STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555755	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare Center	8101 E Hill Drive Rosemead, CA 91770

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality of two of four sampled residents (Resident 3 and Resident 226) when: 1. Resident 3's suprapubic catheter (a tube that drains urine from your bladder by being inserted through a small incision made in your lower abdomen, just above your pubic bone) urinary bag (urine drainage bag to collect urine) was observed without a urinary catheter bag cover. 2. Resident 226 who was hard of hearing (HOH) and spoke a foreign language that the facility staffs could not understand, and the resident could not understand the common language in the facility was not accurately assessed and provided the proper means of communicating with the staffs and residents. These deficient practices violated the resident's rights to maintain privacy, enhanced self-esteem, self-worth, that resulted in Resident 226 expressed frustration, weeping, and stated she suffered a lot because of poor communication and her needs were not met. Findings: 1. During a review of Resident 3 ' s, Admission Record (AR), dated 2/5/2025, indicated Resident 3 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including benign prostatic hyperplasia (a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), obstructive and reflux uropathy (obstructive uropathy happens when urine can't flow through the urinary tract, while reflux uropathy occurs when urine flows backward into the kidneys), and history of urinary tract infection. A review of Resident 3 ' s History and Physical Examination (H&P), dated 12/3/2024, indicated Resident 3 does not have the capacity to understand and make decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Minimum Data Set (MDS-a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 3 ' s cognitive status (the mental process of thinking and understanding) was severely impaired. MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, toileting and personal hygiene, and required partial/moderate assistance (helper does less than half the effort) with bathing. A review of Resident 3 ' s facility document titled Order Summary Report (OSR), dated 2/1/2025, the document indicated Resident 3 had a suprapubic catheter attached to a drainage bag for obstructive and reflux uropathy. During a concurrent observation and interview on 2/5/2025 at 8:20 AM with certified nurse assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1 in Resident 3 ' s room, Resident 3 was sitting on his wheelchair with the suprapubic catheter urinary bag was without a urinary catheter bag cover. CNA 1 stated, she did not know where the urinary bag cover was. LVN 1 stated, Resident 3's urinary bag should have a cover, because not having the cover violates the resident ' s rights for privacy and dignity. During an interview on 2/5/2025 at 2:25 PM with Director of Nurses (DON), DON stated, Resident 3 should have a cover for his urinary bag, not having it violates his rights for privacy and dignity. A review of the facility ' s policy and procedure (P&P) titled, Resident Rights, dated 3/2023, indicated; a) employees shall treat all residents with kindness, respect and dignity, b) federal and state laws guarantee certain basic rights to all residents which includes, dignified existence, be treated with respect and dignity, and privacy and confidentiality. A review of the facility ' s policy and procedure (P&P) titled, Dignity, dated 2/2021, indicated; demeaning practices and standards of care that compromise dignity is prohibited, staff are expected to promote dignity and assist residents to keep urinary catheter bags covered. 48481 2. During a review of Resident 226 ' s Admission Record indicated Resident 226 was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control, dementia (a progressive state of decline in mental abilities), Unspecified abnormalities of Gait and Mobility (changes to the way a person walks or moves due to injuries, medical conditions, or other reasons.) During a review of Resident 226 ' s Minimum Data Set (MDS - a resident assessment tool) dated 10/1/24, indicated Resident 226 was severely cognitively impaired (a condition that makes it very difficult for a person to think, learn, and remember). The MDS also indicated Resident 226 had moderate difficulty in hearing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview 2/5/2025 at 9:05 AM, Resident 226 was observed writing on a piece of paper in foreign language back and forth with Certified Nursing Assistant (CNA) 1. Resident 226 stated the communication has been difficult between her and staffs, because she has hard of hearing (HOH) and she and the staffs do not understand each other sometimes with her limited English. Resident 226 stated there were times that staffs who didn't understand her language walked out of the room and did not come back. Resident 226 stated she had never been offered communication board, audio or video materials in the language that she speaks. Resident 226 was observed expressing frustration, weeping, and stated she suffered a lot because of poor communication and her needs were not met. During an interview on 2/5/25 at 9:15 AM with CNA 1, CNA 1 stated Resident 226 has HOH, speaks limited language that the facility uses, CNA 1 stated she communicates to the resident in writing when she was called to help translate in the language that the residents speak. CNA1 also stated she had noticed Resident 226 expressed sadness and frustration when complaining to her about not understanding the staffs and not being understood by the staffs. During an interview on 2/5/25 at 9:35AM, with Licensed Vocational Nurse (LVN)4, LVN 4 stated she communicated with Resident 226 via phone translation (connect with a live interpreter via phone for real-time translation), and she was aware the Resident 226 had HOH, and has language communication barrier, sometimes staffs assist translation, LVN 4 stated there was no communication board available at bedside for Resident 226 to use, and stated she does not use phone translation due to Resident 226 had a HOH so the method was not very effective. During an interview on 2/6/25 at 11:00 AM with Registered Nurse (RN) 2, RN 2 stated he uses body language, to communicate with Resident 226. RN 2 stated there was no communication board available. RN 2 stated he couldn ' t always ensure if Resident 226 understood him, sometimes based on translator ' s feedback. During a review of Resident 226 ' s Licensed Nurses Notes, dated 1/9/25 throughout 2/4/25, no documented evidence that indicated a translator and/or communication board was provided to the resident in a foreign language that the resident speaks and understands. During an interview on 2/6/25 at 9:16 AM with Director of Nursing (DON), DON stated when a resident is admitted with communication-sensory or language barrier, admission nursing staff should identify the risk factors, residents ' needs, develop and implement a person-centered care plan. Failure to communicate effectively between staffs and residents will impair resident rights. The DON stated communication is important, staffs should have properly assessed Resident 226 ' s needs, developed and implemented comprehensive care plan, and used effective communication methods to ensure staffs understand her, and Resident 226 can relate to the staffs. It's totally not acceptable to have resident's rights compromised due to any barrier. During a review of the facility ' s policy and procedure titled Resident Rights dated 2/2021, indicated Federal and State laws guarantee certain basic rights to all residents in the facility. These include resident ' s right to: a. be treated with respect, kindness, and dignity. b. be supported by the facility in exercising his or her rights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure titled Dignity dated 2/2021, indicated Each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The facility culture supports dignity and respect for resident goals, choices, preferences, values, and beliefs.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure residents the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, treatment and treatment alternatives or treatment options for four of four sampled residents (Residents 37, 12, 69 and 14) by failing to: 1. Obtain an informed consent for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) medications for Resident 37, who was prescribed Quetiapine (medication used to treat a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) for schizophrenia, and Divalproex Sodium (medication used to treat mental/mood conditions) for mood disorder. 2. Ensure the residents, or the responsible party was informed about the Physician Orders for Life-Sustaining Treatment (POLST) for Resident 12, 69 and 14. This deficient practice had violated resident rights to be informed when choosing the type of care or treatment to receive, make decisions on alternative measures the resident or responsible party preferred, which can negatively affect Residents 37,12, 69, and 14's quality of life and/or delay in residents care that could ultimately result to adverse health outcomes. Findings: 1. During a review of the admission record indicated Resident 37 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), psychotic disorder (affect the mind, where there has been some loss of contact with reality), and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and actions). The admission record indicated Resident 37 had a family member that has power of attorney [POA] and is considered the resident's representative [RR] and emergency contact. A review of Resident 37's History and Physical Examination, dated [DATE], indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Minimum Data Set (MDS - a resident assessment tool), dated [DATE], indicated Resident 37 required partial/moderate assistance (helper does less than half the effort) with eating, toileting, personal hygiene, and bathing. During a review of Resident 37 ' s facility document Order Summary Report (OSR), dated [DATE], the document indicated physician orders for: a) Quetiapine 100 mg (unit of weight) to give 1 tablet every 12 hours for schizophrenia ordered [DATE], and b) Divalproex Sodium 500 mg to give 1 tablet every 12 hours for mood disorder, ordered [DATE]. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on [DATE], at 9:45 AM, with Registered Nurse (RN) 1, Resident 37's facility document titled Informed Consent for medications Quetiapine and Divalproex sodium, dated [DATE], was reviewed. The documents did not have the signature of the prescriber nor the signature of Resident 37 ' s RR or POA. RN 1 stated, Resident 37 ' s informed consents were not complete, it should have the signature of the prescriber within 24 hours of admission. RN 1 stated, it is important to have a complete informed consent for psychotropic medications to ensure the Resident or the responsible party are aware of the cause and effect of the medications and other alternatives available. During a concurrent interview and record review, on [DATE], at 9:55 AM, with RN 1, Resident 37's electronic health records (EHR) was reviewed from admission[DATE] until [DATE] was reviewed. The EHR did not have any documentation that informed consent for the psychotropic medications Quetiapine and Divalproex sodium was obtained by the prescriber. RN 1 stated, she could not see any documentation specifically stating informed consent for the psychotropic drugs was obtained by the prescriber. During an interview on [DATE] at 10:00 AM with MDS Nurse (MDSN) 1, MDSN 1 stated, the informed consent for psychotropic drugs is not complete without the prescriber ' s signature. MDSN 1 stated, it is important to have informed consent for psychotropic drugs to ensure the resident or the responsible party are aware of the pros (advantages) and cons (disadvantages) of the medication prior to making a decision, it is also for patient safety. During an interview on [DATE] at 10:20 AM with Director of Nurses (DON), the DON stated, Resident 37's informed consent for psychotropic medications Quetiapine and Divalproex sodium was not complete, it should have been signed by the prescriber as soon as possible within 24 hours. The DON stated, he did not have proof consent for psychotropic drugs was obtained by the prescriber from Resident 37 or responsible party. The DON stated, it is to ensure the informed consent was done and the medications was explained to Resident 37 and /or the responsible party about the pros and cons of the medications and other alternative treatments. During a review of the facility's policy and procedure (P&P) titled Informed Consent for Psychotropic Drug Use (undated), indicated: a) prior to prescribing a psychotropic medication, the licensed prescriber shall examine the resident and obtained informed consent either from the resident (if able) or the resident ' s representative, b) the license nurse shall verify written informed consent specifying the disclosure of material information for proper informed consent c) licensed nurse shall verify from the resident and/or legal representative whether the consent has been obtained for the use of psychotropic medication and will sign the form and document the person who gave consent and the date the consent was verified, and d) the licensed prescriber, Resident representative may sign the informed consent using remote technology, if possible and as soon as practicable. 2. A review of Resident 12's Admission Record indicated the facility admitted Resident 12 on [DATE] and readmitted on [DATE] with diagnoses that included schizoaffective disorder (symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), Chronic Obstructive Pulmonary Disease (COPD) (a common lung disease causing restricted airflow and breathing problems), and history of urinary tract infection. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], indicated that Resident 12's cognitive status (the mental process of thinking and understanding) was moderately impaired. The MDS Indicated Resident 12 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity. Helper assists only prior to or following the activity) with eating and bathing and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with toileting and personal hygiene. During a concurrent interview and record review, on[DATE], at 12:27 PM, with Registered Nurse (RN) 1, Resident 12 facility document titled Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE] was reviewed. The POLST indicated DNR (It instructs providers not to do CPR (cardiopulmonary resuscitation) if a patient's breathing stops or if the patient's heart stops beating) status, but it was missing the responsible party ' s signature. RN 1 stated, the POLST is not valid because it is missing the responsible party ' s signature. RN 1 stated, Resident 12 POLST is used as a Physician Order by other medical professionals when Resident 12 goes to the hospital or incase of emergency, not having a valid POLST may delay the care of Resident 12. A review of Resident 69's Admission Record indicated that the facility originally admitted Resident 69 on [DATE] and readmitted on [DATE] with diagnoses that included Dementia (a group of related symptoms associated with an ongoing decline of the brain and its abilities), coronary artery dissection (a condition that affects your heart), and diabetes (lifelong condition that causes a person's blood sugar level to become too high). A review of Resident 's MDS, dated [DATE], indicated that Resident 69's cognitive status (the mental process of thinking and understanding) was moderately impaired. The MDS Indicated Resident 69 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity, helper assists only prior to or following the activity) with eating, toileting, bathing and personal hygiene. During a concurrent interview and record review, on[DATE], at 12:30 PM, with Registered Nurse (RN) 1, Resident 69 facility document titled Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE] was reviewed. The POLST indicated DNR status, but it was missing the responsible party's signature. RN 1 stated, the POLST is not valid because it is missing the responsible party's signature. RN 1 stated, Resident 69 POLST is used as a Physician Order by other medical professionals when Resident 69 goes to the hospital or in case of emergency, not having a valid POLST may delay the care of Resident 69. During an interview on [DATE] at 2:30 PM with Director of Nurses (DON) , DON stated, the POLST needs to have the signature of the Physician, the Resident or the responsible party to be considered valid. DON stated, the POLST are kept in the Resident physical chart to be used by medical professionals as a Physician Order during transfers to the hospitals and/or during emergency, not having a valid POLST may cause delayed of care. 36925 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 14's Admission Record indicated that the facility admitted Resident 14 on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], indicated that Resident 14's cognition (mental action or process of acquiring knowledge and understanding) was intact. A review of Resident 14's medical records indicated that the facility prepared a POLST on [DATE] but failed to obtain the signature of the resident before placing it in the resident's chart. During an interview on [DATE] at 3:37 PM, LVN 4 stated that the facility should offer the Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) and the POLST to the resident on admission and have it signed accordingly. LVN 4 stated that without these records in place, the facility would not know the medical interventions the resident wanted during end-of-life situations. During an interview on [DATE] at 3:51 PM, the medical records director (MRD) stated that it was his responsibility to ensure that the facility offered the resident an Advance Directive and a POLST during admission and to have it filled out and signed accordingly before he uploads those documents to the PCC and place them in the chart of the resident. The MRD stated that without these records in place, the staff would not know what end-of-life treatment the resident wanted during emergency situations. The MRD stated that he must have overlooked it. A review of the facility's policy and procedure (P&) titled, POLST dated ,d+[DATE], indicated ; a) the facility follows the guidance attached Quick Reference Guide ON POLST IN NURSING HOME which indicates the POLST isn't valid unless it is signed by a (1) physician, nurse practitioner or physician assistant and (2) the resident, if resident lacks capacity, the resident's legally recognized healthcare decision maker, b) by signing POLST, which becomes a medical order, the physician, nurse practitioner, or physician assistant certifies that the order on the form are consistent with the resident medical condition and preferences, and c) when completed by the patient or legally recognized representative a physician, nurse practitioner or physician assistant the POLST becomes a medical order that should also be included in the patient's medical record. A review of the facility's policy titled, Charting and Documentation, Version 1.2, revised in ,d+[DATE], indicated that documentation in the medical record should be complete and accurate. During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated ,d+[DATE], indicated, federal and state law guarantee certain basic rights to all residents of the facility, these rights included resident rights to: a) be informed about his rights and responsibilities, and b) be informed of his medical condition and of any changes in his condition.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925 Based on interview and record review, the facility failed to implement its policy and procedure on Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) by failing to ensure the Advance Directive was offered and explained and the signed AD was in the chart for two of four sampled residents (Residents 14 and 39). This deficient practice has the potential to omit the residents ' medical decisions if they become incapacitated (unable to make decision for self) leading to unnecessary or unwanted treatments due to lack of clear instructions regarding their end-of-life care. Findings: 1. A review of Resident 14's Admission Record indicated that the facility admitted Resident 14 on 11/15/2024 with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2024, indicated that Resident 14 ' s cognition (mental action or process of acquiring knowledge and understanding) was intact. A review of Resident 14's medical records showed that the resident did not have an Advance Directive in his chart or in the facility's Point Click Care database program (PCC, a cloud-based software platform that helps healthcare organizations manage care and services of the residents). A review of Resident 14's Admission Assessment and Nurse ' s Notes, dated 11/15/2024, showed no indication that the facility offered an Advance Directive to Resident 14 during admission. 2. A review of Resident 39's Admission Record indicated that the facility initially admitted Resident 39 on 9/4/2019 and readmitted the resident on 10/31/2024 with diagnoses that included pneumonia (an infection/inflammation in the lungs) and schizophrenia. A review of Resident 39's History and Physical evaluation, dated 10/31/2024, indicated that the resident did not have the capacity to understand and make decisions. A review of Resident 39's MDS dated [DATE], indicated that Resident 39's cognition was intact. A review of Resident 39's medical records showed that the resident did not have an Advance Directive or a Physician's Orders for Life-Sustaining Treatment (POLST, a portable, medical order form that documents a patient's preferences for end-of-life care) in his chart or in the facility's PCC database program. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/2025 at 3:10 PM, Licensed Vocational Nurse (LVN) 3 stated that the facility should place the Advance Directive and the POLST in the chart of the resident. LVN 3 stated that she does not know who is responsible in ensuring that these forms are in place. During an interview on 2/4/2025 at 3:37 PM, LVN 4 stated that the facility should offer the Advance Directive and the POLST to the resident on admission and have it signed accordingly. LVN 4 stated that without these records in place, the facility would not know the medical interventions the resident wanted during end-of-life situations. During an interview on 2/4/2025 at 3:51 PM, the medical records director (MRD) stated that it was his responsibility to ensure that the facility offered the resident an Advance Directive and a POLST during admission and have it filled out and signed accordingly before he uploads them to the PCC and puts them in the chart of the resident. The MRD stated that without these records in place, the staff would not know what end-of-life treatment the resident wanted during emergency situations. The MRD stated that he must have overlooked it. A review of the facility's undated policy titled, Advance Directives, version 2.0, revised in 9/2022, indicated that prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. If the resident or representative indicates that he or she has not established advance directives, the facility staff will help in establishing advance directives and the nursing staff will document in the medical record that assistance was offered and the resident ' s decision to accept or decline assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident for two of two sampled residents (Resident 9 and 226) in accordance to the facility's policy and procedure and the resident's rights by [NAME] to ensure: 1. A plan of care was developed to address Resident 9 with behavior of physically aggression towards staffs and the residents and went to other resident's rooms and took their personal belongings. 2. A plan of care was developed to address Resident 226's concern of hard of hearing (HOH) and communication in a foreign language that the facility staffs could not understand, These deficient practices resulted for Resident 9 to have multiple incidents of aggressive behavior that potentially exposed other residents to physical and psychological harm. In addition Resident 226 had verbalized frustration and the potential not to receive the necessary care and services the resident needed especially in an event of emergency. Cross reference to F550 and F740 Findings: 1. A review of Resident 9's Admission Record indicated that the facility initially admitted Resident 9 on 2/27/2012 and readmitted the resident on 1/14/2025 with diagnoses that included schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, indicated that Resident 9's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated that Resident 9 required partial/moderate assistance (helper does less than half the effort of the task) from a person when performing most of her daily living activities. A review of Resident 9's Change of Condition (COC) assessment, dated 1/16/2025 and 1/28/2025, indicated that Resident 9 showed an aggressive behavior towards the staff and residents. The COC on 1/16/2025 indicated that Resident 9 was trying to attack the staff and residents and went to the room of other residents to take their personal belongings. The COC on 1/28/25 indicated that Resident 9 was again trying to strike out at the staff and residents. A review of Resident 9's medical records indicated that the facility did not create a care plan for Resident 9 ' s COC on 1/16/2025 when Resident 9 tried to attack the staff and residents and went to the rooms of other residents to take their personal belongings. A review of Resident 50's Admission Record indicated that the facility initially admitted on [DATE] and readmitted the resident on 3/13/2025 with diagnoses that included schizophrenia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 50's MDS, dated [DATE], indicated that Resident 50's cognition was moderately intact. The MDS indicated that Resident 50 required partial/moderate assistance (helper does less than half the effort of the task) from a person when performing most of her daily living activities. During an interview with Resident 50 on 2/5/2025 at 10:50 AM, she stated that about three weeks ago, Resident 9 went to her room, took her pillow, and left. Resident 50 stated that on 2/4/2025, Resident 9 went back to her room, stood at the doorway, and refused to leave when she asked her to go back to her room. Resident 50 stated that she reported the incident to one of the licensed nurses. During an interview with licensed vocational nurse (LVN) 4 on 2/5/2025 at 1:51 PM, LVN 4 stated that she initiated a COC for Resident 9 on 1/16/2025 since Resident 9 became physically and verbally aggressive towards the staff and other residents; however, she stated that Resident 9 did not have physical contact with any resident. LVN 4 stated that Resident 9 also went to the rooms of other residents on the same day and took their personal belongings. During an interview with LVN 1 on 2/5/2025 at 1:58 PM, LVN 1 stated that she initiated a COC for Resident 9 on 1/28/2025 since Resident 9 became physically aggressive towards the staff and other residents; however, LVN 1 stated that Resident 9 did not have physical contact with any resident. During an interview and a record review of Resident 9's medical records with the director of nursing (DON) on 2/7/2025 at 7:50 AM, the DON stated that the facility did not conduct an interdisciplinary team (IDT, a group of professionals from different disciplines who work together collaboratively to achieve a common goal) meeting or created a care plan to address Resident 9's behavior on 1/16/2025. The DON stated that the facility should have conducted an IDT meeting and created a care plan for Resident 9 to ensure the safety of the residents, prevent harm, and promote dignity and privacy among the residents. A review of the facility's undated policy titled, Care Plans, Comprehensive Person-Centered, version 2.0, revised in 3/2022, indicated that the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, should develop and implement a comprehensive, person-centered care plan to meet the physical and psychosocial needs of each resident. 48481 2. During a review of Resident 226 ' s Admission Record indicated Resident 226 was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control, dementia (a progressive state of decline in mental abilities), Unspecified abnormalities of Gait and Mobility (changes to the way a person walks or moves due to injuries, medical conditions, or other reasons.) During a review of Resident 226 ' s Minimum Data Set (MDS - a resident assessment tool) dated 10/1/24, indicated Resident 226 was severely cognitively impaired (a condition that makes it very difficult for a person to think, learn, and remember). The MDS also indicated Resident 226 had moderate difficulty in hearing. During a review of Resident's 226's Care Plan dated 1/10/25, indicated Resident 226 was at risk of having needs unmet related to difficulty in communication secondary to hard of hearing and spoke a foreign language. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident will be able to relate to others effectively daily until the next assessment. 2. Resident will have communication needs met by use appropriate interventions daily until the next assessment. During a concurrent observation and interview 2/5/2025 at 9:05 AM, Resident # 226 was observed writing on a piece of paper in foreign language back and forth with Certified Nursing Assistant (CNA) 1. Resident 226 stated the communication has been difficult between her and staffs, because she has hard of hearing (HOH) and she and the staffs do not understand each other sometimes with her limited English. Resident 226 stated there were times that staffs who didn't understand her language walked out of the room and did not come back. Resident 226 stated she had never been offered communication board, audio or video materials in the language that she speaks. Resident 226 was observed expressing frustration, weeping, and stated she suffered a lot because of poor communication and her needs were not met. During an interview on 2/5/25 at 9:15 AM with CNA 1, CNA 1 stated Resident 226 has HOH, speaks limited language that the facility uses, CNA 1 stated she communicates to the resident in writing when she was called to help translate in the language that the residents speak. CNA1 also stated she had noticed Resident 226 expressed sadness and frustration when complaining to her about not understanding the staffs and not being understood by the staffs. During an interview on 2/5/25 at 9:35AM, with Licensed Vocational Nurse (LVN)4, LVN 4 stated she communicated with Resident 226 via phone translation (connect with a live interpreter via phone for real-time translation), and she was aware the Resident 226 had HOH, and has language communication barrier, sometimes staffs assist translation, LVN 4 stated there was no communication board available at bedside for Resident 226 to use, and stated she does not use phone translation due to Resident 226 had a HOH so the method was not very effective. During an interview on 2/6/25 at 11:00 AM with Registered Nurse (RN) 2, RN 2 stated he uses body language, to communicate with Resident 226. RN 2 stated there was no communication board available. RN 2 stated he couldn ' t always ensure if Resident 226 understood him, sometimes based on translator ' s feedback. During a review of Resident 226 ' s Licensed Nurses Notes, dated 1/9/25 throughout 2/4/25, no documented evidence that indicated a translator and/or communication board was provided to the resident in a foreign language that the resident speaks and understands. During an interview on 2/6/25 at 9:16 AM with Director of Nursing (DON), DON stated when a resident is admitted with communication-sensory or language barrier, admission nursing staff should identify the risk factors, residents ' needs, develop and implement a person-centered care plan. Failure to communicate effectively between staffs and residents will impair resident rights. Communication is important, staffs should have properly assessed Resident 226 ' s needs, developed and implemented comprehensive care plan, and used effective communication methods to ensure staffs understand her, and Resident 226 can relate to the staffs. It's totally not acceptable to have resident's rights compromised due to any barrier. During a review of the facility ' s policy and procedure titled Care Plans, Comprehensive Person-Centered dated 3/2022, indicated The comprehensive, person-centered care plan: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Includes measurable objectives and timeframes. b. Describe services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. c. Builds on the resident ' s strengths. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and relevant clinical decision making.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481 Based on observation, interview, and record review, the facility failed to ensure a resident received proper assistive devices to maintain hearing abilities for one of 3 sampled residents (Resident 226) who was not assisted by the facility in arranging a referral for audiologist (a physician specialized in hearing loss) consult. This deficient practice resulted in a delay of services and Resident 226 not being able to hear adequately while communicating with staffs. Findings: During an observation on 2/4/25 at 8:33 AM, Resident 226 was observed alert, lying in bed, with a raised voice speaking to a laboratory staff, who also had to raise volume for Resident 226 to hear the resident. Resident 226 also pulled out pieces of paper and requested to communicate in writing. During an interview on 2/4/25 at 9:31 AM, Resident 226 stated she has hard of hearing (HOH), has no device, to assist her with the difficulty hearing whatever the staffs say to her. During a concurrent observation and interview on 2/5/25 at 9:15 AM with CNA 1, CNA 1 was observed writing on a paper to communicate with Resident 226, CNA 1 stated writing works better than speaking to Resident 226. CNA1 also stated aware that Resident 226 has HOH, speaks limited language formally used in the facility. CNA 1 stated she was often called by staffs to Resident 226 ' s room to help translate in a language that the resident speaks and understands. CNA 1 stated she often hear Resident 226 complained not understanding the staffs and not being understood. During an interview on 2/5/25 at 9:20 AM, LVN 5 stated she aware that Resident 226 was HOH, and has language barrier. LVN 5 stated sometimes she use body gestures to communicate with the resident but can ' t be sure if Resident 226 fully understood what she ' s trying to tell Resident 226. During a review of Resident 226's Admission Record indicated Resident 226 was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Unspecified Dementia (a progressive state of decline in mental abilities), abnormalities of Gait and Mobility (changes to the way a person walks or moves due to injuries, medical conditions, or other reasons.) During a review of Resident 226's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/24, indicated Resident 226 was severely cognitively impaired (a condition that makes it very difficult for a person to think, learn, and remember). The MDS also indicated Resident 226 had moderate difficulty in hearing. During a review of a physician order dated 1/9/25, indicated Resident 226 was referred to Audiology consult PRN (as needed) for hearing problems. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/25 at 8:50 AM with Social Service Director (SSD). SSD stated spoke to Resident 226 and her responsible party upon admission. SSD stated Resident 226 did not have hearing disability, that ' s why ENT (Ear, Nose, Throat) doctor appointment arranged set up necessary. No staffs reported SSD re: hearing disability. During an interview on 2/6/25 at 9:16 AM with Director of Nursing (DON), DON stated when a resident is admitted with communication-sensory barrier, the SSD has to do the assessment, MDS also assess resident upon admission, and reassess if there's discrepancy in the assessments. Then SSD arrange audiology consult and make appointment for resident. Failure to report resident ' s needs for specialty consultation delay the care and services, and impaired resident rights. Communication is important, staffs should have properly assessed Resident 226 ' s needs and used effective communication methods to ensure resident can understand. It's totally not appropriate to have resident's care delayed due to any barrier. During a review of the facility's policy and procedure titled Accommodation of Needs Related to Communication Deficits revision date 3/2021, indicated Communication needs will be identified, and appropriate interventions will be developed in order to accommodate the needs of the residents. Communication needs will be assessed as follows: a. Psycho-Social Assessment form; Resident Identifying Date- Language Spoken b. Rehabilitation Screening- Mode of Expression, etc c. Communication Section on Social Service Progress Notes. During a review of the facility's policy and procedure titled Accommodation of Needs, revision dated 3/2021, indicated that facility ' s environment and staff behavior are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The resident ' s individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. Interact with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) received appropriate treatment and services to prevent urinary tract infection (UTI-when bacteria gets into your urine and travels up to your bladder), in accordance with the facility's policy and procedures (P&P) on Infection Prevention and Control Program. 1. On 2/4/2025, Resident 3 was observed while sitting on his wheelchair, Resident 3's suprapubic catheter (a tube that drains urine from your bladder by being inserted through a small incision made in your lower abdomen, just above your pubic bone) drainage bag (urine drainage bag to collect urine) was hanging on the wheelchair ' s left arm rest (positioned higher than Resident 3's bladder). 2. On 2/5/2025, Resident 3 was observed with the suprapubic catheter tubing wrapped around his left leg while sitting on his wheelchair. This deficient practice had the potential for Resident 3 to have recurrent urinary tract infection and negatively affect Resident 3's quality of life. Findings: During a review of Resident 3's, Admission Record (AR), dated 2/5/2025, indicated Resident 3 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including benign prostatic hyperplasia (a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), obstructive and reflux uropathy (Obstructive uropathy happens when urine can't flow through the urinary tract, while reflux uropathy occurs when urine flows backward into the kidneys), and history of urinary tract infection (UTI). During a review of Resident 3's History and Physical Examination (H&P), dated 12/3/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 3's cognitive status (the mental process of thinking and understanding) was severely impaired. The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, toileting and personal hygiene, and required partial/moderate assistance (helper does less than half the effort) with bathing. During a review of Resident 3's care plan (CP) for suprapubic catheter, at risk for complication from catheter use (i.e. recurrent urinary tract infection) initiated 12/27/2019, the CP indicated staff to maintain proper alignment of the suprapubic catheter to promote proper drainage. During a review of Resident 3's facility document titled NC-COC/Interact Assessment Form (SBAR), dated 9/14/2022, the document indicated Resident 3 had a UTI and was placed on antibiotic (medicines that fight bacterial infections) therapy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Order Summary Report (OSR), dated 2/1/2025, the OSR indicated, an order date of 11/30/2024 the use of suprapubic catheter attached to drainage bag for obstructive and reflux uropathy. During a concurrent observation and interview on 2/4/2025 at 10:15 AM with Registered Nurse (RN) 1 in the Dining Room, Resident 3 was sitting on his wheelchair, his suprapubic catheter drainage bag was hanging on the wheelchair's left armrest (positioned higher than Resident 3's bladder). RN 1 stated, the urinary drainage bag should not be hanging on the armrest, it should be under the wheelchair seat and must be positioned lower that Resident 3's bladder. RN 1 stated, the position of the urinary drainage bag could cause backflow of urine back to Resident 3's bladder and can cause UTI. During a concurrent observation and interview on 2/5/2025 at 8:20 AM with Licensed Vocational Nurse (LVN) 1, and Certified Nurse Assistant (CNA) 1 in Resident 3 ' s room, Resident 3 while sitting on his wheelchair, noted his suprapubic catheter tubing was wrapped around his left leg. CNA 1 did not have an answer to why the suprapubic catheter tubing was wrapped around Resident 3's left leg, LVN 1 stated, Resident 3's suprapubic catheter tubing wrapped around his leg is not appropriate, the urine will not flow freely and could cause backflow to Resident 3's bladder and had the potential to cause UTI. During an interview on 2/5/2025 at 2:05 PM with the Infection Preventionist (IP), the IP stated, the suprapubic catheter urinary bag should always be positioned below the resident's bladder. The IP stated the suprapubic catheter tubing should not be wrapped around residents' leg because these practices could cause back flow to Resident 3's bladder and had the potential to cause UTI. During an interview on 2/5/2025 at 2:25 PM with the Director of Nurses (DON), the DON stated, the suprapubic catheter urinary bag should not be hanging on Resident 3's wheelchair arm rest, it should always be positioned below Resident 3's bladder, and the tubing should not be wrapped around Resident 3's leg, otherwise it could cause backflow to Resident 3's bladder and cause UTI. During a review of the facility's P&P titled, Suprapubic Catheter Care, dated 10/2010, the P&P indicated; a)the purpose of the procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident ' s urinary tract, b) to review the resident ' s care plan to assess for any special needs of the resident and c) the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. During a review of the facility's P&P titled, Infection Prevention and Control Program revised 4/2023, the P&P indicated; a) the facility established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and b) important facets of infection prevention include instituting measures to avoid complications or dissemination (to spread or scatter).

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 36925 Based on interview and record review, the facility failed to implement its policy and procedure on behavioral health services by failing to provide one of two sampled residents (Resident 9) a referal to psychiatrist (a physician specialized in mental and behavioral health) consultation evaluation for aggressive behavior towards the staff and residents to attain the resident's highest practicable physical, mental, and psychosocial well-being. This deficient practice had the potential to worsen the mental health symptoms of the resident, increase risk of relapse, decrease quality of life, and increase the likelihood of needing more intensive interventions like hospitalization in the future. Findings: A review of Resident 9's Admission Record indicated that the facility initially admitted Resident 9 on 2/27/2012 and readmitted the resident on 1/14/2025 with diagnoses that included schizophrenia (a mental illness characterized by disturbances in thought and false belief of reality). A review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, indicated that Resident 9's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated that Resident 9 required partial/moderate assistance (helper does less than half the effort of the task) from a person when performing most of her daily living activities. A review of Resident 9's Change of Condition (COC) assessment, dated 1/16/2025 and 1/28/2025, indicated that Resident 9 showed an aggressive behavior towards the staff and residents. The COC dated 1/16/2025 indicated Resident 9 was trying to attack the staff and residents, went to a resident's room, and took the personal belongings of another resident. The COC on 1/28/2025 indicated that Resident 9 was again trying to strike out at the staff and residents. A review of Resident 9's medical records indicated that the facility created a care plan on 1/28/2025 to address Resident 9's aggressive behavior towards the staff and residents. The interventions in the care plan included a consultation with a psychiatrist to evaluate the resident 's behavior. During an interview with Licensed Vocational Nurse (LVN) 4 on 2/5/2025 at 1:51 PM, LVN 4 stated that she initiated a COC on 1/16/2025 since Resident 9 became physically and verbally aggressive towards the staff and other residents. During an interview with LVN 1 on 2/5/2025 at 1:58 PM, LVN 1 stated that she initiated a COC on 1/28/2025 since Resident 9 became physically aggressive towards the staff and other residents. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and a record review of Resident 9's medical records with the Director of Nursing (DON) on 2/7/2025 at 7:50 AM, the DON stated that the facility created a care plan on 1/28/2025 to address the aggressive behavior of Resident 9 with an intervention to consult a psychiatrist to evaluate the resident. The DON stated that the facility overlooked that intervention and failed to refer Resident 9 to the psychiatrist. A review of the facility's undated policy titled, Behavioral Health Services, version 1.0, revised in 2/2019, indicated that the facility would provide residents with behavioral services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident in accordance with the comprehensive assessment and plan of care.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36925 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five (5) percent (%) during medication pass by committing four (4) medication errors on one of six sampled residents (Resident 15) during medication observation with 29 medication opportunity that resulted to a 13.79% medication error rate. This deficient practice had the potential to result in adverse reaction) undesired effect of a drug or other type of treatment) to the medications that could jeopardize the safety of the residents that could lead to serious harm, injury, or death. Findings: A review of Resident 15's Admission Record indicated that the facility initially admitted Resident 15 on 4/3/2024 and readmitted the resident on 10/9/2024 with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 12/27/2024, indicated that Resident 15's cognition (mental action or process of acquiring knowledge and understanding) was severely impaired. A review of Resident 15's Order Summary Report, indicated that as of 2/1/2025, the physician ordered to administer the following medications to Resident 15: 1. Depakote Sprinkles Oral Capsule Delayed Release Sprinkle (used to treat seizure disorders and mental/mood conditions) 125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). Give one capsule by mouth two times a day. 2. Docusate Sodium (a stool softener to treat constipation) Oral Tablet 100 mg. Give one tablet by mouth one time a day. 3. Multivitamin-Minerals (a combination of vitamins and minerals to prevent nutrient deficiencies) Oral Tablet. Give one tablet by mouth one time a day. 4. Sodium Chloride (an electrolyte replenisher) Oral Tablet 1 gram (metric unit of measurement, used for medication dosage and/or amount). Give one tablet by mouth one time a day. During a medication administration observation on 2/6/2025 at 8:42 AM, LVN 3 prepared four (4) oral medications (Docusate Sodium tablet, Depakote Sprinkles capsule, Multivitamin-Minerals tablet, and Sodium Chloride tablet), crushed them, and mixed them in a single container with apple sauce. The surveyor interrupted LVN 3 before she was about to administer the medications to Resident 15. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with LVN 3, she stated that she realized she was not supposed to mix the medications all together. LVN 3 stated that Resident 15 would not know what medication she would be taking if she crushes and mixes them. During an interview on 2/7/2025 at 1:46 PM, the director of nursing (DON) stated that ideally, the licensed nurse should administer crushed medications separately, unless the resident wants to take them all together in a single container. The DON stated that it is a matter of resident preference whether to administer crushed medications individually or separately. A review of the facility's undated policy titled, Administering Medications, version 2.1, revised in 4/2019, indicated that medications should be administered in a safe and timely manner. The policy did not have a specific instruction or procedure on how to properly administer crushed medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36925 Based on observation, interview, and record review, the facility failed to implement its policy and procedure on how to properly and safely store medications and biologicals by failing to separately store Hydrogen Peroxide Topical Solution (an external [outside the body] medication with mild antiseptic used on the skin to prevent infection of minor cuts, scrapes, and burns) on the same shelf with oral (medications given by mouth) medications such as stool softeners and vitamins. This deficient practice had the potential to cause medication errors and expose residents to adverse reactions (an undesired harmful effect) that could lead to serious harm or death. Findings: During an inspection of the facility's East Wing medication storage room with licensed vocational nurse (LVN) 3 on 2/6/2025 at 10:05 AM, a bottle of Hydrogen Peroxide Topical Solution, an external (applied outside the body) medication used on the skin to prevent infection of minor cuts, scrapes, and burns, was observed on the same shelf where oral medications were kept. During a concurrent interview with LVN 3, LVN 3 stated that the facility should not store external medications on the same shelf where oral medications are kept to prevent medication errors. During an interview on 2/7/2025 at 1:56 PM, the director of nursing (DON) stated that the facility should keep oral medications and external medications separately to avoid medication errors. The DON stated that storing oral and external medications together increases the risk of misidentification and accidental ingestion of an external medication, especially if the containers look similar. The DON stated that he did not know who placed the external medication on the same shelf where oral medications were stored. A review of the facility's undated policy titled Medications Storage in the Facility, effective 4/2008, indicated that medications and biologicals should be stored safely, securely, and properly. The policy indicated that orally administered medications should be kept separate from externally used medications, such as suppositories, liquids, and lotions.

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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. 48481 Based on observation, interview, and record review, the facility failed to ensure one of the two refrigerators (located in the temporary food storage room at nearby facility) temperatures were monitored and documented before and between meal service activities for stable temperatures. This deficient practice placed the facility residents at risk for foodborne illness an (illness that comes from eating contaminated food) due to inconsistent refrigerator temperature monitoring and documentation. Findings: During a follow up kitchen tour on 2/6/25 at 12PM with the Dietary Service Supervisor (DSS) in the temporary food storage room located outside the kitchen, three (3) refrigerators and one (1) freezer were observed in this storage room. Each was observed with one thermometer inside. A Refrigerator and Freezer Temperature Log for February 2025 was observed hanging on the door. The log for 2/4/25 PM through 2/6/25 for Refrigerator 2 was blank. The log for Refrigerator 3 and Freezer was blank from 2/4/25 through 2/6/25. During an interview with on 2/6/25 at 12:10 PM, the DDS stated that the cooks for AM and PM shift are designated for checking all the temperature in the refrigerators and freezers and logs. DSS stated she was not sure if the cooks checked the logs, but the DDS should have not missed daily inspection of the logs. DSS also stated she was responsible for checking the logs and supervising the staffs for keep the log to ensure all the temperature in the refrigerators and freezers being monitored for safe food storage. During a review of the facility's policy and procedure titled, Refrigerators and Freezers dated 11/2022, indicated Monthly tracking sheets include time, refrigerator temperature, temperature of PHF/TCS food, initials, and action taken, The last column will be completed only if temperatures are not acceptable. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure a system in preventing, controlling infections and communicable diseases were in place, when one of two sampled residents (Resident 3) according to the facility's Infection Prevention and Control Program. Resident 3 who was on an enhance barrier precaution (EBP) (taking extra steps to prevent the spread of serious infections, like using gowns and gloves) due to a suprapubic catheter (a tube that drains urine from your bladder by being inserted through a small incision made in your lower abdomen, just above your pubic bone) was observed receiving high contact care (fixing Resident 3 ' s suprapubic catheter tubing and urine drainage bag) from Licensed Vocational Nurse (LVN) 1 and Certified Nurse Assistant (CNA) 1). LVN 1 and CNA 1 failed to use an isolation gown as part of their PPE (Personal Protective Equipment) and proceeded to the Nurses Station without performing hand hygiene (a way of cleaning the hands, which can prevent the spread of germs) after the care. These deficient practices had the potential to cause and/or spread of infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) in the facility. Findings: During a review of Resident 3's, Admission Record (AR), dated 2/5/2025, indicated Resident 3 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including benign prostatic hyperplasia (a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), obstructive and reflux uropathy (Obstructive uropathy happens when urine can't flow through the urinary tract, while reflux uropathy occurs when urine flows backward into the kidneys), and history of urinary tract infection. During a review of Resident 3's History and Physical Examination (H&P), dated 12/3/2024, indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 3's cognitive status (the mental process of thinking and understanding) was severely impaired. MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating, toileting and personal hygiene, and required partial/moderate assistance (helper does less than half the effort) with bathing. During a review of Resident 3's care plan (CP) for suprapubic catheter, at risk for complication from catheter use (i.e. recurrent urinary tract infection) revised 1/31/2025, the CP indicated intervention included Enhance Standard Precaution due to status post suprapubic catheter. During a review of Resident 3's care plan (CP) for Enhance Barrier Precaution due to suprapubic catheter use, revised 1/31/2025, the CP indicated interventions that included hand hygiene during any direct contact, and providing enhance standard precaution gloves, gowns, mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Order Summary Report (OSR), dated 2/1/2025, the OSR indicated; a) an order date of 11/30/2024 the use of suprapubic catheter attached to drainage bag for obstructive and reflux uropathy, and b) an order date of 12/2/2024, Resident 3 was placed on Enhanced Barrier Precautions due to suprapubic catheter in place. During an observation on 2/5/2025 at 8:30 AM in Resident 3's room, Resident 3, who was on an Enhance Barrier Precaution, was receiving a high contact care (fixing Resident 3's suprapubic catheter tubing and urine drainage bag) from two nursing staff (CNA 1 and LVN 1), both nursing staff was not wearing a gown as part of their PPE, then both staff proceeded to the nurses station after the care without performing hand hygiene. During an interview on 2/5/2025 at 8:45 AM with CNA 1, CNA 1 did not have an answer to why she did not wear a gown as part of her PPE prior to taking care of Resident 3, and not performing hand hygiene after taking care of Resident 3. During an interview on 2/5/2025 at 8:50 AM with LVN 1, LVN 1 stated, she was aware that she was supposed to wear a gown as part of her PPE when she took care of Resident 3 who was on EBP, and she was also aware that she was supposed to perform hand hygiene after providing care to Resident 3, she just forgot. LVN 1 stated, not using PPE prior to taking care of Resident 3 and not performing hand hygiene after providing care to Resident 3 had the potential to spread virus and bacteria in the facility. During an interview on 2/5/2025 at 2:05 PM with Infection Preventionist (IP), IP stated, Resident 3 is on enhance barrier precaution because he has a suprapubic catheter, as per policy staff should use PPE's which includes wearing a gown prior to direct care to the resident and practice hand hygiene before and after direct care to Resident 3. IP stated, adhering to EBP policy is for the protection of Resident 3 and other residents and staff, not following the enhance barrier precaution had the potential to cause the spread of virus, bacteria and multi-drug-resistant organisms (MDROs) in the facility During an interview on 2/5/2025 at 2:25 PM with the Director of Nurses (DON), the DON stated, Resident 3 is on an enhance barrier precaution, which means when staff has high contact care with the resident the staff should wear PPE's which includes gloves and gown and perform hand hygiene before and after the care of Resident 3. DON stated, performing care with Residents 3's suprapubic catheter tubing and urine drainage bag are considered high contact care. DON stated, LVN 1 and CNA 1 should have been wearing a gown prior to Resident 3's care and should have performed hand hygiene after the care, these mistakes of the staff had the potential to cause the spread of virus, bacteria and MDROs in the facility. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 6/5/2024, the P&P indicated; a) Enhance barrier precaution are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents, b) gloves and gown are applied prior to performing the high contact resident care activity, and c) example of high-contact resident care activities requiring the use of gowns and gloves for EBP included device care or use (urinary catheter). (continued on next page)

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F 0880 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, Infection Prevention and Control Program, revised 4/2023, the P&P indicated; a) the facility established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and b) important facets of infection prevention include instituting measures to avoid complications or dissemination (to spread or scatter).

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure three of 40 resident rooms (Rooms 6, 15. and 26) did not accommodate more than four residents per room. This deficient practice had the potential to affect the health and safety of the residents in the room due to inadequate space for resident care, mobility, and privacy of the residents. Findings: On 2/4/2024, the Administrator (ADM) submitted a written room waiver request for three resident rooms, which had five resident beds in each room. A review of the letter for room waiver indicated the following: Room # Number of beds square feet (sq. ft) 6 5 332.5 sq. ft 15 5 441 sq. ft 26 5 496 sq. ft A review of the room waiver request indicated the residents' needs were accommodated and there were no adverse effects (undesired outcome) to the health, safety, and welfare to the residents occupying these rooms. The maximum number of beds allowed in a multiple resident bedroom should be no more than four beds per room. During a tour of the facility conducted on 2/7/2025 at 9AM, Residents in rooms. 6, 15, and 26 were observed without difficulty getting in and out of their bedrooms. The nursing staff had full access to provide treatment, administer medications and assist residents to perform their individual routine activities of daily living. 1. During a review of Resident 67's Admission Record indicated the facility originally admitted Resident 67 on 2/24/2024 and readmitted on [DATE] with diagnoses that included kidney failure (kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance, hypertension (elevated blood pressure), and depression (a low mood or loss of pleasure or interest in activities for long periods of time). During a review of Resident 67's Minimum Data Set (MDS, a Resident assessment tool), dated 1/16/2025, indicated Resident 67 cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 67 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity. Helper assists only prior to or following the activity) with eating, toileting and personal hygiene. (continued on next page)

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/7/2025 at 9:05 AM, Resident 67, stated he had enough room to do the things he wanted to do, and did not mind sharing the room with other residents. 2. During a review of Resident 36's Admission Record indicated the facility originally admitted Resident 36 on 3/31/2014 and readmitted on [DATE] with diagnoses that included encephalopathy (a disease, disorder, or damage that affects the brain's structure or function), seizures (a brief episode of abnormal electrical activity in the brain that causes temporary changes in behavior and movement), and depression. During a review of Resident 36's Minimum Data Set, dated dated [DATE], indicated Resident 36 cognitive skills was intact. The MDS indicated Resident 36 required set up or clean-up assistance with eating, and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with toileting and personal hygiene. During an interview on 2/7/2025 at 9:10 AM, Resident 36, stated he had no issues with room space and did not mind sharing the room with other residents. 3. During a review of Resident 20's Admission Record indicated the facility admitted Resident 20 on 9/27/2024 with diagnoses that included cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque (fatty deposits) inside the artery walls), encephalopathy, and Rhabdomyolysis (a rare but serious condition that occurs when muscle tissue breaks down and releases harmful substances into the blood). During a review of Resident 20's Minimum Data Set, dated dated [DATE], indicated Resident 20 cognitive skills was intact. The MDS indicated Resident 20 required set up or clean-up assistance with eating, toileting and personal hygiene. During an interview on 2/7/2025 at 9:15 AM, Resident 20, stated he had no concerns with his room space and roommates. During an interview on 2/7/2025 at 10:00 AM, certified nurse assistant (CNA) 2, stated she had enough room to take care of the residents and residents had no concern about room space. During an interview on 2/7/2025 at 10:05 AM, Licensed Vocational Nurse (LVN) 2, stated she had enough room to do her care and have not heard any concern from residents about room space.

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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** 47882 Based on observation, interview, and record review, the facility failed to ensure the resident ' s bedrooms measure at least 100 square feet (sq. ft) per resident in a single resident room or measure at least 80 sq. ft. In multiple resident's room for four of 12 single rooms (Rooms 4, 5, 16 and 17). This deficient practice had the potential to affect the quality of care, health and safety of the residents in the room due to inadequate space for resident care, mobility, and privacy of the resident. Findings: On 2/4/2025, the Administrator submitted a written room waiver request for four single bedrooms, which Included the square footage of each room. A review of the waiver letter Indicated the following: Room # # Beds square feet (sq. ft.) 4 1 76.00 sq. ft. 5 1 76.00 sq. ft. 16 1 99.75 sq. ft. 17 1 99.75 sq. ft. A review of the facility's document titled Client Accommodation Analysis (a form that indicate the room sizes in the facility, with room size measurement), indicated Rooms 4,5,16, and 17, did not meet the CMS (Centers for Medicare & Medicaid Services- a federal agency) requirement to ensure single bedrooms had at least 100 sq. ft per resident areas. During an observation on 2/7/2025 at 10:20 AM, the room sizes did not affect the care and services provided to the residents when facility staff were providing care. During an observation from 2/7/2024 at 10:25 AM, the residents residing in the Rooms 4,5.16, and 17 were observed with sufficient space for the residents to move freely inside the rooms during the care delivery and daily activities. During a review of Resident 8's Admission Record indicated the facility originally admitted Resident 8 on 1/30/2009 and readmitted on [DATE] with diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), hypertension (high blood pressure), and anxiety disorder (a mental health condition that causes excessive and persistent feelings of fear, worry, and dread). (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/7/2025, indicated Resident 8 cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 8 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity. Helper assists only prior to or following the activity) with eating, toileting and personal hygiene. During an interview on 2/7/2025 at 10:30 AM, Resident 8, stated she had enough space in her room, and she did not have any issues with her care. During an interview on 2/7/2025 at 10:35 AM, certified nurse assistant (CNA) 3, stated she had enough space to take care of Residents with single rooms. During an interview on 2/7/2025 at 10:40 AM, Licensed Vocational Nurse (LVN) 2, stated she had enough space to work in single rooms, she had not heard any complaints from residents.

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F 0913 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide bedrooms that have direct access to an exit hallway. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation. interview, and record review the facility failed to ensure four of 40 resident's bedrooms (Rooms 4, 5, 16, and 17) had direct access to the exit corridor without passing through another resident's bedroom. This deficient practice had the potential to affect the privacy, health and safety of the residents in the room due lack of direct access to an exit during an emergency. Findings: During tour of the facility on 2/7/2025 at 11:05 AM, Rooms 4, 5, 16, and 17 did not have direct access into an exit corridor. Residents in rooms [ROOM NUMBERS] had to enter room [ROOM NUMBER], and rooms [ROOM NUMBERS] had to enter room [ROOM NUMBER] to get to the nearest exit corridor. During an observation on 2/7/2025 the residents in Rooms 4, 5, 16 and 17 were ambulatory (able to walk without a device or assistance). The nursing staff had to pass through access rooms [ROOM NUMBERS] through room [ROOM NUMBER] and rooms [ROOM NUMBERS] through room [ROOM NUMBER], to provide treatments, administer medications, and assist with residents' individual routine care and activities of daily living. (ADLs, such as transferring, dressing, eating. and toileting). During the survey period from 2/4/2025 to 2/7/2025, a room variance (a waiver for exception to the current regulations) for the residents' bedrooms received on 2/4/2025 indicated the residents' needs were accommodated and there were no adverse effects (undesired effect) to the health, safety, and welfare of the residents occupying these rooms. During a review of Resident 46's Admission Record indicated the facility originally admitted Resident 46 on 9/28/2018 and readmitted on [DATE] with diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), hypertension (high blood pressure), and anxiety disorder (a mental health condition that causes excessive and persistent feelings of fear, worry, and dread). During a review of Resident 46's Minimum Data Set (MDS, a Resident assessment tool), dated 1/14/2025, indicated Resident 46 cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 46 required set up or clean-up assistance (helper sets up or clean up resident; resident completes activity, helper assists only prior to or following the activity) with eating, toileting and personal hygiene. During an interview on 2/7/2025 at 11:05 AM, Resident 46 stated he had been going in and out of his room through room [ROOM NUMBER] and he did not have any issue with it, and he felt safe. During an interview on 2/7/2025 at 11:10 AM, Certified Nursing Assistant (CNA) 2 stated, the residents in room [ROOM NUMBER] and 17 could come out of the room by passing room [ROOM NUMBER] with no issues, no one had voiced concern about their room location. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555755	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare Center	8101 E Hill Drive Rosemead, CA 91770

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 0913 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/7/2025 at 11:15 AM, Licensed Vocational Nurse (LVN) 2 stated residents in room [ROOM NUMBER] and 17 were ambulatory and they would walk in and out of their rooms through room [ROOM NUMBER] and no issue with it.