for possible AV fistula/graft complications using checklist tool. On 12/8/2025 at 2:46 p.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the survey team accepted the Plan of Action and removed the immediacy in the presence of the Risk Management & Program Quality Assurance Coordinator, Standard and Compliance Director and Nurse Administrator.		

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F 0686 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to implement their policy to ensure the provision of pressure-injury (damage to skin from pressure) prevention, monitoring, and treatment were consistent with professional standards of practice for two of 21 sampled residents (Resident 30 and Resident 4). 1. Resident 30's buttocks were previously identified as areas of impaired skin integrity and were not monitored for two months. In addition, Resident 30's Low Air Loss mattress (LAL-pressure relieving air mattress) was not set to the accurate weight in accordance with the manufacturer's instructions. 2. Resident 4's ischial tuberosity (sit bone) was previously identified as an area of impaired skin integrity and was not monitored for three weeks. In addition, Resident 4's LAL mattress was not set to the accurate weight in accordance with the manufacturer's instructions. These failures resulted in Resident 30 developing three painful, unidentified wounds: Stage II pressure injury (open sore with a red or pink wound bed), on the left buttock, a Stage II pressure injury and a Deep Tissue Injury (DTI-dark purple spot showing underlying skin damage), on the right buttock and Resident 4 developing a Stage II pressure injury (open sore with a red or pink wound bed), to the ischial tuberosity. In addition, the failure of leadership oversight led to missed opportunities for timely identification and early interventions in wound care management for Resident 30 and Resident 4. Findings: 1. During a review of Resident 30's Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 9/3/2025, the MDS indicated Resident 30 was admitted to the facility on [DATE], with a diagnosis of Type 2 Diabetes Mellitus (inability to monitor blood sugar). The MDS indicated Resident 30 required maximum assistance (needing extensive two-person physical help) for all mobility, was dependent on a wheelchair and at risk for developing pressure injuries. The MDS further indicated Resident 30's BIMS (Brief Interview for Mental Status) score was 9 (score of 9 indicated moderate difficulty with thinking). During a review of Resident 30's Height/Weight/BMI [body mass index] Record, [undated], the Height/Weight/BMI Record indicated Resident 30's weight in November 2025 was 167.8 lbs. (pounds). During an observation on 12/1/2025 at 2:14 p.m., in Resident 30's room, Resident 30 was lying flat on his back on an inflated LAL mattress programmed for 400 lbs. (despite Resident 30 not weighing 400 lbs). During a concurrent observation and interview on 12/2/2025 at 3:15 p.m. in Resident 30's room with Resident 30, Resident 30 was lying flat on his back in bed on an LAL mattress. Resident 30 reported having a painful wound on his bottom and stated he was not receiving wound care. During an interview on 12/2/2025 at 3:50 p.m. with Registered Nurse Shift Lead (RNSL) 2, RNSL 2 confirmed Resident 30 required an LAL mattress and that the device must be programmed based on the resident's actual weight to function correctly. During a concurrent interview and record review on 12/4/2025 at 11:52 a.m. with RNSL 1, the following documents were reviewed: 10/9/2025 Impaired Skin Integrity Risk Care Plan: Two boils on gluteal area are open. mild redness to surrounding area noted. Monitor the patient's skin both buttocks and abdomen area noting, color, moisture, texture and temperature, qshift [every shift]. 10/10/2025 Photographic Wound Documentation: photograph shown three open sores to the right buttocks that had deep red wound bed and two areas on the right buttocks that were intact and deep red, that were not included in the assessment, treatments, and interventions. October 2025 to December 2025 Medication and Treatment Records: no wound treatment entries or weekly wound assessments after 10/10/2025. Further review from the above documents indicated missed opportunities for early interventions. RNSL 1 stated he was unaware that Resident 30 had any pressure injuries to the buttock's area and confirmed that there were multiple wounds shown in the photograph on 10/10/25 without assessments, treatments and interventions. RNSL 1 further stated each wound should have an individual assessment, treatment and intervention. During a concurrent interview and record review on 12/4/2025 at 3:49 p.m. with Registered Nurse Unit Supervisor (RNUS 1), Resident 30's full health-record was reviewed. RNUS 1 confirmed there were multiple wounds (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	identified on 10/10/25 that did not have wound care assessments and treatments. RNUS 1 stated she was unaware if Resident 30 had pressure injuries. RNUS 1 confirmed that daily RN assessments, weekly wound photographs, and treatment documentation should have been completed for each individual wound. During a concurrent observation and interview on 12/4/2025 at 3:53 p.m. in Resident 30's room with Resident 30 and RNSL 2, during a toileting observation with RNSL 2, Resident 30 was noted to have: Approximately 1 centimeter (cm- unit of measurement) open sore with a red wound bed with approximately 5 cm of redness to the area around the wound on the left buttock; Approximately 1.5 cm open sore with a red wound bed with approximately 10 cm of redness to the area around the wound on the right buttock; Approximately 1.5 cm deep purple discoloration that was non-blanchable on the right buttock; Resident 30 stated he developed the wounds from being stuck in the wheelchair for long periods. During the observation RNSL 2 stated the open sore with a red wound bed on the left buttock was a stage II pressure injury, the open sore with a red wound bed on the right buttock was a stage II pressure injury and the non-blanchable (skin discoloration that does not fade to white when pressed on) deep purple discoloration was a DTI. RNSL 2 also confirmed there was no previous wound documentation for the three newly identified, untreated pressure injuries. During an interview on 12/5/2025 at 9:24 a.m. with Medical Doctor (MD 1), MD 1 stated he was unaware of the status of Resident 30's wounds and he did not physically see Resident 30's wounds/pressure injuries until the untreated wounds/pressure injuries were discovered on 12/4/25. During an interview on 12/5/2025 at 4:56 p.m. with Program Director (PD), PD stated she was involved with record keeping of wound care and photographs. PD further stated program management did not have a tracking system for monitoring wounds. During a review of facility's policy and procedure (P&P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, All patients shall have an assessment of the condition and integrity of their skin. the assessment shall be conducted. as clinically indicated. the RN shall assess wound or pressure injury daily. The Physician/Nurse Practitioner shall assess the wound on a weekly basis and more often if clinically indicated. Measure wound weekly to track and measure the progression of healing. inspection and monitoring at least daily when patients are deemed at risk for pressure injury or have an existing impaired skin integrity. PRESSURE INJURY PREVENTION. Conduct a comprehensive skin inspection for those at risk as soon as possible. subsequent inspections and monitoring at least daily when patients are deemed at risk for pressure injury or have an existing impaired skin integrity. During a review of the Operational Manual for [low air loss mattress name], [undated], the manual indicated, System is designed for prevention, treatment and management of pressure ulcers. Press up or down buttons to select the correct patient weight. 2. During a review of Resident 4's Minimum Data Set (MDS-federally required assessment tool used to guide resident care), dated 9/23/25, the MDS indicated an admission date on 6/17/24 with Non-Traumatic Brain Dysfunction (damage to the brain by internal factors). The MDS indicated Resident 4 required maximum assistance (needing extensive two-person physical help) for mobility, was dependent on a wheelchair, and at risk for developing pressure injuries. During a review of Resident 4's Height/Weight/BMI [body mass index] Record, [undated], the Height/Weight/BMI Record indicated Resident 4's weight in November 2025 was 163.0 lbs. (pounds). During an observation on 12/2/25 at 11:18 a.m. in Resident 4's room, Resident 4 was lying flat on his back in bed on an inflated LAL mattress (pressure relieving air mattress), programmed for 300 lbs. (despite Resident 4 not weighing 300 lbs). Resident 4 was non-interview able. During an interview on 12/2/25 at 3:50 p.m. with Registered Nurse Shift Lead (RNSL) 2, RNSL 2 stated Resident 4 did not have any wounds/pressure injuries. RNSL 2 confirmed Resident 30 required an LAL mattress and that the device must be programmed based on the resident's actual weight to function correctly. During an interview on 12/5/25 at 9:24 a.m. with Medical Doctor (MD 1), MD 1 stated Resident 4 previously had a wound/pressure injury that was treated, and he was not aware of any new or current wounds/pressure injuries. During a concurrent interview and record review on 12/8/25 at 2:22 p.m. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	with Supervising Registered Nurse (SRN 1), the following documents were reviewed:-11/13/25 Photographic Wound Documentation: Previous pressure injury to the left ischial tuberosity (sit bones- on the buttocks area) appeared closed. Intervention was to continue to monitor the skin for further skin break down and signs/symptoms of infection.-Medication and Treatment Record for November 2025 indicated no weekly assessment/monitoring to the left ischial tuberosity was completed after 11/13/25.-11/19/25 Altered Skin Integrity Care Plan: Assess the patient's skin, noting color, moisture, texture, and temperature. Also observe for erythema (reddening of skin), edema, and tenderness every shift. Observed wounds, noting characteristics of wound size, appearance, and drainage every shift.-12/8/25 Photograph of pressure injury: A new unidentified open sore with a red wound bed approximately 8 cm to the left buttocks was present.Further review from the above documents indicated missed opportunities for early interventions.SRN 1 stated, after the Photographic Wound Documentation on 11/13/25 there was no documentation of skin assessments or monitoring being completed of the left ischial tuberosity, that was previously identified as an area of skin impairment. SRN 1 confirmed the open sore with a red wound bed to the left buttock was a Stage II pressure injury and considered a new wound.During a review of facility's policy and procedure (P&P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, PRESSURE INJURY PREVENTION. Conduct a comprehensive skin inspection for those at risk as soon as possible . subsequent inspections and monitoring at least daily when patients are deemed at risk for pressure injury or have an existing impaired skin integrity.During a review of the Operational Manual for [low air loss mattress name], [undated], the manual indicated, System is designed for prevention, treatment and management of pressure ulcers. Press up or down buttons to select the correct patient weight.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation measures were maintained in the kitchen according to standards of practice and facility policy when:1. Two cutting boards used for food preparation were found to have discolorations and deep gouges on the surface.2. Five resident food trays were dirty with built-up food debris and found stacked in the clean tray area.3. One open box of previously frozen french toast was found uncovered and labeled with a date of 3/25/25. These failures had the potential to place residents at risk for developing foodborne illness (any illness resulting from eating contaminated/spoiled foods) by exposing residents to contaminated food and unsanitary practices. Findings:1. During a concurrent observation and interview on 12/1/25 at 12:16 p.m. with the Food Service Supervisor (FSS) in the kitchen, two cutting boards used for preparation of resident meals were found to have areas of discoloration and deep gouges on the surface. The FSS stated the cutting boards were worn out and both needed to be thrown away. During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section 4-501.12-Cutting Surfaces, the FDA Food Code indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.2. During a concurrent observation and interview on 12/1/25 at 12:20 p.m., with the Food Service Supervisor (FSS) in the kitchen, five resident food trays were dirty with areas of old, built-up chocolate pudding and rice, and had unknown black marks. The FSS confirmed the five trays were stored in the clean tray area and needed to be re-cleaned. During a review of the facility's policy and procedure (P&P) titled, Infection Control: Client, Staff, Equipment & Food Safety, dated July 2018, the P&P indicated, All kitchen and dining room utensils along with food contact surfaces used in preparation and/or serving of food and drink are cleaned and sanitized before use, after being used and after each meal.3. During a concurrent observation and interview on 12/1/25 at 12:46 p.m., with the Director of Dietetics (DD) in the kitchen, an opened box of previously frozen french toast was found in a refrigerator uncovered and labeled with a date of 3/25/25. The DD stated the food was previously in the freezer and was placed in the refrigerator to thaw (the process of bringing frozen food to an unfrozen state). The DD stated, the box should also be completely closed and covered. The DD further stated the food was expired and it was not known when the food was brought into the refrigerator to thaw. During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section 3-501.18-Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, the FDA Food Code indicated, Food which is prepared and held, or prepared, frozen, and thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to update its Facility Assessment (document that determines the necessary resources to care for residents competently during day-to-day operations and emergencies) annually. In addition the facility failed to include the specific competencies (measurable pattern of knowledge, skills and abilities to perform occupational functions successfully) of the licensed nursing staff and how often the competency evaluations needed to be done to properly care for the residents. This failure resulted in substandard quality of care related to treatment and services of dialysis AV fistulas (arteriovenous fistula - a surgically created connection between an artery and a vein for dialysis access) and an Immediate Jeopardy (a critical deficiency in healthcare facilities where non-compliance creates a high likelihood of serious harm or death) situation. Cross reference F698 Findings: During a review of the facility assessment titled, Program 6: Skilled Nursing Facility Program Description, [undated], the facility assessment indicated, the required skills and competencies for licensed staff based on resident population and needs was not found. During an interview on 12/5/25 at 4:44 p.m. with the Program Director (PD), PD confirmed the facility assessment was last updated in 2021 and stated that it was completed by herself and one Supervising Registered Nurse. PD was unaware of how frequently the assessment was required to be updated. PD stated the facility assessment does not break down required skills and competencies required by licensed nursing staff and the skills and competencies were dependent upon staff license. PD confirmed the facility assessment does not contain the required education, training and staff competencies related to ongoing needs of residents. During an interview on 12/8/25 at 10:22 a.m., with the Standards Compliance Director (SCD), SCD stated the facility does not have a policy on the requirements of the facility assessment. Facility was unable to provide a policy and procedure (P&P) for Facility Assessment.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure their Quality Assurance and Performance Improvement (QAPI- a program that enables a facility to evaluate and improve the quality of Resident care and services through data collection, staff input, and other information), did not implement their plan to identify areas for improvement for residents at risk for developing pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence).This failure resulted in an ineffective QAPI program that did not identify systemic problems related to the monitoring of pressure ulcers.Cross Reference F686.Findings:During an interview on 12/8/25 at 2:53 p.m. with Nursing Coordinator (NC), NC stated performance improvement plans (PIP) were based on the previous year's survey results and included monitoring for resident call light accessibility, resident dignity while dining, and the use of enhanced barrier precautions (infection control guidelines) for identified residents. There were no PIPs that included monitoring of pressure ulcers and no PIPs for assessment of AV fistulas (Arteriovenous, an irregular connection between an artery and a vein), for those resident's requiring dialysis (treatment that filters waste from your blood). NC stated there was no formal mechanism for prioritizing issues.During an interview on 12/8/25 at 2:58 p.m., with the Program Director (PD), PD stated the QAPI team did not have any data to monitor and were not aware of any issues in the incidences (occurrence) of pressure ulcers or assessments of AV fistulas because there was not a baseline assessment for residents returning from outside facilities so a comparison of before and after could not be made.During a review of the facility's plan titled, Department State Hospital-Metropolitan Program VI Skilled Nursing QAPI Plan, dated December 2024, the plan indicated, Plan to Address Key Issues: . Identify and use data to monitor our performance; Establish goals and thresholds for our performance measurement; Utilize resident and staff input; Identify and prioritize problems and opportunities for improvement; Systematically analyze underlying causes of systemic problems and adverse events; Develop corrective action or performance improvement activities.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices that protect residents from the spread of communicative diseases and infections when:1.Unit 404's clean linen room had multiple pieces of laundry piled on a chair, in a corner on the floor, and on the floor in front of the storage shelving; there was also uncovered clean laundry storage and an opened water bottle on the floor mixed in with clean laundry.2.Resident 4's foley catheter (medical device- tube that drains urine from the bladder into a bag) collection bag was not below the waistline.3.Licensed Psychiatric Technician (LPT 1) did not wear Personal Protective Equipment (PPE, specialized clothing or equipment used to reduce exposure to hazards or infections), while performing a glucose (blood sugar) monitoring test on Resident 10.These failures had the potential to spread infection in a medically fragile population of 60 residents.Findings: 1. During an observation on 12/1/25 at 12:21 PM in Unit 404's clean laundry room, three linen covers were not covering clean laundry, multiple pieces of laundry was observed on the floor and on a chair. Observed an opened water bottle on the floor mixed in with laundry. During an interview on 12/1/25 at 12:24 PM with Unit Supervisor (US), in the clean linen room, US confirmed a mostly empty water bottle was found on the floor mixed in with laundry and stated staff should not be drinking in the clean laundry room. US stated the laundry on the floor and chair should have been picked up and did not belong there. US stated laundry should be covered to prevent dust and contamination. Review of facility's policy and procedures (P&P) titled, Transportation and Management of Clean Linen, dated May 2023, the P&P indicated, Purpose: To Maintain standard precautions by guarding and protecting against the possibility of transmission of infection and bacterial diseases. Clean linen should be handled,. stored by methods that will ensure its cleanliness to avoid the contamination. 5. Place clean linen on shelves with protective covering. DO NOT store . other equipment/items in the clean linen room. DO NOT store soiled linen/clothing with clean linen. 2. During a review of Resident 4's Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 9/23/25, the MDS indicated Resident 4 was admitted to the facility on [DATE], with diagnosis of urine retention (inability to completely empty the bladder of urine) and required an indwelling catheter (long term use of a foley catheter). During a concurrent observation and interview on 12/3/25 at 2:59 p.m., in Unit 404's Day Hall with the Registered Nurse (RN 10), Resident 4 was lying in a geriatric chair (large padded multi-position recliner designed for seniors and individuals with limited mobility) with a foley collection bag lying across Resident 4's lap. The foley tubing had cloudy yellow urine with a moderate amount of sediment (visible particles). RN 10 stated Resident 4's foley collection bag needed to be placed below the bladder to drain properly. During a review of Resident 4's Urinary Retention Care Plan, dated 10/8/25, the Urinary Retention Care Plan indicated, Perform catheter care every shift. keep the drainage bag below bladder. 3. During a review of Resident 10's Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 11/12/25, the MDS indicated Resident 10 was admitted to the facility on [DATE], with diagnoses of Diabetes Mellitus (condition when the body cannot use insulin correctly (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and sugar builds up in the blood) and Human Immunodeficiency Virus (HIV- life long virus that attacks cells that help the body fight infection). During an observation on 12/2/25 at 11:44 a.m. in Unit 404's day hall, LPT 2 was not wearing gloves and poked Resident 10's right index finger with a lancet (tiny needle) then applied pressure to Resident 10's right index finger with his ungloved right hand to assist with blood flow. LPT 2 inserted a glucose test strip (disposable strip that reacts with drops of blood to measure blood sugar) into the glucometer (machine used to measure the concentration of sugar in the blood) and checked Resident 10's blood sugar. During an interview on 12/2/25 at 12:04 p.m. with LPT 2, LPT 2 confirmed he did not wear gloves while checking Resident 10's blood sugar. LPT 2 stated he should always wear PPE when checking blood sugar. During an interview on 12/2/25 at 3:54 p.m. with Registered Nurse Shift Lead (RNSL 2), RNSL 2 stated staff needed to always wear PPE, at minimum gloves, for checking a resident's blood sugar. During a review of Resident 10's Acquired Immunodeficiency Syndrome [AIDS-chronic condition caused by HIV] and Human Immunodeficiency Virus [HIV] Care Plan, dated 11/18/25, the AIDS and HIV Care Plan indicated, NSG [nursing] to wear PPE, including gloves, gowns, and eyewear, during invasive procedures involving blood or body fluids as clinically indicated. NSG to use appropriate barrier protection, safe injection practices, and meticulous hand hygiene, at all times.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review the facility failed to ensure Licensed nurses were competent (having the necessary ability, knowledge, or skill to do something successfully), in assessing and monitoring dialysis residents when two licensed nurses, Registered Nurse Shift Lead [RNSL 2], and Registered Nurse Unit Supervisor [RNUS]), were unable to properly demonstrate how to assess and monitor for bruits and thrills (bruit is a swooshing sound heard over a blood vessel, while a thrill is the vibrating or buzzing sensation felt over the same vessel, both indicating a strong blood flow of an AV fistula- surgical connection of an artery and a vein that allows for blood to flow directly to provide a long-term access point for filtering blood in residents with kidney disease), for one of 21 sampled residents (Resident 10). In addition two licensed nursing staff (Licensed Psychiatric Technician [LPT 1]) and LPT 2, were unable monitor dialysis residents for bruits and thrills. This failure resulted in the inability of properly monitoring and assessing for dialysis complications in dialysis residents and the potential for harm. Cross Reference F698 Findings: During a review of Resident 10's Face sheet (demographics), the Face sheet indicated Resident 10 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease (ESRD- a medical condition that occurs when the kidneys permanently fail and cannot clean the blood or manage fluids anymore), dependence on renal dialysis, type 2 diabetes mellitus (condition when the body cannot use insulin correctly and sugar builds up in the blood), hypertension (high blood pressure) and heart failure. During a review of Resident 10's Physician's Orders, dated 11/24/25, the Physician Orders indicated, AV shunt [fistula] on LUA [left upper arm], check for bruit and thrill every shift. During a review of Resident 10's ESRD Care Plan, dated 11/18/25, the ESRD Care Plan indicated, Assess non-functional AV fistula on the left upper arm for bleeding (if any), thrombosis (thrill) [thrombosis is a formation of a blood clot that would be found by checking for thrills], and stenosis (bruit) [stenosis is abnormal narrowing of a vein that would be found by checking for bruits], q shift [every shift], Monitor for pain q shift, Monitor increased swelling to left upper extremity/arm, daily. During an interview on 12/2/25 at 12:05 p.m. with LPT 1, LPT 1 stated he was unsure how to monitor an AV fistula site. LPT 1 further stated he has not received any training for caring for dialysis residents. During an interview on 12/5/25 at 8:46 a.m. with RNSL 2, RNSL 2 stated, I don't know when asked how to assess for bruits and thrills with an AV fistula. During an interview on 12/5/25 at 9:05 a.m. with RNUS 1, RNUS 1 stated she was not familiar with how to assess bruits and thrills on an AV fistula, and the facility did not provide training for caring for dialysis residents. During an interview on 12/5/25 at 9:45 a.m. with LPT 2, LPT 2 stated she did not know how to monitor an AV fistula. LPT 2 further stated she has not received any training on caring for dialysis residents. During an interview on 12/5/25 at 10:32 a.m. with Standard and Compliance Director (SCD), SCD stated the facility does not provide specific training for caring for dialysis patients/residents or how to assess AV fistulas. During an interview on 12/5/25 at 4:56 p.m. with Program Director (PD), PD stated the facility does not provide training to staff for caring for residents that have dialysis and assessing AV fistulas. During an interview on 12/8/25 at 11:20 a.m. with Nurse Coordinator (NC), NC stated the facility does not provide training to staff or check staff competency with assessing AV fistulas. NC further stated the facility should have provided AV fistula training and check for staff competency. During an interview on 12/8/25 at 1:32 p.m. with the Director of Nursing Education (DNE), DNE confirmed the facility's training provided to staff did not cover caring for dialysis residents or assessing AV fistula. During a review of the facility's policy and procedure (P&P) titled, CARE OF THE VASCULAR ACCESS FOR HEMODIALYSIS [life-sustaining medical treatment that acts as an artificial kidney by using a machine and a special filter to clean the blood and remove excess fluids] ARTERIOVENOUS (AV) FISTULA, AV GRAFT [surgical connection between an artery and a vein, typically in the arm to (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide access for hemodialysis] AND VENOUS CATHETHERS [a thin tube inserted into a large vein in the neck, chest or groin that leads to a major vein near the heart], dated April 2025, the P&P indicated, RN's (registered nurses) will be responsible for assessing the resident every shift. Notify physician immediately of signs and symptoms of possible complications. The RN will: Assess the vascular access site every shift. assess for evidence of venous or arterial stenosis and thrombosis by assessing for pulse, thrill and bruit:. Thrill: A thrill is a palpable vibration of the resident's pulse over the AV graft/fistula. It is best evaluated using the palm of the hand. A thrill is soft and continuous. Any turbulent flow may indicate the presence of a stenotic lesion (thrombosis). REPORT IMMEDIATELY TO PHYSICIAN. Bruit: Using a stethoscope, you can hear blood flowing through the vascular access known as the bruit. If the sound gains in pitch and sounds like a whistle, the blood vessels could be tightening (stenosis). If the tightening becomes to severe, blood flow could be cut off completely. REPORT IMMEDIATELY TO PHYSICIAN. MONITORING 1. Licensed nursing staff will monitor and report signs/symptoms/complaints to the RN for assessment. Notify physician of findings. 2. Signs/symptoms/complaints may include: a. diminishing, absent or change in character of pulse, thrill, or bruit.		

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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. Based on observation, interview, and record review, the facility failed to ensure four of five outside dumpsters were covered. This failure had the potential to attract pests and/or rodents that carried diseases and could result in food borne illness (a sickness caused by consuming food, or drinks contaminated with harmful substances) in a medically fragile population of 60 residents. Findings: During a concurrent observation and interview on 12/1/25 at 12:53 p.m. with the Dietetics Director (DD) in the outside loading dock area of Program VI building, there were four dumpsters with overflowing garbage that were uncovered. There were many flies and a foul odor coming from the dumpsters. The DD stated the dumpsters should have been covered and the area should have been kept clean. During a review of the 2022 Food and Drug Administration's (FDA) Food Code-Section 5-501.15 Outside Receptacles, the FDA food code indicated, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to maintain an effective abuse and neglect training program for 13 of 116 skilled nursing employees (Licensed Psychiatric Technician [LPT] 1, LPT 2, LPT 3, LPT 4, LPT 5, LPT 6, LPT 7, LPT 8, LPT 9, Registered Nurse [RN] 4, RN 5, RN 6 and RN 7), when employee abuse and neglect training was not completed annually. This failure had the potential for abuse and neglect to go unnoticed and/or not reported by the staff. Findings: During a concurrent interview and record review on 12/8/25 at 10:10 a.m. with Supervising Registered Nurse (SRN 1), the employee Recognizing and Reporting Abuse Neglect training records were reviewed. The records indicated the following: 1. LPT 1's annual abuse training last completed 5/21/24. 2. LPT 2's annual abuse training last completed 10/12/21. 3. LPT 3's annual abuse training last completed 9/28/24. 4. LPT 4's annual abuse training last completed 10/24/24. 5. LPT 5's annual abuse training last completed 9/29/24. 6. LPT 6's annual abuse training last completed 11/15/24. 7. LPT 7's annual abuse training last completed 11/25/24. 8. LPT 8's annual abuse training last completed 11/26/24. 9. LPT 9's annual abuse training last completed 5/23/24. 10. RN 4's annual abuse training last completed 10/29/24. 11. RN 5's annual abuse training last completed 7/16/24. 12. RN 6's annual abuse training last completed 1/16/24. 13. RN 7's annual abuse training last completed 10/28/24. SRN 1 confirmed the abuse training dates for the 13 licensed nursing staff and stated they were past due for their annual abuse training. SRN 1 confirmed the 13 staff were currently employed and assigned to the skilled nursing units and that they were not out on long-term leave. During an interview on 12/8/25 at 11:08 a.m., with the Nursing Coordinator (NC), NC stated Nursing Education provides a monthly list of staff who are due for training. NC stated when the list is received, she sends it to the Unit Supervisors so that staff can be signed up for the training. NC stated that staff are scheduled to complete annual training during their birth month and confirmed that since it is based off birth month and not month of last completion, staff could go longer than a year between trainings. NC stated that not receiving abuse training annually would cause staff to not receive the most current updates, and stated staff might miss information. NC confirmed abuse training should be completed annually. During a review of facility's policy and procedures (P&P) titled, Reporting Patient Abuse and Neglect, dated 5/7/25, the P&P indicated, 12.0 Employee Training. 12.2 Training All employees are required to complete annual patient abuse prevention training.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's expressed desire for privacy and dignity for one of 21 sampled residents (Resident 10) when Licensed Psychiatric Technician (LPT 2) denied Resident 10 privacy during medication administration. This failure resulted in Resident 10 being exposed in view of other residents. Findings: During a review of Resident 10's Face sheet (demographics), the Face sheet indicated Resident 10 was admitted to the facility on [DATE], with a diagnosis of type 2 diabetes mellitus (condition when the body cannot use insulin correctly and sugar builds up in the blood). During an observation on 12/2/25 at 11:51 a.m., in Unit 404's Day Hall, Resident 10 was sitting in a wheelchair at a table with a food tray in front of him and there was a total of six other residents in the Day Hall. LPT 2 wheeled the medication cart over to Resident 10 and informed Resident 10 that he needed insulin (crucial hormone produced by the pancreas that regulates blood sugar) due to elevated blood sugar level. LPT 2 uncovered Resident 10's abdomen by pulling up his shirt. Resident 10 pulled his shirt back down and informed LPT 2 he did not want to get undressed in the Day Hall while eating with other residents. LPT 2 informed Resident 10 it's okay and proceeded to lift Resident 10's shirt back up again and administered insulin to Resident 10 in lower quadrants of abdomen. During an interview on 12/2/25 at 12:04 p.m. with LPT 2, LPT 2 confirmed Resident 10 requested for privacy by stating he did not want to get undressed in the Day Hall. LPT 2 stated he should have taken Resident 10 to his room or the treatment room to administer insulin. During an interview on 12/2/25 at 3:55 p.m. with Registered Nurse Shift Lead (RNSL) 2, RNSL 2 stated staff should always provide privacy to residents during medication administration. RNSL 2 further stated LPT 2 should have brought Resident 10 to his room for administering insulin. During a review of the facility's policy and procedure (P&P) titled, Dignity and Respect of Individuality, dated March 2025, the P&P indicated, Maintain resident's privacy of body including residents sufficiently covered.		

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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. Based on interview and record review, the facility failed to assess and submit accurate data for two of 21 sampled residents (Resident 1 and 21) when the Minimum Data Set (MDS- federally required assessment tool used to guide resident care) did not reflect Resident 1 and Resident 21's current status. This failure resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS). Findings: During a concurrent interview and record review on 12/3/25 at 3:09 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 21's MDS 3.0 Section I- Active Diagnoses, dated 10/4/25, and Active Orders, dated 11/26/25, were reviewed. Resident 21's MDS 3.0 Section I- Active Diagnoses indicated under infections Resident 21 had an active diagnosis of viral hepatitis (an infection that damages the liver). Resident 21's Active Orders indicated there was no treatment for viral hepatitis. The MDSC stated Resident 21 was diagnosed with hepatitis C in 2015 and has not received any treatment for hepatitis while residing at the facility. The MDSC confirmed Resident 21's MDS should not have indicated viral hepatitis was an active infection. During a concurrent interview and record review on 12/3/25 at 3:15 p.m. with MDSC, Resident 1's MDS 3.0 Section I- Active Diagnoses, dated 8/23/25, and Active Orders, dated 11/26/25, were reviewed. Resident 1's MDS 3.0 Section I- Active Diagnoses indicated under infections Resident 1 had an active diagnosis of viral hepatitis. Resident 1's Active Orders indicated there was no treatment for viral hepatitis. The MDSC stated Resident 1 was diagnosed with hepatitis C in 2022 and has not received any treatment for hepatitis while residing at the facility. The MDSC confirmed Resident 1's MDS should not have indicated viral hepatitis was an active infection. During a review of the CMS Long-Term Care Facility [LTCF] Resident Assessment Instrument [RAI] 3.0 User's Manual, dated October 2024, the CMS LTCF RAI 3.0 User's Manual indicated, Code disease that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments . Example of inactive Diagnoses . the resident has recovered . with no residual effects and no continued treatment.		

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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** Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice when: 1. Three of three licensed nurses (Licensed Psychiatric Technician [LPT] 10, LPT 11, LPT 12) inaccurately completed skin assessments for Resident 30. This failure had the potential to result in delayed wound healing and unidentified new wounds. 2. Licensed Vocational Nurse (LVN 1) administered Trazadone (a prescription antidepressant medication) to Resident 29 by mouth, instead of crushed via G-tube (surgically placed tube into the stomach for feeding, medication, or drainage) as ordered by the physician. This failure had the potential to result in Resident 29 aspirating (accidentally inhaling food, liquids, particulates into the lungs). Findings: 1. During a review of Resident 30's Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 9/3/25, the MDS indicated Resident 30 was admitted to the facility on [DATE], with a diagnosis of Type 2 Diabetes Mellitus (inability to monitor blood sugar). The MDS indicated Resident 30 required maximum assistance (needing extensive two-person physical help) for all mobility, was dependent on a wheelchair and at risk for developing pressure injuries (localized skin and tissue damage from sustained pressure). During a concurrent interview and record review on 12/4/25 at 3:35 p.m. with Registered Nurse Shift Lead (RNSL 2), Resident 30's documents were reviewed: -Impaired Skin Integrity Risk Care Plan, dated 10/9/25, indicated an active care plan for five boils (painful fluid filled skin infection) to the buttocks, one boil to the left abdomen and two boils on gluteal area (buttocks). -Photographic Wound Documentation, dated 9/19/25, 10/3/25 and 10/10/25 indicated on going wound care for a Stage III (deep full thickness skin wound where the skin is lost and revealing fat) pressure injury (localized skin and tissue damage from sustained pressure) to sacral (bony area between hip and pelvis) area. -Weekly Body Check, dated 10/1/25, signed by LPT 12 and LPT 11 indicated there was no skin impairment -Weekly Body Check, dated 10/8/25, signed by LPT 12 and LPT 10 indicated there was no skin impairment -Weekly Body Check, dated 11/12/25, signed by LPT 12 indicated there was no skin impairment -Weekly Body Check, dated 12/3/25, signed by LPT 11 indicated there was no skin impairment RNSL 2 stated LPT 10, LPT 11, and LPT 12 should have filled out the condition of the skin to include all of the on-going wounds that were being treated on Resident 30's Weekly Body Check Report. During an interview on 12/4/25 at 3:49 p.m. with Unit Supervisor (US), US stated she reviewed the Weekly Body Check reports, dated 10/1/25, 10/8/25, 11/12/25, 12/3/25, and confirmed LPT 10, LPT 11, and LPT 12 did not accurately document the current status of Resident 30's skin and stated staff expectation was to fill out the weekly body checks to accurately reflect Resident 30's skin. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Dept of State Hospitals - Metropolitan Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 11401 South Bloomfield Avenue Norwalk, CA 90650	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, Pressure Injury Prevention . Conduct a comprehensive skin inspection for those at risk as soon as possible . subsequent inspections and monitoring at least daily when patients are deemed at risk for pressure injury or have an existing impair skin integrity. 2. During a review of Resident 29's Face Sheet (demographics), the face sheet indicated Resident 29 was re-admitted to the facility on [DATE] with a diagnoses that included: schizoaffective disorder-bipolar type (a serious mental illness blending symptoms of schizophrenia [hallucinations, delusions, disorganized thinking] with those of bipolar disorder [manic highs and depressive lows]), dysphagia (difficulty swallowing food or liquids) and gastrostomy status (having a surgically placed tube [G-tube] into the stomach for feeding, medication, or drainage). During an observation on 12/3/25 at 12:01 p.m. in Resident 29's room, LVN 1 was observed to prepare Resident 29's noon medication. LVN 1 was observed to prepare one 100 mg (milligrams), Trazadone HCL tablet, by crushing it and mixing it in pudding. LVN 1 identified resident as Resident 29 and then administered the medication to Resident 29 by mouth. During a review of Resident 29's Medication and Treatment Administration Record (MTAR), dated December 2025, the MTAR indicated Resident 29 was to receive Trazadone HCL 100 mg tablet, oral at noon (Crushed) give via g-tube. During an interview on 12/3/25 at 2:50 p.m., with LVN 1, LVN 1 confirmed Resident 29's noon medication order was to administer Trazadone crushed via G-tube. LVN 1 stated she saw Resident 29 eating by mouth so she just administered the medication by mouth. During an interview on 12/3/25 at 2:54 p.m. with the Registered Nurse (RN 1), RN 1 stated if a Resident was given a medication by mouth that was ordered to be given via G-tube, he would be concerned for risk of aspiration. RN 1 stated the expectation was that staff follow medication orders as written. During a concurrent interview and record review on 12/3/25 at 3:08 p.m. with RN 1, Resident 29's Physician's Orders, dated 11/25/25 at 2130 was reviewed. The physician orders indicated Resident 29 had Choking/Aspiration Precautions, and the physician ordered Trazadone HCL 100 mg tablet, oral daily at noon 1200 (crushed) give via g-tube. RN 1 confirmed the physician order indicated Resident 29 should have received 100 mg Trazadone, crushed via G-tube per physician orders. During a record review of Resident 29's Dysphagia/Choking Screen, dated 1/31/25 at 0830, the record indicated Resident 29's annual assessment indicated active dysphagia. During a review of the facility's policy and procedure (P&P) titled, Medication Administration Protocol, dated November 2023, the P&P indicated, Prior to administering medication to a resident, Medication-Competent nursing staff will confirm the right: resident, medication, form, dose, route, date, time and the ordered indication. During a review of the facility's policy and procedure (P&P) titled, Medication Administration Guidelines, dated October 2025, the P&P indicated Medications and/or treatment shall be administered .as appropriately ordered via an authorized prescriber.		

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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** Based on observation, interview and record review, the facility failed to provide care consistent with professional standards of practice for two of 21 sampled residents (Resident 9 and Resident 10) when:1.Resident 9's oxygen order did not specify amount or frequency of oxygen to be administered.2.Resident 10's CPAP (Continuous Positive Airway Pressure- machine that delivers pressurized air through a mask to keep airways open during sleep, prevents breathing pauses and improves oxygen levels), machine was not cleaned or maintained for over six months.3.Resident 10's oxygen concentrator humidifier (small, water-filled bottle attached to an oxygen machine which adds moisture to oxygen therapy for comfort), was not changed in 4 days.These failures had the potential to result in respiratory complications, equipment malfunction, and reduced effectiveness of prescribed therapy for the residents.Findings: 1.During a record review of Resident 9's Face Sheet (demographics), the face sheet indicated Resident 9 was re-admitted to the facility on [DATE] with a diagnoses that included: major neurocognitive disorder (a significant decline in at least one cognitive area [memory, attention, language.] severe enough to interfere with independence in daily activities) and disorders of the diaphragm (issues with the main breathing muscle). During a concurrent observation and interview on 12/1/25 at 1:00 p.m. with the Registered Nurse (RN 8), in Resident 9's room, observed oxygen (O2) running at 2L (liters-unit of measurement) per minute, via nasal cannula (tubing that delivers oxygen via the nasal passages). Observed Resident 9's nasal cannula prongs (tube used to deliver oxygen directly into the nose), outside his nose. RN 8 confirmed the nasal cannula prongs should have been in Resident 9's nose, and stated Resident 9 is on 2L of oxygen continuously. During a concurrent interview and record review on 12/3/25 at 11:25 a.m. with the Health Service Specialist (HSS), Resident 9's Physician Orders, dated 11/26/25 at 2035, were reviewed. The physician orders indicated, Respiratory. May apply Oxygen to keep Oxygen Saturation 92% or above. HSS confirmed there was no amount to be administered and stated the order should specify the amount of oxygen. During an interview on 12/3/25 at 3:48 p.m. with the Medical Doctor (MD 2), MD 2 stated he did not put the specific liters of oxygen to be administered to Resident 9 and that 2 liters are administered instinctively. MD 2 further stated he could have put the liters of oxygen to be administered into the order. During an interview on 12/4/25 at 9:36 a.m. with the RN Shift Lead (RNSL 1), RNSL 1 stated oxygen is considered a medication. RNSL 1 further stated oxygen orders should have parameters for how much oxygen to deliver to Resident 9 as well as titration parameters (dose increase to achieve a therapeutic effect). During a review of Resident 9's Care plan for Activity Intolerance Risk, dated 12/10/25, related to COPD (Chronic Obstructive Pulmonary Disease - a condition involving constriction of the airways and difficulty or discomfort in breathing), indicated Resident 9 will not exhibit shortness of breath during activities of daily living or at rest. is on continuous nasal cannula O2 per order. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration and Storage, (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated March 2025, the P&P indicated, Medication competent licensed nursing staff may administer oxygen per Physician's/Nurse Practitioner's order. 2. During a review of Resident 10's Minimum Data Set (MDS- federally required assessment tool used to guide resident care), dated 11/12/25, the MDS indicated Resident 10 was admitted to the facility on [DATE], with a diagnosis of Obstructive Sleep Apnea (sleep disorder where the throat muscles relax and block the airway while sleeping causing a pause in breathing). During a review of Resident 10's Physician Orders, dated 11/26/25, the physician orders indicated, CPAP- On at HS [night], Off when awake in AM (morning). During a concurrent observation and interview on 12/2/25 at 10:28 a.m. with Resident 10, in Resident 10's room, Resident 10 was sitting on the edge of his bed with a CPAP mask on. Resident 10 stated he cleaned his CPAP tubing and mask in the public bathroom sink, and he had never received training on cleaning the CPAP components. Resident 10 further stated staff have not cleaned or changed any of the CPAP components since admission in May 2025. During an interview on 12/3/25 at 12:32 p.m. with the Registered Nurse Shift Lead (RNSL) 1, RNSL 1 confirmed staff have not cleaned Resident 10's CPAP machine because there was no documentation on the form CPAP/BiPAP [Bilevel Positive Airway Pressure- a breathing therapy device that delivers two pressure levels of air through a mask] Parts Cleaning Log. During an interview on 12/5/25 at 8:40 a.m. with the Respiratory Therapist (RT), RT stated she was unaware of Resident 10 having a CPAP machine. RT further stated CPAP components- mask, tubing and water chamber needed to be dumped out and cleaned daily to prevent mold buildup. During a review of the facility's policy and procedure (P&P) titled, Nasal CPAP & BiPAP System, dated July 2023, the P&P indicated, When the treatment is over, follow these steps . Clean and disinfect the equipment using a facility-approved disinfectant, according to the manufacturer's instructions . Document cleaning of the CPAP/BiPAP parts on the CPAP/BiPAP Parts Cleaning Log. 3. During a concurrent observation and interview on 12/1/25 at 2:09 p.m., with the Registered Nurse (RN 9), in Resident 10's room, the humidifier on Resident 10's oxygen concentrator was labeled, change Thursday 11/28/25. RN 9 confirmed the date on the label and stated the humidifier should have been changed and it is supposed to be changed daily. During an interview on 12/3/25 at 12:32 p.m., with the Registered Nurse Shift Lead (RNSL 1), RNSL 1 stated staff were responsible for oxygen equipment and supplies and the humidifiers are changed every day. During an interview on 12/5/25 at 8:40 a.m., with the Respiratory Therapist (RT), RT stated the humidifiers on the residents' oxygen concentrators are changed daily and staff will label it with the date it needs to be changed on. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration and Storage, dated March 2025, the P&P indicated, Replace humidifier every 24 hours, labeling with expiration sticker.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure three of 16 sampled residents' (Resident 15, Resident 32 and Resident 49) medical records were complete when:1.For Resident 32, the staff did not document on the Repositioning Schedule.2. For Resident 15, the staff did not document on the Repositioning Schedule. 3.The Medication and Treatment Record (MTAR) for Resident 49 had missing entries. These failures had the potential to negatively affect the plan of care related to the specific care being provided and monitored. Findings: 1. During an observation on 1/20/2026 at 12:10 p.m. in Resident 32's room, a Repositioning Schedule form was observed posted at the wall next to Resident 32's bedside. During a review of Resident 32's Repositioning Schedule Form dated 1/20/2026, the form indicated there was no repositioning entry on the form from 12 a.m. to 5 a.m. Further review of the form indicated, Directions: At least every 2 hours while in bed, resident's position should be changed, place your initials in the column noting which position the resident is in. When out of bed (OOB), place a [check mark] in the chair column.During an interview on 1/20/2026 at 12:12 p.m. with the Nursing Coordinator (NC), the NC stated a staff initial should have been entered on the repositioning form. 2. During an observation on 1/20/2026 at 12:13 p.m. in Resident 15's room, a Repositioning Schedule form was observed posted at the wall next to Resident 15's bedside. During a review of Resident 15's Repositioning Schedule Form dated 1/20/2026, the form indicated there was no repositioning entry on the form from 12 a.m. to 12 p.m. Further review of the form indicated, Directions: At least every 2 hours while in bed, resident's position should be changed, place your initials in the column noting which position the resident is in. When out of bed (OOB), place a [check mark] in the chair column.During an interview on 1/20/2026 at 12:15 p.m. with the Registered Nurse (RN 1), RN 1 stated Resident 15 was repositioned, but it was not documented on the form. RN 1 stated a staff initial should have been entered on the repositioning form. 3. During a review of Resident 49's Face Sheet (demographic), dated 11/18/2025, the face sheet indicated Resident 49 had a diagnosis of End Stage Renal Disease (ESRD -where the kidneys lose nearly all functions, failing to filter waste, fluids, and electrolytes). During a review of Resident 49's Physician's Orders, dated 11/27/2025 at 6 p.m., the physician orders indicated the following orders for Resident 49:a. Dialysis (a life-sustaining treatment that filters waste, electrolytes, and fluid from the blood when the kidneys fail and are unable to), on Tuesday, Thursday, and Saturday.b. Registered Nurse (RN) Assessment every shift: left upper extremity (LUE) arteriovenous fistula (AV fistula, a surgical connection of an artery and a vein that allows for blood to flow directly to provide a long-term access point for filtering blood in residents with kidney disease) .assess for bleeding and signs and symptoms (s/sx) of infection including lesions (abnormal change in the skin), swelling, erythema (redness), warmth, tenderness, soreness, pus/purulent drainage.c. RN Assessment every shift: Assess for s/sx of aneurysm (bulge), thinning of skin, depigmentation (loss or lightening of color), ulcerations (breakage of skin surface) or bleeding, s/sx vascular insufficiency including painful cold and pale extremity, capillary refill (a quick clinical test assessing peripheral blood flow by measuring how long it takes for color to return to a blanched nail bed after pressure is released) and distal pulse.d. RN Assessment every shift: Assess for s/sx venous or arterial stenosis (abnormal narrowing) /thrombosis (blood clot) by assessing pulse, thrill and bruit (thrill is the vibrating or buzzing sensation felt over a vessel and bruit is a swooshing sound heard over the same blood vessel, both indicating a strong blood flow of the AV fistula). During a concurrent interview and record review on 1/20/2026 at 2:03 p.m. with the Registered Nurse (RN 2), Resident 49's MTAR, for the month of January 2026 was reviewed. RN 2 stated Resident 49 had an AV fistula on the LUE and the LUE AV fistula was assessed every shift. A review of Resident 49's MTAR indicated missing entries on the following dates and time:1/7/2026 PM shift-RN Assessment every shift: AV fistula LUE, (assess for bleeding, and s/sx of infection including lesions, swelling, erythema, warmth, tenderness, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soreness, pus/purulent drainage. Check for placement and dressing q shift. May re-enforce dressing if dislodged).-RN Assessment every shift: Assess for s/sx of aneurysm (including bulging, thinning of skin, depigmentation, ulcerations, or bleeding; s/sx vascular insufficiency including painful, cold, and pale extremity, capillary refill, and distal pulse). -RN Assessment every shift: AV fistula LUE, (assess for s/sx of venous or arterial stenosis/thrombosis by assessing pulse, thrill, and bruit). 1/13/2026 PM shift-RN Assessment every shift: AV fistula LUE (assess for bleeding, and s/sx of infection including lesions, swelling, erythema, warmth, tenderness, soreness, pus/purulent drainage. Check for placement and dressing q shift. May re-enforce dressing if dislodged).-RN Assessment every shift: Assess for s/sx of aneurysm (including bulging, thinning of skin, depigmentation, ulcerations, or bleeding; s/sx vascular insufficiency including painful, cold, and pale extremity, capillary refill, and distal pulse). -RN Assessment every shift: AV fistula LUE (assess for s/sx of venous or arterial stenosis/thrombosis by assessing pulse, thrill, and bruit). RN 2 confirmed the missing entries on 1/7/2026 PM shift and on 1/13/2026 PM shift. During a review of the facility's policy and procedures (P&P) titled, Care of the Vascular Access for Hemodialysis Arteriovenous (AV) Fistula, AV Graft and Venous Catheter, dated December 2025, the P&P indicated, Documentation 1. Document the assessment and care provided every shift in the Medication and Treatment Record.		