STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555770	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camarillo Healthcare Center	205 Granada St Camarillo, CA 93010

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49405 Based on observation, interview, and record review the facility failed to ensure: 1. One of 25 sampled residents (Resident 624) was treated with dignity (the feeling of being valued and respected as a person) and respect, during and after a room change. This failure had the potential to negatively affect Resident 624's sense of self-worth and care needs to go unmet. 2. One resident (Resident 31) was free of foul body odor. This failure had the potential to violate resident 31's rights to receive quality care and freedom from neglect. Findings: 1. During a concurrent observation and interview, on 2/6/25, at 5:12 p.m., inside Resident 624's room, with Resident 624's family member (Fam 1), the Fam 1 was visibly upset, shaking and in tears. Resident 624's call light was observed hanging on the wall above Resident 624's bed and out of reach. Resident 624's belongings were also observed on a bedside table and out of reach by Resident 624. The Fam 1 verbalzied Resident 624 had been moved to a new room and facility staff had left Resident 624 in the new room, with the call light and personal belongings out of Resident 624's reach. The Fam 1 stated You don't treat a human like this, [Resident 624] cannot speak for [Resident 624], and Resident 624, was left like this, unable to call for help, if she needed it. During an interview on 2/6/25, at 5:12 p.m., with the Housekeeping Supervisor (HS) and Director of Staff Development (DSD), inside Resident 624's room, the HS confirmed Resident 624's call light was out of reach and verbalzied the call light should have been within reach of Resident 624. The HS verbalized housekeeping staff had moved Resident 624 into the room and not nursing staff. The DSD verbalzied it was not facility practice for staff to leave personal items out of reach of residents after a room change. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/7/25, at 2:00 p.m., with the Director of Nursing (DON), the job description for housekeeping staff was reviewed. The job description for housekeeping staff did not indicate moving/transporting residents to different rooms was a duty/task for housekeeping staff to perform. The DON verbalized it was not in the job description for housekeeping staff to move residents, it was a nursing task. During a review of the facility's policy and procedure titled Nursing Clinical subject Call Light/Bell undated, indicated in part Leave the resident comfortable. Place the call device within resident's reach before leaving room. During a review of facility's policy and procedure titled, Resident Rights, dated 09/2007, indicated, POLICY: It is the policy of this facility that Social Services assures that the facility respects each Resident Rights . 3. Resident in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of other residents would be endangered. 50657 2).During a concurrent observation and interview on 02/05/25 at 10:29 a.m., inside the resident's room, Resident 31 was in bed, on flat position, awake, with head of bed (HOB) flat. The resident was noted with a hospital gown on, stained with food on the front area. Food stains were also noted on the sheets covering the resident from waist down. Resident's hair was tangled, and a pungent urine, musty, and sour unpleasant odor could be smelled from outside to inside of Resident 31's room. Resident 31 stated, I refused to be showered , I prefer bed baths, but had none in several days. During a review of the medical record for Resident 31, the Care Plan (CP), dated 08/30/22, indicated, the resident requires maximum assistance for bed mobility, showers totally dependent (TD),and toileting , hygiene were also totally dependent on staff. During a review of the facility record titled Task Bathing dated 1/7/25 to 2/5/25 indicated on 2/5/25 at 10: 30 a. m. Resident 31 received a sponge bath. During an interview on 02/05/25 at 11:12 a.m., with certified nursing assistant (CNA5), who was outside Resident 31's room, CNA 5 acknowledged the presence of a strong, foul odor permeating to the outside of Resident 31's room. CNA 5 indicated not knowing if Resident 31 received a bed bath in the morning. During an observation and interview with Resident 31 inside the resident's room on 2/5/25 from 10:29 a.m., to 12:00 p.m., no bed baths were noted to be administered to the resident, contrary to what was recorded /documented on the facility record titled Task Bathing. During an interview with the facility's shower technician (ST) on 2/5/25 at 11:31 a.m., when was Resident 31 last showered, ST indicated not remembering when was the resident last showered. ST further indicated not giving bed baths, and it's the CNAs tasks to do so.

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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. 49405 Based on interview and record review, the facility failed to ensure an advance directive (AD - a written statement of a person's wishes regarding medical treatment) was noted in residents re-admission agreement for one of 25 sampled residents (Resident 85). This failure had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment and had the potential to cause conflict with Resident 85's wishes regarding health care. Findings: During review of Resident 85's medical record on 02/05/25 at 08:44 a.m., the medical record indicated that resident 85 was readmitted to facility on 07/05/24 and Resident 85's AD was completed and signed on 04/04/24. During a review of Resident 85's Re-admission Agreement dated 07/05/24, the re-admission agreement indicated Resident 85 did not have an AD on readmission 07/05/24. During a concurrent interview and record review on 02/06/25 at 10:30 a.m. with Director of Admission (DOA), Resident 85's Electronic Health Record (EHR) was reviewed. The EHR indicated Physician Orders for Life-Sustaining Treatment (POLST) was dated 11/14/23, Resident's AD was dated 04/08/24, resident readmission agreement dated 07/05/24 and signed by Resident 85 on 07/08/24. DOA confirmed that Resident 85 had an AD prior to re-admission to facility 07/05/24. DOA stated that the facilities re-admission agreement reinstates a legally binding contract that in part the resident acknowledges that all personal and identifying information and supplements attached accurately reflects the residents current personal and identifying information and the Readmission Agreement indicates that the resident does not have an AD on admission 07/05/24. During an interview on 02/06/25 at 11:47 a.m. with DOA, DOA stated, that resident had an AD dated 4/8/24 and was presented to facility on readmission 07/05/24. DOA confirms the re-admission paperwork did not reflect the resident had an advance directive on readmission and should have. During a review of the facility's policy and procedure titled, Physician Orders for Life Sustaining Treatment (POLST) dated 12/2009, indicated in part, The POLST form should be executed as part of the health care planning process and ideally is a complement to a resident's advance directive. A POLST does NOT replace an advance directive .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40560 Based on observation, interview, and record review, the facility failed to: 1. Maintain two rooms in good repair, for one unsampled Resident (Resident 14) and one sampled Resident (Resident 87). 2. Monitor hot water temperature readings and air conditioner temperature recordings. These facility failure had the potential for Resident 14 and Resident 87 to not be provided with a homelike and comfortable environment and had the potential for resident health problems and poor well-being of residents. Findings: 1. During a concurrent observation and interview, on 2/4/25, starting at 11:14 a.m., with the Housekeeping Supervisor (HS), the Maintenance and Housekeeping Log was reviewed. The HS verbalized the logbook indicated there were no outstanding items that were in disrepair. During a tour of Resident 87's room an observation was made of a closet drawer unable to be opened. The HS confirmed the drawer could not be opened and verbalized it was off its track. In Resident 14's room an observation was made of a broken electrical outlet cover above Resident 14's bed. The HS verbalized the electrical outlet cover would need to be replaced. During a review of the facility's policy and procedure titled Safe and Homelike environment dated 12/23, indicated in part Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. 2. During an interview on 02/04/24 at 3:48 PM with Maintenance Supervisor (MS) and Administrator (ADM), MS verbalized that the facility has no monitoring logbooks for hot water temperature and thermostat levels for air conditioning. During a review of Policies and Procedures (P&P) titled Hot Water Temperature dated 01/23 , the Hot Water Temperature indicated in part, standards for water temperatures in resident areas is 105 F minimum and 120 F maximum. Standards for water temperatures in Laundry and Kitchen is 140 F minimum and 160 F maximum. Take water temperatures in various resident rooms at the beginning, middle and the end of each water heater loop, various resident showers, dining rooms and handwashing sinks .make adjustments of the water heaters as needed During a review of P&P titled Air Temperatures dated 01/23, the Air Temperatures indicated in part, standards in resident areas indicate Heat to minimum of 68 F, Cool to comfortable range between 78-85 F. Measure air temperatures in various resident rooms and common spaces. Take temperatures in different rooms each day .adjust the thermostat as needed.

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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** 50657 Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident #31), had a comprehensive care plan that included interventions (actions) for the refusal of sitting upright while eating. This failure had the potential for Resident 31 to choke on food or liquids which can result in aspiration and possibly death. Findings: During a review of Resident 31's Admission Record (AR), undated, the AR indicated admitted [DATE] with diagnoses including congestive heart failure (weakened heart with difficulty pumping blood throughout the body), chronic respiratory failure with hypoxia (not enough oxygen in the body causing shortness of breath), gastro-esophageal reflux disease (irritation of the food pipe lining causing symptoms such as burning pain), and cognitive communication deficit (a disorder that affects a person's ability to communicate). During a concurrent observation and interview on 02/04/25 at 3:42 p.m. with Resident 31 inside the resident's room, Resident 31 was awake, lying flat on the bed eating lunch by self. Resident 31 had spilled food and had food stains on resident's clothing and on the bed was noted. Resident 31 stated, I prefer eating lying down because of pain and difficulty breathing when sitting up. During a concurrent interview and record review on 02/04/25 at 3:51 p.m. with nurse supervisor (NS1), Resident 31's Care Plan (CP), dated 02/04/25 included resident refused to elevate HOB while eating on bed and at all time. No interventions to address the refusal to elevate the HOB while eating was located in the interventions of the CP. NS1 stated there were no nursing interventions in the care plan to educate the resident. During an interview on 02/04/25 at 4:10 p.m. with certified nurse assistant (CNA4), CNA4 stated [Resident 31's name] eats laying down all the time and the CNA's are instructed to place the meal trays in front of Resident 31's on bedside table. During an interview on 02/04/25 at 4:31 p.m. with licensed nurse (LN3), LN3 stated that Resident 31 refuses to eat upright because of pain. LN3 also stated, the resident eats laying down with the bed part flat all the time. During a review of Resident 31's medical record, no notes of physician notification of the resident 's refusal to sit upright while eating was located in the medical record. During an interview on 2/04/25 at 4:40 p.m. with the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Registered Dietician (RD), and the Director of Rehabilitation (DOR), DON, ADON, RD, and DOR indicated there are notes in the medical record about the physician being notified of Resident 31 refusal to eat upright and notes of the risks of eating lying flat were explained. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further record review no notes were located of the physician being notified of Resident 31's refusal to eat upright and no documentation that the risks of eating while lying down were explained to the resident and the resident representative from 1/26/24 to 2/4/25. During a concurrent interview and record review on 2/04/25 at 5:18 p.m. with the ADON, Resident 31's electronic medical record (eMR) was reviewed. The ADON was not able to produce documentation in the progress notes, care plan, interdisciplinary team meetings, or in the health and physical that addressed educating Resident 31 on the risks of eating while lying down. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 11/2024, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive Person-Centered Care Plan for each resident based on resident's needs to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 48668 Based on observation, interview and record review, the facility failed to ensure there was monitoring for signs and symptoms of bleeding for a resident (Resident 53) who is on anticoagulant Eliquis (Medication that prevent or treat blood clots). This failure had the potential for Resident 53 to be unmonitored while on Eliquis, and have side effects of bleeding. Findings: During a concurrent interview and record review on 2/5/25 at 10:00 a.m. the medication administration record (MAR) dated January 2025, indicated an order of Eliquis 2.5 mg 1 tablet by mouth two times a day. There was no monitoring for signs of bleeding seen in the MAR. Minimum Data Set (MDS) coordinator verified that there was no monitoring for bleeding side effect found in the chart. During a review of facility's policy and procedure (P&P), titled Medication Management, dated May 2022, P&P indicated In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, attending physician, and the pharmacistperform ongoing monitoring for appropriate, effective, and safe medication use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48668 Based on interview and record review, facility failed to ensure: 1. There was a physician's justification for the use of antianxiety medication Xanax (a medication used to help reduce symptoms of aniety disorders) for use beyond 14 days in one of three selected residents for unnecessary medication review (Resident 53). 2. A physician signature was completed on informed consents for psychotherapeutic medications for one of 25 sampled residents (Resident 85). These failures had the potential for Resident 53 to be on unnecesary medication Xanax and the potential for Resident 85 not being informed of their medications and the potential side effects of the psychotropic medications. Findings: 1. During a concurrent interview and record review on 2/5/25 at 11:00 a.m. the medication administration record (MAR) dated January 2025 indicated an order of Xanax 0.25 mg by mouth as needed for anxiety started on 12/17/24 with duration of 90 days. Infection Preventionist (IP) nurse, who is in charge of psychotropic monitoring stated last progress note received from the provider was dated 1/14/25 and there was nothing for February 2025 yet. During the exit conference on 2/7/25 at 5:00 p.m., the facility was given a chance to provide policy on use of as needed psychotropic medication but was unable to provide the right policy. Code of Federal Regulations (CFR) at section S483.45(e)(4) indicated PRN orders for psychotropic drugs are limited to 14 days. Except as provided in S483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 49405 2. During a review of facility's policy and procedure titled, Use of Psychoactive Medications dated 05/2015, indicated in part, Requirements for use of Psychoactive Medication: When drugs are used to control behavior or to treat a disordered thought process, the following shall apply: . An Inform Consent [a patient agrees to take a medication after understanding its risks, benefits, and alternatives] shall be obtained by the prescriber . During a review of Resident 85's Facility Verification of Resident Informed Consent Psychotherapeutic Medications, indicated consents dated below did not have a signature from a prescribing Physician: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 02/03/25 for Xanax [a medication that produces a calming effect on the brain, which helps to reduce anxiety and promote relaxation] 0.25 mg [dose of medication], PO [abbreviation for oral route given by mouth] PRN [as needed] anxiety [mental health condition characterized by excessive worry, fear, and unease] panic attack AEB [abbreviation as evidence by] palpitation [sensations where a person feels their heartbeat pounding, racing, or fluttering in their chest or throat]. - 11/10/24 for Ambien [a medication that treats insomnia (a sleep disorder)] 10mg, PO at HS [bedtime]. - 07/23/24 for Ambien 10 mg. 10mg PO QHS [at bedtime] insomnia MB [manifested by] inability to sleep. - 07/22/24 for Ambien 5 mg QHS PRN (as needed) for Insomnia mb inability to sleep . During a concurrent interview and record review on 02/06/25 11:07 a.m. with Director of Nursing (DON), Facility Verification of Resident Informed Consent Psychotherapeutic Medications, dated 2/3/25, 11/10/24, 7/22/24 and 7/23/24 were reviewed. The Facility Verification of Resident Informed Consent Psychotherapeutic Medications for dates indicated there was no signature from a prescribing Physician. DON stated, there should be signature from a physician and confirmed that consents on dates listed were missing a physician signature.

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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. 40560 Based on observation, interview, and record review, the facility failed to dispose of expired medications per policy and procedure. This failure had the potential for expired medications to be administered to residents. Findings: During a concurrent observation and interview, on 2/6/25, starting at 8:53 a.m., with licensed nurse (LN 4), three expired medications were found in medication cart two. One vial of Latanoprost 0.005% solution (a medication used to treat high eye pressure) one vial of Prednisolone Acetate 1% (a medication used to relieve symptoms such as swelling and redness) and one vial of Brinzolamide 1% (a medication used to treat high eye pressure). All three medications had an expiration date of 2/4/25. The LN 4 verbalized all three medications were expired and needed to be placed in the waste container in the medication room. During a review of the facility's policy and procedure titled Nursing Administration subject Storage of Medications undated, indicated in part Expired medications will be removed from use, for appropriate disposal.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50657 Based on observation, interview and record review, the facility failed to ensure a physician order of renal diet no added salt (NAS) order did not have a salt packet on the lunch tray for one of one sampled resident (Resident 82) who was on dialysis treatment. This failure had the potential for Resident 82 to have fluid retention for an already compromised condition (dialysis). Findings: During an observation on 2/05/25 at 12:15 p.m. of the lunch tray check and distribution process, in the hallway outside of resident rooms, Resident 82's lunch tray had a packet of salt. Upon checking the tray card for Resident 82, the diet order indicated renal diet. During an interview on 2/06/25 at 9:40 a.m. with the Registered Dietician (RD), the RD acknowledged that Resident 82's diet order is renal, should be no added sodium (NAS) and should not have salt packets added to meals/on trays. During an interview on 2/06/25 at 11:30 a.m. with the Director of Staff Development (DSD) who was in charge of verifying the resident meal trays, the DSD stated the salt packet was not removed because the meal card did not indicate NAS. During a review of Resident 82's Order Summary (OS), dated 1/15/25, the OS indicated, Resident 82 was prescribed a renal NAS diet by the physician. During a review of the facility's policy and procedure (P&P) titled, Liberal Renal Diet, dated April 2024, the P&P indicated in part, The HPSI Liberal Renal Diet restrictions are based on current recommendations. Because the nutritional needs of kidney patients are often specific to the individual, this diet may not fit the needs of every kidney patient. In this this instance, a licensed and registered dietician should be consulted for an individualized assessment and recommendations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50657 Based on observation, interview, and record review, the facility failed to follow their cleaning policy and procedure (P&P) when: 1. A floor drain in the dry goods storage area and the floors were not maintained in a sanitary manner. 2. Two of two ice chests used to distribute ice to residents were not cleaned before and after use. These failures had the potential to cause food borne illness to a highly susceptible resident population. Findings: 1. During a concurrent observation and interview on 02/04/25 at 9:23 a.m., with the Registered Dietician (RD) and the Dietary Assistant Manager (DAM), extensive debris and grime was visible in and around the floor drain in the dry storage area. Produce (red tomatoes/a potato), food scraps, and trash debris were observed behind, and under, metal racks of the walk-in refrigerator in the dry storage area and behind the ice machine on the floor. DAM and RD acknowledged the drain was dirty and the floor in the walk-in refrigerator appeared like it had not been swept or mopped. During a review of the facility's policy and procedure (P&P) titled General Cleaning of Food & Nutrition Services Department, dated 2023, the P&P indicates in part 1. Floors must be mopped at least once per day. 2. Sweep floor, pushing all debris forward. 8. Mop under and around equipment, along the walls and in corners .Drains: 1. FNS staff should remove large debris as it accumulates . 2. During an observation of the posted Ice Container Daily Cleaning Log (ICDCL), dated for the month/year of February 2025, the ICDCL indicates no cleaning of ice chests was performed on 02/04/25 and 02/05/25. During a concurrent interview and record review on 02/06/25 at 9:55 a.m., with the Registered Dietician (RD) and the Dietary Assistant Manager (DAM), DAM reviewed the ICDCL, dated for the month/year of February 2025, and acknowledged the ice chest cleaning log was incomplete as it indicated the ice chests were not cleaned on 02/04/25 and 02/05/25. During record review of the facility's policy and procedure (P&P) titled Ice Chest Cleaning Procedure dated 2023, the P&P indicates All ice chests will be cleaned and sanitized before and after each use, and when contaminated or visibly soiled, using the following procedure.

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	555770	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 49405 Based on observation, interview and record review, the facility failed to ensure proper infection control was practiced when: 1. Staff did not wear Personal Protective Equipment (PPE - protective clothing, equipment, and supplies worn by healthcare workers to shield themselves from potential spread of disease such as a gown and gloves) when giving direct care to a resident on Enhanced Barrier Precaution (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) and did not follow policy and procedure for removal of PPE for one of 25 sampled residents (Resident 624). 2. Staff did not label oxygen tubing and Intravenous (IV 5% Dextrose)- a tube inserted into a vein of a resident to administer fluids and medications directly into the bloodstream) tubing with date per facility policy for one of 25 sampled residents (Resident 49). 3. Respiratory care equipment was not stored in a manner to prevent cross contamination (accidently transferring harmful bacteria) for one of 25 sampled residents (Resident 467). These failures had the potential to result in cross contamination and spread infections to residents, compromising their wellbeing. Findings: 1.During an observation on 02/05/25 at 10:15 a.m. in Resident 624's room, with Occupational Therapist (OT) 2. Resident 624 had a sign on the door informing Resident 624 was on EBP and OT2 was observed assisting Resident 624 to sit up in bed and put shoes on resident without a gown (PPE). During an observation on 02/05/25 at 10:21 a.m. in Resident 624's room, with OT2 and Certified Nursing Assistant (CNA) 7. CNA7 came into Resident 624's room put on a gown, OT2 stated, Oh, I have to have a gown?. CNA7 asked another staff member in the hall for a gown and OT2 placed a gown on before continuing to assist resident into wheelchair and assist with oral hygiene. During an observation on 02/05/25 at 10:42 a.m. in Resident 624's room, with OT2 and CNA7. OT2 was observed stepping outside of Residents room and removed the gown, then proceeded to reenter Resident 624's room to place used gown in dirty bin. During and interview on 02/05/25 at 10:51 a.m. with OT2, OT2 stated she should have been wearing a gown at the start of direct care to Resident 624 and acknowledged that she was giving care without a gown prior to CNA7 handing her a gown. OT2 confirmed Resident 624 was on EBP due to indwelling urinary catheter (a tube placed inside the bladder to drain urine) and states that her gown should have been removed in the room prior to exiting Resident 624s room. (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 facility policy and procedure titled, IPCP Standard and Transmission-Based Precautions, dated 10/2024, indicated, POLICY . to implement infection control measures to prevent and spread of communicable diseases and conditions. Enhanced Barrier Protection (EBP): expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities . PPE: The use of gown and gloves for high-contact resident care activities is indicated . i. Wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents. c. examples of high-contact resident care activities requiring gown and glove use for Enhance barrier Precautions include: Dressing . transferring, providing hygiene . 6. Implementation: . d. discarding PPE after removal, prior to exit of the room . 48668 2. During an observation on 2/4/25 at 10:21 a.m. Resident 49 was observed to be sleeping in bed with head slightly elevated, with nasal cannula tubing without label connected to oygen concentrator running at 2 liters per minute. There was an intravenous fluid IV 5% Dextrose running by gravity at 10-15 drops per minute, lines was observed to have label but without date and nurse's initial. During an interview on 2/4/25 at 10:30 a.m., certified nurse assistant (CNA6) confirmed there was no label on the oxygen tubing , and the label on the IV fluid did not have nurse's initial and there was no date making it impossible to know who and when the fluid was started. During the interview on 2/6/25 at 2:45 p.m. with the assistant director of nursing (ADON), ADON stated the tubings and IV fluids needed to be labeled dated and signed per policy. During a review of facility's policy and procedure (P&P), titled Oygen Therapy, dated 11/2024, P&P indicated it is the facility policy to administer oxygen in a safe manner, with weekly tubing changes and with appropriate labeling. During a review of facility's policy and procedure (P&P), titled Administration Set (undated), it indicated A label system shall be established to indicate time and date of the tubing change and initials of the nurse performing the procedure. 50707 3. During a review of Resident 467's Admission Record (AD), the AD indicated Resident 467 was admitted on [DATE] with diagnoses that include acute respiratory failure with hypoxia (a serious medical condition that occurs when the body doesn't receive enough oxygen) and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During an observation on 2/4/25 at 11:05 a.m., in Resident 467's room, a nasal canula was observed on top of an oxygen concentrator (a medical device used to deliver oxygen) exposed and not covered. Additionally, a nebulizer mask was observed on top of a nightstand exposed and not covered. During a concurrent observation and interview on 2/4/25 at 2:44 p.m., with Licensed Nurse (LN) 1, in Resident 467's room, a nasal cannula and a nebulizer mask were observed in the same placement as observed prior. LN 1 acknowledged the nasal canula and nebulizer mask are exposed and not covered. LN 1 stated they should be stored in a bag when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 10:52 a.m., with the Infection Preventionist (IP), the IP stated nasal cannulas and nebulizer masks should be stored in a plastic bag when not in use. During an interview on 2/7/25 at 11:34 a.m. with the Director of Staff Development (DSD), the DSD stated oxygen tubing and nebulizer masks should be placed in plastic bags when not in use. The facility was unable to provide a policy and procedure to address the proper storage of oxygen nasal cannula tuing and nebulizer mask when not in use.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40560 Based on observation, interview, and record review, the facility failed to answer call lights per policy and procedure, for one of 25 sampled residents (Resident 104) and one unsampled Resident (Resident 54) when: 1. Staff turned off Resident 54's call light and left the room, without addressing Resident 54's concern. 2. Call light was turned off by staff without meeting the request/needs for Resident 104. These facility failures had the potential for Resident 54 and Resident 104's needs to go unmet and/or result in a delay in care. 1. During an observation on 2/6/25, starting at 8:37 a.m., Resident 54's call light was observed on. An unidentified staff member (USM 1) entered Resident 54's room, turned off the call light, and left the room. During a concurrent observation and interview, on 2/6/25, at 9:00 a.m., with Resident 54, Resident 54's call light was activated for a second time. Resident 54 was asked if USM 1 had addressed Resident 54's previous concern before leaving the room. Resident 54 verbalized no, and verbalized Resident 54 had activated the call light a second time, for the same concern, regarding Resident 54's bed remote control not working. During an interview on 2/6/25, at 9:05 a.m., with the Infection Preventionist (IP), who responded to second call light, the IP verbalzied facility policy was to leave call lights on until the residents issue has been addressed. The IP verbalized Resident 54's call light should not have been turned off until Resident 54's remote control issue had been addressed by the Housekeeping Supervisor (HS). During a review of the facility's policy and procedure titled Nursing Clinical subject Call Light/Bell undated, indicated in part, the facility call light procedure was to Listen to resident's request/need .Respond to the request. If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions .turn off the call light/bell when needs met. 50657 2. During a review of Resident 104's Admission Record (AR) undated, indicated, Resident 104 was admitted to the facility on [DATE], with diagnoses including hemiplegia (loss of strength in the arm, leg, and sometimes the face on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (blood flow to the brain is blocked, leading to symptoms such as speech difficulty, headache, and motor weakness) affecting the left non-dominant side, encephalopathy (a disease of the brain that alters brain function or structure resulting in an altered mental status), other abnormalities of gait and mobility, and the need for assistance with personal care. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/4/25 at 11:41 a.m. with Resident 104 in the resident's room, Resident 104 verbalized having a soiled brief and needing assistance getting out of bed. Resident 104 pressed the call light for staff assistance at 11:41 a.m. Resident 104 verbalized facility staff struggled often in answering Resident 104's call light. During an observation on 2/4/25 at 11:48 a.m. in the patient room hallway, the Director of Staff Development (DSD) entered Resident 104's room, turned off the call light and left the room without speaking to Resident 104 or addressing any of Resident 104's care needs. During an interview on 2/4/25 at 11:51 a.m. with licensed nurse (LN 2), the LN 2 stated when staff respond to resident call lights, staff must check in with each resident in the room. During an interview on 2/4/25 at 11:59 a.m. with the DSD, the DSD acknowledged turning off Resident 104's call light and exiting the room, without checking in or assisting with Resident 104. The DSD stated I didn't realize there was a resident in bed C [Resident 104]. During a review of the facility's policy and procedure (P&P) titled, Call Light/Bell, undated, the P&P indicated in part, Answer the light/bell within a reasonable time. Listen to the resident's request/need .Turn off the call light/bell when needs met.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 Based on observation, interview and Record Review the facility failed to ensure the safety of patients, staff and visitors when OXYGEN IN USE signs were not placed outside resident rooms per policy and procedure for 2 of 25 sampled residents (Resident 49 and Resident 57). This failure had the potential to result in an increase fire risk while oxygen is in use. Findings: During a review of facility policy and procedure titled, Oxygen Therapy, dated 11/2024, indicated, PROCEDURES: Equipment: . NO SMOKING/OXYGEN IN USE signs. During a concurrent observation and interview on 02/07/25 at 11:12 a.m. with Housekeeping/Maintenance/Central Supply Supervisor (HS) in hall outside room [ROOM NUMBER]C, there was not an OXYGEN IN USE sign outside room. HS stated that it is the nurses responsibility to make sure there is an OXYGEN IN USE sign is placed outside of resident rooms when they are on oxygen and stated that Resident 49 was on oxygen in room [ROOM NUMBER]C, and HS confirmed there was not an OXYGEN IN USE sign outside of Resident's room. During a concurrent observation and interview on 02/05/25 at 12:40 p.m. with Certified Nurse Assistant (CNA) 7, in hall outside room [ROOM NUMBER]C, Resident 57 was on oxygen and there was not an OXYGEN IN USE sign outside of room. CNA7 stated that Resident 57 was on oxygen and an OXYGEN IN USE sign should be on the door of Resident 57 room. CNA confirmed that there was no sign that alerted oxygen was in use in the residents room as required by facility policy and procedure.