STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555786	A. Building B. Wing	05/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Park Healthcare	2828 Pico Boulevard Santa Monica, CA 90405

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure that one out of three sampled residents (Resident 10) was free from physical restraint by failing to ensure the use of bed siderails and geriatric chair with lap tray informed consent was completed per individualized assessment. This deficient practice violated resident's right to be treated with respect and dignity with the use of physical restraints. Findings: During a record review of the Admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and unspecified dementia (a progressive state of decline in mental abilities). During a record review of the Minimum Data Set (MDS - resident assessment tool) dated 4/22/2025, indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 10 required moderate assistance to supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 10's Order Summary Report indicated: i. As of 5/4/2025, there was no physician order for the use of bed siderails. ii. Physician's order dated 4/18/2025 indicated, Up on geriatric chair (geri-chair - a large, padded chair that is designed to help people with limited mobility) for mobility issues due to difficulty seating on upright positioned. During a record review of Resident 10's Medical Record as of 5/4/2025, there was no Informed Consent for the use of bed siderails and geri-chair with lap tray. During a record review of Resident 10's Care Plan (CP) as 5/4/2025, indicated there are no CP developed for the use of bed siderails. (continued on next page)

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's Physical Restraint Assessment, dated 4/18/2025, it indicated that, Resident 10 has poor safety awareness/judgement; Restraints recommended: Geri chair with tray; Summary: Geri-chair with a tray is recommended for this time, because of poor safety judgement due to inability to consider lack of independence, disorientation and impaired cognition. During the initial tour of the facility and observation of Resident 10 on 5/2/2025 at 5:55 p.m., Resident 10 was observed sitting on a geri-chair with a lap tray in the hallway by herself. Resident 10 was observed talking noncoherently. During an observation of Resident 10 on 5/3/2025 at 10:05 a.m., Resident 10 was sitting on a geri-chair (is a large padded chairs with wheeled bases, and are designed to assist seniors with limited mobility) with a lap tray on in the hallway, right leg was dangling on the side, and no staff was observed assisting Resident 10. Resident 10 appeared confused and was talking incoherently to herself. During an observation of Resident 10 on 5/4/2025 at 9:10 a.m., Resident 10 was observed lying on bed with a bed siderails up. During a concurrent observation and interview with Registered Nurse (RN) 1 on 5/4/2025 at 9:26 a.m., RN 1 observed Resident 10 in the room, lying on a bed with a bed side rails up. RN 1 stated, there should be an order and a Care Plan for the use of bed siderails. RN 1 further stated, Resident 1 also uses a geri-chair with a lap tray on to get her up on bed, but it should be used for mobility. RN 1 stated the side rails and geri-chair with lap tray may cause harm to Resident 10 if it's being used in a wrong way like restricting resident's movement. RN 1 stated, an informed consent must be obtain from the resident and/or resident's representative for any device used that may restrict resident's mobility. During a concurrent interview and record review with Director of Nursing (DON) on 5/4/2025 at 3:50 p.m., DON reviewed Resident 10's Physical Restraint Assessment and stated, they (facility) are not using any restraints to Resident 10. DON stated the geri-chair with lap tray are to be used for mobility and the assessment for Physical Restraint was not properly documented. DON stated, there must be an informed consent for the use of geri-chair with laptray and bed siderails. DON stated, the use of these devices restricts resident's movement. During a record review of the facility policy and procedure (P&P) titled, Use of Restraints, revised on 8/2024, the P&P indicated, If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint . Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; b. Tucking sheets so tightly that a bed-bound resident cannot move; c. Placing a resident in a chair that prevents the resident from rising; and d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint . Treatment restraints may be used for the protection of the resident during treatment and diagnostic procedures if the resident and/or representative have consented to the treatment or procedure and the use of treatment restraints. Treatment restraints shall be applied for no longer than the time required completing the treatment. During a record review of facility's P&P titled, Health, Medical, Treatment, Informing Residents of, revised 12/2024, the P&P indicated, Every resident is informed of his or her options for treatment and/or care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on observation, and interview, the facility failed to maintain a clean, odor-free, well-kept environment for one of five sampled residents (Resident 1), by failing to ensure the resident's room and adjacent hallway were odor free. This failure resulted in a foul-smelling environment in Resident 1's room and the adjacent hallway. Findings: During a record review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 7/23/2024 and Resident 1 was readmitted to the facility on [DATE] with diagnoses including anxiety (a feeling of worry, fear, or unease, often accompanied by physical symptoms like a rapid heartbeat or shortness of breath), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/24/2025, indicated Resident 1 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 5/3/3035, at 7:46 A.M., in Resident 1's room and adjacent hallway, a foul odor of urine was perceived by two surveyors. During a concurrent observation, and interview on 5/3/2035, at 7:50 A.M., with Certified Nursing Assistant (CNA) 4, in Resident 1's room, a foul-smelling urine odor was perceived and Resident 1's beddings were wet. CNA 4 stated that the foul-smelling odor was come from Resident 1, it was the smell of urine, and that when changing Resident 1, Resident 1's draw sheet (a special sheet placed on top of a bed's fitted sheet to make it easier to move someone who is having trouble moving themselves), under pad (using an absorbent pad, also called an under pad or chux, to protect bedding from moisture and accidents, especially related to incontinence) and Resident 1's pants were wet. CNA 4 stated that the strong foul-smelling odor of urine may have been strong because Resident 1 was not changed. CNA 4 stated residents need to be changed every two hours because if not done, this may lead to a urinary tract infection (UTI - an infection in the bladder/urinary tract) skin opening or wounds. During an interview on 5/4/2025, at 6:56 P.M., with the Director of Nursing (DON), the DON stated that the facility needs to maintain a home-like environment with comfort, space and pleasant smell that does not bother the residents, staff and visitors During a record review of the facility policy and procedure (P&P) titled Homelike Environment revised 2/2024, indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use theirpersonal belongings to the extent possible. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. e. clean bed and bath linens that are in good condition. f. pleasant, neutral scents;

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure that two of three sampled residents reviewed for restraints (Residents 3 and 10) were free from physical restraint by: A. Failing to ensure the physician's order for bed siderails was in place and geriatric chair (geri chair - a large, padded, often wheeled chair designed to help seniors or individuals with limited mobility) with lap tray were properly assessed and evaluated for Resident 10. B. Resident 3 was observed with a geri chair parked alongside Resident 3 while she was in bed that restricted the resident's movement. These deficient practices had the potential to result in entrapment and injury with the use of restraints for Residents 3 and 10. Cross Reference F656, F552 Findings: 1. During a record review of the Admission Record indicated Resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and unspecified dementia (a progressive state of decline in mental abilities). During a record review of the Minimum Data Set (MDS - resident assessment tool) dated 4/22/2025, indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 10 required moderate assistance to supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 10's Order Summary Report indicated the following: i. As of 5/4/2025, there was no physician order for the use of bed siderails. ii. Physician's order dated 4/18/2025 indicated, Up on geri-chair for mobility issues due to difficulty seating on upright positioned. During a record eview of Resident 10's Medical Record as of 5/4/2025, there was no Informed Consent for the use of bed siderails and geri-chair with lap tray. During a record review of Resident 10's Care Plan (CP) as 5/4/2025, indicated there are no CP developed for the use of bed siderails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 10's Physical Restraint Assessment, dated 4/18/2025, it indicated that, Resident 10 has poor safety awareness/judgement; Restraints recommended: Geri chair with tray; Summary: Geri-chair with a tray is recommended for this time, because of poor safety judgement due to inability to consider lack of independence, disorientation and impaired cognition. During the initial tour of the facility and observation of Resident 10 on 5/2/2025 at 5:55 p.m., Resident 10 was observed sitting on a geri-chair with a lap tray in the hallway by herself. Resident 10 was observed talking noncoherently. During an observation of Resident 10 on 5/3/2025 at 10:05 a.m., Resident 10 was sitting on a geri-chair with a lap tray on in the hallway, right leg was dangling on the side, and no staff was observed assisting Resident 10. Resident 10 appeared confused and was talking incoherently to herself. During an observation of Resident 10 on 5/4/2025 at 9:10 a.m., Resident 10 was observed lying on bed with a bed siderails up. During a concurrent observation and interview with Registered Nurse Supervisor 1 (RNS 1) on 5/4/2025 at 9:26 a.m., RN 1 observed Resident 10 in the room, lying on a bed with a bed side rails up. RN 1 stated, there should be an order and a Care Plan for the use of bed siderails. RN 1 further stated, Resident 1 also uses a geri-chair with a lap tray on to get her up on bed, but it should be used for mobility. RN 1 stated the side rails and geri-chair with lap tray may cause harm to Resident 10 if it's being used in a wrong way like restricting resident's movement. RN 1 stated, an informed consent must be obtain from the resident and/or resident's representative for any device used that may restrict resident's mobility. During a concurrent interview and record review with Director of Nursing (DON) on 5/4/2025 at 3:50 p.m., DON reviewed Resident 10's Physical Restraint Assessment and stated, they are not using any restraints to Resident 10. DON stated the geri-chair with lap tray are to be used for mobility and the assessment for Physical Restraint was not properly documented. DON stated, there must be an informed consent for the use of geri-chair with laptray and bed siderails. DON stated, the use of these devices restricts resident's movement. During a record review of the facility policy and procedures (P&P) titled, Use of Restraints, revised on 8/2024, the P&P indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls . If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint . Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; b. Tucking sheets so tightly that a bed-bound resident cannot move; c. Placing a resident in a chair that prevents the resident from rising; and (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising . Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint . 45528 2. During a record review of Resident 3's Admission Record indicated the facility admitted Resident 3 on 12/4/2023 and Resident 3 was readmitted to the facility on [DATE] with diagnoses including abnormality of gait and mobility (having trouble walking or moving around smoothly and efficiently), Parkinson's (a condition where nerve cells in the brain that produce dopamine [a chemical messenger] start to die off or become damaged), and unspecified psychosis (someone is experiencing symptoms of psychosis, like hallucinations [seeing or hearing things that aren't real) and delusions (holding strong, false beliefs]). During a record review of Resident 3's MDS dated [DATE], indicated Resident 3 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 3 was dependent on staff for ADL. During a concurrent observation and interview on 5/4/2025, at 1:56 P.M., with Certified Nursing assistant (CNA) 3 in Resident 3's room, a geri chair was observed parked alongside Resident 3's bed. CNA 3 stated that the geri chair should not be placed alongside the bed of Resident 3 for safety reasons. CNA 3 stated the geri chair at the bedside may lead to Resident 3 bumping into the chair, trip, fall, it is dangerous. During a concurrent interview and record review, on 5/4/2025, at 2:01 P.M., with the RNS 1, a picture of the geri chair parked alongside Resident 3's bed was reviewed. RNS 1 stated that the geri chair should not be placed alongside Resident 3's bed as it is a restraint when used in that manner. RNS 1 stated Resident 3 may fall trying to get out of bed. During an interview on 5/4/2025, at 6:52 P.M., with the DON, the DON stated the geri chair should not be at the bedside as Resident may not be able to get out of bed, their access may be blocked and get the resident entrapped or trapped. During a record review of the facility's P&P titled, Use of Restraints, revised 8/2024, indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 43454 Based on interview and record review, the facility failed to ensure residents' notice of proposed transfer/discharge notification was sent to the Office of the State Long-Term Care Ombudsman (public advocate) on a timely manner for one of three sampled discharged residents reviewed (Resident 39) as indicated in the facility's policy. This deficient practice had the potential to deny Resident 39's protection from being inappropriately discharged . Findings: During a record review of the Admission Record, Resident 39 was admitted to the facility 11/18/2024 with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), chronic pancreatitis (a long-lasting inflammation of the pancreas, a gland behind the stomach that helps with digestion and regulates blood sugar), and muscle weakness (weakening, shrinking, and loss of muscle). During a record review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/24/2025, indicated Resident 39's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 39 required moderate assistance to supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 39's Discharge Summary Plan of Care, dated 2/11/2025, it indicated, Resident 39 was discharged at an Assisted Living Facility (ALF - provides housing and personal care services for individuals who need help with daily tasks like bathing, dressing, and eating, but don't require the 24-hour medical care of a nursing home) on 2/11/2025. During a record review of Resident 39's Notice of Proposed Transfer/Discharge indicated the notification was sent to Ombudsman via facsimile transmission dated 5/4/2025. During an interview with the Director of Nursing (DON) on 5/4/2025 at 1:15 p.m., DON stated, Resident 39's discharge notification was sent today (5/4/2025) via fax to the Ombudsman's office. DON stated that they have 30 days to send the notification to the Ombudsman after discharge. DON then reviewed the policies and procedure (P&P) and stated, the written notifications to the Ombudsman and residents/resident's representative shall be given with an advance 30-day written notice of an impending transfer or discharge. DON further stated, Ombudsman must be given an advance notice so that they may be able to assist residents if they don't agree with the discharge planning. During a record review of the facility policy and procedures (P&P) titled, Transfer or Discharge Notice, reviewed/revised on 3/20/2025, the P&P indicated, Our facility shall provide a resident and/or the resident's representative (sponsor) with a 30-day written notice of an impending transfer or discharge . A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interviews and record review, the facility failed to ensure the assessment entries were accurate for one of one sampled resident reviewed for resident's assessment (Resident 12) by failing to appropriately assess residents' diagnosis in the Minimum Data Set (MDS - resident assessment tool). This deficient practice had the potential to result in a negative effect on residents' plan of care and delivery of services. Cross Reference F658 Findings: During a record review of the Admission Record indicated Resident 12 was originally admitted to the facility 4/1/2021 and readmitted on [DATE] with diagnoses including chronic pulmonary edema (a condition caused by excess fluids in the lungs usually caused by a heart condition), atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a record review of the MDS dated [DATE], Resident 12's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 12 had an active diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). During an interview and observation of Resident 12 on 5/2/2025 at 6:12 p.m., Resident 12 stated, she is doing well and likes participating in the Activity room. Resident 12 appeared calm, compliant with care and followed direction. During an interview with Minimum Data Set Nurse (MDSN) on 5/4/2025 at 10:36 a.m., MDSN stated MDSN mistakenly quoted Resident 12's MDS assessment with a diagnosis of schizophrenia but they don't have all documentation that supports the diagnosis according to DSM-V (officially known as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition - a book used by mental health professionals to diagnose and classify mental health disorders). MDSN further stated, Resident 12 is cooperative and does not show any hallucinations, and delusions. During an interview with the Director of Nursing (DON) on 5/4/2025 at 3:58 p.m., DON stated, Resident 12's needs to meet all criteria before they quote them with a schizophrenia diagnosis on the MDS. DON stated, they need to have a medical professional that will provide the supporting documents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility policy and procedures (P&P), titled, Resident Assessment Instrument, revised 3/2025, the P&P indicated, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements . The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555786	A. Building B. Wing	05/04/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review, the facility failed to ensure that a Pre-Admission Screening Resident Review level II (a detailed assessment that determines if someone with a mental illness [like serious mental illness, intellectual disability, or related conditions] needs specialized services and the most appropriate place to receive them) was obtained and maintained in the residents chart for two of three sampled residents (Residents 1 and 25). This deficient practice had the potential to negatively affect the appropriate care and services rendered to Residents. 1 and 25 Findings: During a record review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 7/23/2024 and Resident 1 was readmitted to the facility on [DATE] with diagnoses including anxiety (a feeling of worry, fear, or unease, often accompanied by physical symptoms like a rapid heartbeat or shortness of breath), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/24/2025, indicated Resident 1 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review, on 5/4/2025, at 10:32 A.M., with the Minimal Data Set Nurse (MDSN) nurse, Resident 1's PASARR level I and chart were reviewed. The PASARR level I dated 11/11/2024, indicated Resident I was positive for PASARR level I and required to have an evaluation for PASARR level II. The MDS nurse stated that the facility process for a PASARR level II is that the PASARR level II office will call within three days for a follow up however, it they do not call, then the facility has to follow up. The MDSN stated that there was no documented evidence that the PASARR level II office called or that the facility made a follow up with the PASARR level II office. The MDSN stated that the facility should have followed up with the PASARR level II off to ensure that Resident 1's care was customized to the resident so that Resident 1 can be given care that Resident 1 is supposed to be receiving. During a record review of Resident 25's Admission Record indicated the facility admitted Resident 25 on 6/29/2023 and readmitted Resident 25 on 4/8/2025 with diagnoses including hypertension (HTN-high blood pressure), anxiety (a feeling of worry, fear, or unease, often accompanied by physical symptoms like a rapid heartbeat or shortness of breath), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 25's MDS dated [DATE], indicated Resident 25 had cognitive impairment. The MDS indicated Resident 25 was dependent on staff for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review, on 5/4/2025, at 11:07 A.M., with MDSN nurse, Resident 25's PASARR level I and chart were reviewed. The PASARR level I indicated that Resident 25 was positive for PASARR level I and required to have an evaluation for PASARR level II. The MDSN stated that the facility process for PASARR level II is that the PASARR level II office will call within three days for a follow up however, it they do not call, then the facility has to follow up. The MDSN stated that there was no documented evidence that the PASARR level II office called or that the facility made a follow up with the PASARR level II office. The MDSN stated that the facility should have followed up with the PASARR level II office to ensure that Resident 25's care was specialized to the residents so that Resident 25 did not have missing information needed to provide Resident 25 with the care that is needed. During an interview on 5/4/2025, at 6:46 P.M., with the Director of Nursing (DON), the DON stated that the PASARR is an assessment that evaluates the placement of the resident's care into the facility, if they residents need a referral to mental health and obtain resources needed for the residents. The DON stated that the facility process for PASARR level II is that the facility will make a referral to the PASARR office for level II and follow up with them. The DON stated not having a PASARR level II follow up may lead to a delay in care and the residents will not have proper follow-up care like mental health care for instance. During a record review of the facility Policy and Procedures (P&P) titled, Pre-Admission Screening Level II Resident Review (PASRR Level II, dated 3/20/2025, indicated, To coordinate assessments with the pre-admissions screening and resident review (PASRR) program under Medicaid/Medical to the maximum effort possible to avoid duplicative testing and effort .The facility staff will coordinate the recommendations from the level II PASRR determination and the PASRR evaluation report with the residents' assessment, care planning and transitions of care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of 12 sampled residents (Resident 10) by failing to develop a comprehensive (CP) with the use of bilateral bed siderails for Resident 10. This deficient practice had the potential to result negative impact on residents' health and safety, as well as the quality of care and services received. Findings: During a record review of the Admission Record indicated Resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and unspecified dementia (a progressive state of decline in mental abilities). During a record review of the Minimum Data Set (MDS - resident assessment tool) dated 4/22/2025, indicated Resident 10's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 10 required moderate assistance to supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 10's Order Summary Report indicated: i. As of 5/4/2025, there was no physician order for the use of bed siderails. During a record review of Resident 10's Care Plan (CP) as 5/4/2025, indicated there are no CP developed for the use of bed siderails. During an observation of Resident 10 on 5/4/2025 at 9:10 a.m., Resident 10 was observed lying on bed with bed siderails up. During a concurrent observation and interview with Registered Nurse 1 (RN 1) on 5/4/2025 at 9:26 a.m., RN 1 observed Resident 10 in the room, lying on a bed with a bed side rails up. RN 1 stated, there should be an order and a Care Plan for the use of bed siderails. RN 1 stated the side rails may cause harm to Resident 10 if it's being used in a wrong way like restricting resident's movement. During a concurrent interview and record review with Director of Nursing (DON) on 5/4/2025 at 3:50 p.m., DON stated, there must be a CP developed for the use of devices that may restrict resident's movement. DON stated, there was no CP developed for Resident 10's used of bed siderails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility policy and procedures (P&P) titled, Use of Restraints, revised on 8/2024, the P&P indicated, If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint . Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed . Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). During a record review of the facility P&P titled, Care Planning - Interdisciplinary Team, reviewed 3/20/2025, the P&P indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to meet professional standards of quality of care for one of three sampled residents reviewed for behavior, (Resident 12) by failing to ensure failed to ensure the assessment entries were accurate for one of three sampled residents (Resident 12) by failing to appropriately assess residents' diagnosis in the Minimum Data Set (MDS - resident assessment tool). This deficient practice had the potential to result in a negative effect on residents' plan of care and delivery of services. Findings: During a record review of the Admission Record indicated Resident 12 was originally admitted to the facility 4/1/2021 and readmitted on [DATE] with diagnoses including chronic pulmonary edema (a condition caused by excess fluids in the lungs usually caused by a heart condition), atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a record review of the MDS dated [DATE], Resident 12's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 12 had an active diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). During an interview and observation of Resident 12 on 5/2/2025 at 6:12 p.m., Resident 12 stated, she is doing well and likes participating in the Activity room. Resident 12 appeared calm, compliant with care and followed direction. During an interview with Minimum Data Set Nurse (MDSN) on 5/4/2025 at 10:36 a.m., MDSN stated MDSN mistakenly quoted Resident 12's MDS assessment with a diagnosis of schizophrenia but they don't have all documentation that supports the diagnosis according to DSM-V (officially known as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition - a book used by mental health professionals to diagnose and classify mental health disorders). MDSN further stated, Resident 12 is cooperative and does not show any hallucinations, and delusions. During an interview with Director of Nursing (DON) on 5/4/2025 at 3:58 p.m., DON stated, Resident 12's needs to meet all criteria before they quote them with a schizophrenia diagnosis on the MDS. DON stated, they need to have a medical professional that will provide the supporting documents. During a record review of facility's policy and procedures (P&P), titled, Resident Assessment Instrument, revised 3/2025, the P&P indicated, The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements . The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Substance Abuse and Mental Health Services Administration. Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US), dated 6/2016, Table 3.20, DSM-IV to DSM-5 Psychotic Disorders Available from: https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t20/, it indicated, to diagnos schizophrenia, two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), with grossly disorganized or catatonic behavior and negative symptoms,(i.e., diminished emotional expression or avolition).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on observation, interview, and record review, facility failed to ensure that the resident was safe during mobility using a geri chair (a large, padded, often wheeled chair designed to help seniors or individuals with limited mobility) for one of two sampled residents (Resident 25). This deficient practice had the potential to cause harm/injury and possible hospitalization for Resident 25. Cross Reference F689 Findings: During a record review of Resident 25's Admission Record indicated the facility admitted Resident 25 on 6/29/2023 and Resident 25 was readmitted to the facility on [DATE]with diagnoses including hypertension (HTN-high blood pressure), anxiety (a feeling of worry, fear, or unease, often accompanied by physical symptoms like a rapid heartbeat or shortness of breath), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) During a record review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, indicated Resident 25 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 25 was dependent on staff for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 5/2/2035, at 6:49 P.M., in Resident 25's room, certified nursing assistant (CNA) 5 was pushing Resident 25 in a geri chair with Resident 25's feet dragging on the floor and Resident 25's head partially on the head rest and midair. During a concurrent observation, and interview on 5/2/3035, at 6:51 P.M., with CNA 5, in Resident 25's room, CNA 5 stated that Resident 25's feet were dragging on the floor and Resident 25's head was not comfortable, not fully resting on the chair on one side. CNA 5 stated she was going to reposition Resident 25 so that Resident 25's feet were not dragging on the floor and Resident 25 is aligned in the chair with the head resting on the chair completely. CNA 5 stated she was repositioning Resident 25 because Resident 25's position was not good and Resident 25 may get hurt and the feet may get swollen. During an interview on 5/4/2025, at 6:47 P.M., with the Director of Nursing (DON), the DON stated that residents need to be properly positioned every two hours and as needed or as indicated when in the geri chair. The resident's feet should be completely off the ground, resident should be propped up, straight alignment and head of the resident resting on the back of the chair for comfort and to prevent resident getting caught up in the geri chair and getting injured. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's Policy and Procedures (P&P) titled, Safety and Supervision of Residents, revised 7/2024, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on observation, interview, and record review, facility failed to ensure that the resident's feet did drag on the floor during mobility using a geri chair (a large, padded, often wheeled chair designed to help seniors or individuals with limited mobility) for one of two sampled residents (Resident 25). This deficient practice had the potential to cause harm/injury and possible hospitalization for Resident 25. Cross Reference F684 Findings: During a record review of Resident 25's Admission Record indicated the facility admitted Resident 25 on 6/29/2023 and Resident 25 was readmitted to the facility on [DATE]with diagnoses including hypertension (HTN-high blood pressure), anxiety (a feeling of worry, fear, or unease, often accompanied by physical symptoms like a rapid heartbeat or shortness of breath), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) During a record review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, indicated Resident 25 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 25 was dependent on staff for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 5/2/2035, at 6:49 P.M., in Resident 25's room, certified nursing assistant (CNA) 5 was pushing Resident 25 in a geri chair with Resident 25's feet dragging on the floor and Resident 25's head partially on the head rest and midair. During a concurrent observation, and interview on 5/2/3035, at 6:51 P.M., with CNA 5, in Resident 25's room, CNA 5 stated that Resident 25's feet were dragging on the floor and Resident 25's head was not comfortable, not fully resting on the chair on one side. CNA 5 stated she was going to reposition Resident 25 so that Resident 25's feet were not dragging on the floor and Resident 25 is aligned in the chair with the head resting on the chair completely. CNA 5 stated she was repositioning Resident 25 because Resident 25's position was not good and Resident 25 may get hurt and the feet may get swollen. During an interview on 5/4/2025, at 6:47 P.M., with the Director of Nursing (DON), the DON stated that residents need to be properly positioned every two hours and as needed or as indicated when in the geri chair. The resident's feet should be completely off the ground, resident should be propped up, straight alignment and head of the resident resting on the back of the chair for comfort and to prevent resident getting caught up in the geri chair and getting injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's Policy and Procedures (P&P) titled, Safety and Supervision of Residents, revised 7/2024, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45528 Based on interview and record review, the facility failed to ensure that the nursing staff met the skills and staff competency evaluation requirements. This deficient practice had the potential for knowledge, training, and certification deficit among the nursing staff, leading to inadequate or delayed care for the residents. Findings: During a concurrent interview and record review, on 5/4/2025, at 9:06 A.M., with the Director of Staff Development (DSD), the DSD, the facility's employee files were reviewed. The employee files indicated that four of five employee files reviewed did not have documented proof of annual competency training for the employees. The DSD stated employee competency training was done upon hire and annually thereafter to assess the staff's competency when providing care to the residents, if the staff need assistance or improvement in their skill. DSD stated if competency training is not done, the facility staff will not be assessed in the way their skills are done when providing resident care in areas including but not limited to activities of daily living (ADL), medication administration and intravenous infusion. The DSD stated lack of skills competency training may lead to a decline in the way care is provided to the residents. During an interview on 5/4/2025, at 6:38 P.M., with the Director of Nursing (DON), the DON stated employee competencies are about ensuring that nursing staff are assessed in their skills when it comes to resident care, this is done to ensure that the staff are on par with how they perform their skills, the staff are upto date and are competent to perform their job duties. The DON stated that the employee competency training is supposed to be done annually and as needed. The employee's skill training process is that the facility utilizes a form that guides the facility on what skills that need to be checked for the facility nursing staff, and needed to be completed with the check mark, may be a narrative note to state whether the employee met or did not meet the required skills assessment. The DON stated if competency training is not done, there may be inaccuracies and delays in the care of the residents. During a record review of the facility policy and procedures (P&P), titled Competency of Nursing Staff, revised 3/2025, indicated, Policy statement: I. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. Participates in a facility-specific, competency-based staff development and training program; and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Demonstrates specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 43454 Based on observation, interview, and record review, the facility failed to post the actual nursing hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift for three of three sampled days (5/2/2025, 5/3/2025, and 5/4/2025). This deficient practice resulted in the actual staffing information not being readily accessible and available to residents and visitors and had the potential to cause inadequate staffing. Findings: During an observation of the facility on 5/2/2025 at 6:23 p.m., observed Direct Care Services Hours Per Patient Day (DHPPD) posted by the nursing station with only the projected hours posted. The information on the forms was incomplete for each shift. No actual hours were posted and no calculation of unlicensed nursing staffing directly responsible for resident care in the DHPPD posting, there was no DHPPD posted for the previous day (5/1/2025). During an observation of the facility 5/3/2025 at 9:23 a.m., observed DHPPD dated 5/3/2025 posted on the wall with only the projected hours. The information on the forms was incomplete for each shift. No actual hours were posted and no calculation of unlicensed nursing staffing directly responsible for resident care in the DHPPD posting, there was no DHPPD posted for the previous day (5/2/2025). During observation of the facility on 5/4/2025 at 6:23 p.m., observed DHPPD dated 5/4/2025 posted by the nursing station with only the projected hours posted. The information on the forms was incomplete for each shift. No actual hours were posted and no calculation of unlicensed nursing staffing directly responsible for resident care in the DHPPD posting, there was no DHPPD posted for the previous day (5/3/2025). During an interview with Director of Staff and Development (DSD) on 5/4/2025 at 6:25 p.m., DSD stated, he is responsible on the DHPPD posting and making sure that the information posted are accurate and complete. DSD stated, the projected hours are posted and does not include the actual hours worked by licensed and unlicensed staff in the facility. DSD then reviewed facility's policy and procedures, and stated, the actual hours worked by staff must be calculated and posted on the NHPPD posting and must be updated two hours after each shift starts. (continued on next page)

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	555786	A. Building B. Wing	05/04/2025

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Ocean Park Healthcare	2828 Pico Boulevard Santa Monica, CA 90405

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility policy and procedures (P&P) titled Posting Direct Care Daily Staffing revised on 3/2025, the P&P indicated, Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format format . Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include: The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility . Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed to follow its policy and procedures for medication storage by failing to ensure proper disposal expired medical supplies from intravenous (IV, a method of administering fluids, medications, or nutrients directly into a vein) medication cart by failing to disposed of: 1. One StatLock catheter stabilization device (device that adheres to the skin where the tubing of the catheter is locked in preventing accidental removal), 2. Nine (9) StatLock PICC (Peripherally Inserted Central Catheter, a long, thin tube inserted into a vein in the arm and threaded upwards through the vein into a larger vein near the heart) Plus catheter stabilization devices (device the adheres to the skin locking in the PICC tubing preventing accidental removal), and 3. Four (4) IV start kits (contains items for starting an IV line). These failures had the potential to result in nursing staff using expired supplies which could expose the residents to infection. Findings During a concurrent observation and interview on [DATE] 10:21 am, with Registered Nurse Supervisor (RNS) 1, the IV medication storage cart reviewed for expired supplies. During the review the following expired supplies were noted: 1. One StatLock catheter stabilization device with use by date of [DATE], 2. Nine (9) StatLock PICC plus catheter stabilization devices with use by date of [DATE], and 3. Four (4) IV start kits with expiration date of [DATE]. RNS 1 verified supplies were expired, gathered them to throw out and stated they could lead to infection and he will remove them to have them incinerated. During a record review of the facility policy and procedures (P&P), titled Storage of Medications, Biologicals, and Medical Supplies, revised [DATE], indicated, The facility shall store all drugs, biologicals and medical supplies in a safe, secure and orderly manner . The facility shall not use discontinued, outdated, or deteriorated drugs, biologicals or medical supplies . shall be returned to the dispensing pharmacy or removed and/or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44252 Based on observation, interview, and record review, the facility failed ensure proper sanitation and food handling practices by failing to ensure: 1. Juice gun (also known as a bar gun, is a device used to dispense various types of carbonated and non-carbonated drinks, including juices) tubing was free of grime build up, 2. Two bulk juices were not labeled with use by dates and, 3. One dry food scoop was being stored on top of a dry food bin in the dry food storage room. This deficient practice had the potential to result in unsafe food management, and foodborne illness. Findings: During an observation in the kitchen on 5/2/25 at 5:38 pm, the juice/soda gun dispenser tubing observed to have brown grime build up. During an observation with concurrent interview on 5/3/25 at 4:11 pm with Dietary Aide (DA) 1, the juice/soda gun dispenser tubing was observed to have brown grime build up, DA 1 verified the finding and stated the person responsible for cleaning the juice/soda gun dispenser tubing was supposed to be the person who cleans ice machine. During the same concurrent observation and interview there was apple juice box connected to the juice gun system with no received or use by dates indicated on the box, there was also a bag of red colored juice marked sugar free that also was lacking the received and use by dates. DA 1 verified the finding and stated they should have the dates and it typically takes a week to go through the bag or box of juice. During a observation with concurrent interview on 5/4/25 at 9:48 am with the Dietary Supervisor (DS), a picture of the juice/soda gun dispenser tubing was reviewed. The DS verified the grime on the tubing and stated the gun should be cleaned by the company that comes out to maintain the juice/soda gun dispenser. During the same concurrent observation and interview with the DS a large dry food storage scoop was observed sitting on top of a dry food storage container in the dry food storage room. The DS verified the scoop was on top of the container and stated it should be somewhere where it doesn't touch the outside of the containers. During a record review of the facility policy and procedures (P&P), titled Sanitization, revised November 2022, indicated, The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris . 2. All utensils, counters, shelves and equipment are kept clean and maintained in good repair .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed ensure the medical record for two of five sampled residents (Residents 32 and 40) was accurate and compete for: 1. Resident 32's Advance Directive Acknowledgement form was filled out completely, 2. Resident 40's Physician's progress note was accurately dated. This failure resulted in an incomplete and inaccurate forms in the medical record and had the potential to effect the delivery of care. Findings: 1. During a record review of Resident 32's Admission Record dated 5/4/25 indicated the resident was admitted to the facility on [DATE] with diagnoses including: diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), anxiety disorder (excessive fear or worry), anemia (a condition where the body does not have enough healthy red blood cells), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a record review of Resident 32's Minimum Data Set (MDS, resident assessment tool), dated 2/13/25 indicated the resident had severe cognitive (the ability to think, learn, and remember clearly) impairment. The MDS further indicated Resident 32 required set up or clean-up assistance from staff for eating, and required supervision or touching assistance for oral hygiene, toileting, dressing, personal hygiene, bed mobility and transferring. During a concurrent interview and record review on 5/4/25 at 11:34 am with the Minimum Data Set Coordinator (MDSC) Advance Directive Acknowledgement form dated 7/25/24 for Resident 32 was reviewed. The MDSC form did not have a check mark indicating if the resident had or had not executed an Advance Healthcare Directive (both check boxes had been left blank). The MDSC verified the empty boxes where a check mark was missing and stated their should be a check on the box for either having or not having executed an advance healthcare directive. 2. During a record review of Resident 40's Admission Record dated 3/9/25 indicated the resident was admitted to the facility on [DATE] with diagnoses including: DM, schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a record review of Resident 40's MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS further indicated Resident 40 required set up or clean-up assistance with eating and was independent for toileting, dressing, personal hygiene, bed mobility, showering and walking. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/3/25 at 5:39 pm with the Director of Nursing (DON), the resident's census and progress notes for March 2025 were reviewed. The resident's census indicated Resident 40 was discharged on [DATE] and there was a physician's progress note dated 3/24/25 (after discharge). The DON verified and stated the physician sees the residents almost every week, he (physician) does late entry so he may have taken his notes and uploaded them all at once may have pertained to a different resident. During a telephone interview on 5/4/25 at 2:13 pm with Medical Doctor (MD) 1, in reference to the note entered after the discharge, MD 1 stated. I don't have my notes to reference but there is a lot of turn-over in patients. It was not intentional most likely a mistake. During a record review of the facility policy and procedures titled Charting/Documentation/Late Entries revised April 2024 indicated All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the residents medical record . Entries may only be recorded in the resident's clinical record by licensed personnel . in accordance with state law and facility policy . Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical record. A late entry, an addendum or a correction to the medical record, bears the current date of that entry.

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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. 43454 Based on observation, interview, and record review, the facility failed to ensure that 11 out of 12 rooms met the 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: On 5/4/2025 at 5:01 p.m., the Maintenance Director (MTD) and Director of Nursing (DON) provided a copy of the Client Accommodation Analysis and the facility letter requesting for a room waiver. A review of the Client Accommodation Analysis indicated 11 of 12 rooms did not have at least 80 sq. ft. per resident. The room waiver request and Client Accommodation analysis showed the following: RM# RM. Size (sq.ft) #of Res sq.ft SQ.FT/Resident 2 234.42 3 78.14 3 235.32 3 78.44 4 234.21 3 78.07 5 234.42 3 78.14 6 311.55 4 77.88 7 298.11 4 74.52 8 286.65 4 71.66 9 301.5 4 75.37 10 298.5 4 74.62 11 302.9 4 75.72 12 306.9 4 76.72 The minimum requirement for a three bedroom should be at least 240 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/3/3035 to 5/4/2025, during general observations, both residents and staff had enough space to move about freely inside the rooms. The nursing staff had enough space to safely provide care to the residents with space for the beds, side tables, dressers, and resident care equipment. The Department is recommending continuation of the Room Waiver Request.