STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555787	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Nursing and Wellness Center, Inc	7926 S Painter Ave Whittier, CA 90602

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50958 Based on observation, interview, and record review, the facility failed to ensure six of 6 sampled residents (Resident 28, 20, 21, 2, 5, and 81), received personal mails when delivered on Saturdays at the facility. This failure resulted in violating Resident 28, Resident 20, Resident 21, Resident 2, Resident 5, and Resident 81 rights to received mail on Saturdays which could result of missing important and timely correspondence. Findings: During an interview on 11/5/2024 at 10:00 AM, during Resident Council Meeting, Resident 28, Resident 20, Resident 21, Resident 2, Resident 5, and Resident 81 stated they received mail unopened on Monday through Friday but did not receive mails on Saturdays. During an interview on 11/5/2024 at 10:45 AM with the Business Office Manager (BOM), the BOM stated she was responsible for releasing the mail from Monday through Friday to Social Service Director (SSD-also was the Activity Director in the facility) or Activity Assistant. The BOM stated the SSD or Activity Assistant were responsible to deliver the mails to the residents. The BOM stated the facility did not deliver mails to resident on Saturdays. During a concurrent observation and interview on 11/6/2024 at 10:51 AM, at the nurse station, a locked mailbox was noted hanging on the wall. The SSD stated the activity staff delivered the mails to residents on Monday through Friday after they (SSD or AA) received the mail from the business office. The SSD stated mails delivered on Saturdays would be placed in the locked mailbox at the nurse station. The SSD stated the business office staff would check the mailbox on Monday and give the residents' mail to activity staff on Monday to deliver to the residents. During an interview on 11/6/2024 at 11:47 AM with the Director of Nursing (DON), the DON stated it was the resident's right to receive the mail timely, and the facility should ensure the residents received the mail on Saturdays. (continued on next page)

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 28's Admission Record (Face Sheet), the Face Sheet indicated Resident 28 was admitted on [DATE] with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition), polyneuropathy (damage to multiple nerves outside of the brain and central nervous system), congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently), dysphagia (difficulty swallowing), muscle weakness, benign prostatic hyperplasia (a condition in which the prostate gland grows larger than normal), schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2024, the MDS indicated Resident 28 had moderate impairment in cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated Resident 28 needed substantial/maximal assistance (another person does more than half the effort) to complete the activity. During a review of Resident 20's Admission Record (Face Sheet), the Face Sheet indicated the facility originally admitted Resident 20 on 8/19/2024 and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia, primary hypertension (HTN-high blood pressure), depression, bipolar disorder, anxiety disorder (a mental illness that causes people to experience excessive and uncontrollable feelings of fear or anxiety), schizophrenia, acute kidney failure (a sudden and often reversible reduction in kidney function). During a review of Resident 20's MDS dated [DATE], the MDS indicated Resident 20 had moderate impairment in cognitive skills for daily decision making. The MDS indicated Resident 20 needed partial/moderate assistance (another person does less than half the effort) to complete the activity. During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted Resident 21 on 7/21/2022 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia, muscle weakness, chronic kidney disease (progressive damage and loss of function in the kidneys), moderate dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), schizophrenia, and anxiety disorder. During a review of Resident 21's History and Physical (H&P), dated 6/29/2024, the H&P indicated Resident 21 had fluctuating capacity to understand and make decisions. During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21 had moderate impairment in cognitive skills for daily decision making. The MDS indicated Resident 21 needed setup or clean-up assistance (another person sets up or cleans up and resident completes the activity). During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility admitted Resident 2 on 3/23/2024 with diagnoses including type 2 diabetes mellitus, dysphagia, malignant neoplasm of cerebral ventricle (a cancerous brain tumor that develops in the brain's cavities), epilepsy (happens as a result of abnormal electrical brain activity, also known as a seizure), hemiplegia and hemiparesis (complete or partial weakness on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain), primary hypertension, schizophrenia. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's History and Physical (H&P), dated 3/25/2024, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had no impairment in cognitive skills for daily decision making. The MDS indicated Resident 2 needed supervision or touching assistance (another person provided verbal cues and/or touching/steadying assistance) to walk 50 feet with two turns. During a review of Resident 5's Face Sheet, the Face Sheet indicated Resident 5 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (a chronic lung disease causing difficulty breathing), epilepsy (happens as a result of abnormal electrical brain activity, also known as a seizure), primary hypertension, schizophrenia, dysphagia, psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review of Resident 5's History and Physical (H&P), dated 4/15/2024, the H&P indicated Resident 5 could make decisions for activities of daily living. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had no impairment in cognitive skills for daily decision making. The MDS indicated Resident 5 needed supervision or touching assistance to walk 50 feet with two turns. During a review of Resident 81's Face Sheet, the Face Sheet indicated Resident 81 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, heart failure, schizophrenia, bipolar disorder, moderate dementia (a progressive state of decline in mental abilities). During a review of Resident 81's History and Physical (H&P), dated 4/15/2024, the H&P indicated Resident 81 did not have the capacity to understand and make decisions. During a review of Resident 81's MDS dated [DATE], the MDS indicated Resident 81 had moderate impairment in cognitive skills for daily decision making. The MDS indicated Resident 81 needed supervision or touching assistance to walk 50 feet with two turns. During a review of the facility's policy and procedure (P&P) titled, Resident [NAME] of Right, undated, the P&P indicated the facility should ensure resident have the right to associate and communicate privately with person of the resident's choice, and to send and receive his or her personal mail unopened. The residents should have ready access to letter writing materials, including stamps, and to mail and received unopened correspondence. The resident has the right to privacy in written communications, including

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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** 36925 Based on observation, interview, and record review, the facility failed to implement the professional standard of practice and the facility ' s policy and procedure titled Emergency Management Codes and Procedures for medical emergency (Code Blue- is a hospital code to alert the facility staffs of a medical emergency) by failing to ensure: 1. Call Code Blue was announced on the facility ' s paging system when Resident 27 was found unresponsive to verbal stimuli and responsive to painful stimuli with decreased heart rate, respiratory rate, and blood pressure (the measurement of the pressure in the blood vessels when the heart relaxes or contracts the force of blood pushing against artery walls as the heart pumps blood throughout the body). 2. Cardiopulmonary Resuscitation (CPR-a lifesaving emergency procedure for a victim who has signs of cardiac arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse]) was initiated immediately and not wait until full code (the patient required resuscitation and all life saving measures during a medical emergency) status of Resident 27 was determined. 3. Rescue breaths (a part of CPR, or cardiopulmonary resuscitation, that involves blowing air into a victim's mouth to deliver oxygen to their lungs) were provided after 30 chest compression (the application of pressure to the chest to prevent it from expanding, used in cardiopulmonary resuscitation) during CPR was performed. These deficient practices resulted in the delayed in providing CPR and/or provisions of emergency care to Resident 27 who was found unresponsive, and the resident could not be revived by the paramedics (emergency medical personnel). Resident 27 was pronounced expired by the paramedics on [DATE] at 10:45 PM in the facility. Findings: During a review of Resident 27 ' s Admission Record (Face Sheet), dated [DATE], the face sheet indicated the facility admitted Resident 27 on [DATE] with diagnoses including diabetes mellitus (elevated sugar in the blood), hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and history of falling. During a review of Resident 27 ' s Physician Orders for Life Sustaining Treatment (POLST- a medical order that allows residents or their representative indicate their preferences for end-of-life care) signed by Resident 27 ' s Family Member 1 (FM 1) on [DATE] and signed and dated by the Resident 27 ' s Physician on 10 /, d+[DATE], indicated to attempt CPR to Resident 27 to restore breathing and heart circulation and heartbeat. During a review of Resident 27 ' s History and Physical (H&P), dated [DATE] indicated, Resident 27 had the capacity to make medical decisions. (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 review of Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and required supervision and extensive assistance from the staff for the activities of daily living. During a review of Resident 27 ' s Change of Condition (COC) record, dated [DATE] indicated at 10:25 PM, during a facility round Certified Nursing Assistance 3 (CNA 3) observed that Resident 27 Did not look good. CNA 3 then called charge nurse to check Resident 27 right away. License Vocational Nurse (LVN) 2, LVN 2 observed Resident 27 unresponsive to verbal stimuli but responsive to painful stimuli. The COC indicated vital signs (measurements of the body ' s basic functions such as the heart rate, respiratory rate, blood pressure) check respiratory rate 8 pulse 30/min blood pressure (BP) ,d+[DATE] Oxygen (O2) absent, O2 inhalation initiated 5 Liters/minute, then bp and carotid pulse diminish, CPR initiated right away. The COC indicated 911 was called and paramedics (person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) was notified immediately, the paramedics arrived within 5 minutes and took over resident. The COC indicated on [DATE] at 10:50 PM the paramedics could not revive the resident and pronounced Resident 27 diseased by the paramedics. The COC indicated Resident 27s family and doctor was notified that Resident 27 expired. During a review of the paramedics run sheet (a report from the paramedics) dated [DATE] timed at 10:20 PM, indicated paramedics arrived at facility at 10:25PM and assessed Resident 27. The report indicated the paramedics found Resident 27 unresponsive and placed the resident on [NAME] device (a device used compress the resident ' s chest to resume blood circulation) and established intraosseous insertion (method of administering medications through the bone) per CPR protocol (a system of rules that explain the correct conduct and procedures to be followed in correct situations). Resident 27 ' s electrocardiogram (EKG- a reading of the electrical activity of the heart) showed asystole (an EKG reading that indicates the heart to stopped pumping) at 10:26 PM. The report indicated TOR (Termination of Resuscitation) and pronounced Resident 27 expired at 10:46 PM During a telephone interview on [DATE] at 4:58 PM with LVN 2, LVN 2 stated he was notified by the Certified Nurse Assistant (CNA) 3 that Resident 27 was found unresponsive. LVN 2 stated he assessed Resident 27 ' s vital signs but was not able to check resident ' s oxygen blood level. LVN 2 stated he instructed CNA 3 to go to Nursing Station (located in front of the Resident 27 ' s room) to get Resident 27 ' s chart and look for the POLST. LVN 2 stated he did not start CPR until CNA 3 informed him that Resident 27 ' s POLST indicated the resident was a full code (full support which includes CPR if the resident has no heartbeat and is not breathing). During an interview on [DATE] at 5:30 PM with CNA 3, stated when she entered Resident 27 ' s room, CNA 3 observed Resident 27 lying in bed and not breathing. CNA 3 stated she went outside Resident 27 ' s room to call the charge nurse for help and returned to Resident 27 ' s bedside. She stated LVN 2 instructed her to check Resident 27 ' s chart for code status. Then CNA 3 stated I went to grab the backboard (a flat piece of platform that is placed under a person ' s body for the purpose of providing effective CPR). CNA 3 stated, CNA 4 helped her place the backboard under Resident 27 ' s back. LVN 2 instructed CNA 3 and CNA 4 to take over CPR, as LVN 2 went to the Nursing Station to call 911. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 5:40 PM with CNA 4, CNA 4 stated on [DATE] she was working inside another resident ' s room when CNA 3 ask her for help. CNA 4 stated LVN 2 was performing CPR to Resident 27. CNA 4 She stated that on [DATE] she did not hear a Code Blue announced in the facility ' s paging system. CNA 4 stated that she and CNA 3 was performing CPR while LVN 2 was on the phone in the Nursing Station, calling 911. CNA 4 stated that after they took over the CPR, LVN 2 placed Resident 27 on oxygen delivered via face mask. CNA 4 stated he CNA 3 only performed chest compressions and did not provide rescue breaths to Resident 27. CNA 4 stated she and CNA 3 continued to perform CPR until paramedics arrived. During a follow up telephone interview on [DATE] at 6:11 PM with LVN 2, LVN 2 stated that he cannot remember if he called out a code blue when Resident 27 was found unresponsive to verbal stimuli and vital signs were checked, LVN 2 stated he stepped out from the room to get the mouthpiece from the crash cart to use to give the two breaths Resident 27, then he started the chest compressions. LVN 2 stated that after completing about one set of CPR (consisting of 2 rescue breaths and 30 chest compressions), LVN 2 stated that he went to grab a mask and deliver oxygen to Resident 27. LVN 2 stated I stepped outside the room to call 911 and the Director of Nurses (DON) and ask for help. I don ' t remember if I called the doctor. LVN 2 stated he only checked the vital signs once when he started the CPR. During an interview on [DATE] at 8:45 AM with the Director of Staff Development (DSD), DSD stated to call for medical emergency in the facility, the staff should overpage Code blue in the facility ' s paging system three times to alert other staff members so they can come to assist. The charge nurse is in charge of assigning roles during the code. During an interview on [DATE] at 11:15 AM with the DON, DON stated in a medical emergency the staff need to page Code Blue and state the room number so everyone could help. The DON stated, CPR should be initiated by facility any staff that comes first to the room and there should be a designated team leader, which is usually the charge nurse. The DON stated any available staff can call 911 in an emergency. DON stated that procedures should be delegated, and the resident should not be left alone. During a review of the facility's policy and procedure (P&P) titled, Emergency Procedure-Cardiopulmonary Resuscitation, revised 2018, indicated if an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: the P&P indicated the facility will: 1. Instruct a staff member to activate the emergency response system (code) and call 911. 2. During CPR rescue breaths will be provided after providing 30 chest compression provide via ambu bag or manually (Manual resuscitator) with CPR shield. 3. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. There are obvious signs of irreversible death (e.g., rigor mortis). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. 5. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. During a review of the facility's policy and procedure (P&P) titled, Emergency Management Codes and Procedures, revised 2014, indicated Medical Emergency (Code Blue).

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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. 36925 Based on observation, interview, and record review, the facility failed to post an accurate facility staffing data in a prominent place where 32 of 32 residents and their representaives and visitors could easily view. This deficient practice had the potential to compromise the quality of care the residents receive due to potential insufficient staffing in the facility. Findings: During an observation on 11/04/24 at 04:28 PM, a staffing data dated 11/04/24 was posted to a wall behind the counter of the facility's nurse's station. The staffing data was not easily visible to read from the countertop in the nursing station that was approximately 10 feet away and was not accessible to the residents or visitors. During a concurrent review of the staffing data, the form indicated that the census was 41 for 11/04/24. A review of the facility's census dated 11/4/24 indicated that the resident census was 32. During an interview with the Director of Staff Development (DSD) on 11/06/24 at 01:07 PM, she stated that the staffing data that she posted on the wall at the Nurses Station in the beginning of the day shift on 11/04/24, indicated that the resident census was 32. She stated she does not know who scribbled over the resident census and wrote 41. A review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, Version 1.1, revised in 7/2016, indicated that within two hours of the beginning of each shift, the number of licensed nurses (Registered Nurses and Licensed Vocational Nurses) and the number of unlicensed nursing personnel (Certified Nurse Assistants) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50012 Based on interview and record review, the facility failed to provide pharmaceutical services as indicated in the facility's policy and procedure title Administering Medications for one of 3 sampled residents (Resident 27), who was administered Amlodipine (medication used to treat high blood pressure) when the resident ' s blood pressure was below the parameters (a fixed limit) set by the physician's order. These deficient practices had the potential to result in unintended complications such as dizziness, drowsiness, syncope (loss of consciousness) due hypotension (abnormally low blood pressure) that could lead to falls and injury. Findings: During a review of Resident 27 ' s Admission Record, dated 10/23/2021, the face sheet indicated the facility admitted Resident 27 on 10/14/2024 with diagnoses including diabetes mellitus (elevated sugar in the blood), hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and history of falling. During a review of Resident 27 ' s History and Physical (H&P), dated 10/16/2024 indicated, Resident 27 had the mental capacity to make medical decisions. During a review of Resident 27's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/20/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living. During a review of Resident 27 ' s physician's order, dated 10/16/2024, indicated to administer Amlodipine Besylate Oral Tablet 2.5 milligrams (mg-a unit of measurement) one tablet by mouth one time a day for hypertension, and to hold if systolic blood pressure (SBP - the amount of pressure in the arteries during contraction of the heart muscle) is less than 110 mm Hg (millimeter mercury) or if heart rate is less than 60. During a record review of Resident 27 ' s Medication Administration Record (MAR), for the month of October 2024, the MAR indicated, to administer Amlodipine 2.5 mg one tablet was administered to the resident on 10/29/2024, at 9AM, and 10/30/2024, at 9AM when the systolic blood pressure was below 110 mm Hg and had a BP systolic readings ranged 102 mm Hg to 108 mm Hg. During a concurrent interview and record review on 11/06/2024 at 12:36 PM with the Director of Nursing (DON), stated Amlodipine 2.5 mg should have not been administered to Resident 27 when systolic blood pressure was less than 110 mmHg according to the physician ' s order. A review of the facility's policy of Administering Medications revised in April 2019 indicated the medications must be administered in accordance with the physician ' s orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36925 Based on interview and record review, the facility failed to accurately and complete the medical information for 3 of 3 sampled residents (Residents 2, 25, and 27) by failing to: 1. For Residents 2 and 25, the facility did not ensure that the responsible party who signed the Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) indicated his relationship to the resident and facility representative who signed the form indicated her title. 2. For Resident 27, the facility did not follow its own policy and procedure in documenting the resident's change of condition and nursing notes. These deficient practices can lead to misdiagnoses, inappropriate treatment, and gaps in patient care that could ultimately result to adverse health outcomes. Findings: 1. A review of Resident 2's Admission Record indicated that the facility admitted the resident on 12/01/2010 and readmitted the resident on 03/23/2024 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 08/30/2024, indicated that the resident's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. A review of Resident 2's Advance Directive indicated that he was not capable of making medical decisions. The resident's representative signed the Advance Directive on but did not indicate his relationship to the resident. The facility representative signed the same Advance Directive on 3/23/24 but did not indicate her title. During an interview on 11/4/24 at 1:11 PM, Registered Nurse (RN) 1 stated that Resident 2 was not capable of making medical decisions for himself. During a concurrent review of his chart with RN 1, she stated that the representative of the resident signed the resident's Advance Directive on 3/23/24 but did not indicate his relationship to the resident. RN 1 stated that not knowing the relationship of the person who signed the form could result in a delay in treatment in case of an emergency. A review of Resident 25's Admission Record indicated that the facility admitted the resident on 10/22/2024 with diagnoses that included schizophrenia. A review of Resident 25's MDS, dated [DATE], indicated that the resident's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was impaired. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 25's records indicated that her representative signed her Advance Directive on 10/22/24 but did not indicate his relationship to the resident. The facility representative signed the same Advance Directive on 10/22/24 but did not indicate her title. During an interview on 11/5/24 at 9:10 AM, the Social Services Director (SSD) stated that the purpose of the Advance Directive is for the facility to know the resident's choice during an emergency. She stated that not knowing the relationship of the representative to the resident could result to a delay in treatment in case of an emergency. During a concurrent review of the Advance Directive of Resident 2 and Resident 25 with the SSD, she stated that the representatives for Residents 2 and 25 signed the form but did not indicate their relationship to the resident. She stated that she also signed the Advance Directive forms for Residents 2 and 25 but she forgot to put her title. A review of the facility's policy titled, Charting and Documentation, Version 1.2, revised in 7/2017, indicated that documentation in the medical record should be complete and accurate. 50012 2. During a review of Resident 27 ' s Admission Record (Face Sheet), dated 10/23/2021, the face sheet indicated the facility admitted Resident 27 on 10/14/2024 with diagnoses including diabetes mellitus (elevated sugar in the blood), hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and history of falling. During a review of Resident 27 ' s History and Physical (H&P), dated 10/16/2024 indicated, Resident 27 had the mental capacity to make medical decisions. During a review of Resident 27's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/20/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living. During a concurrent interview and record review on 11/7/2024 at 11:15 AM, the Director of Nursing (DON) reviewed Resident 27 ' s Progress Notes and Change of Condition (COC), both dated 10/30/2024. The DON stated that she documented the progress notes on behalf of the charge nurse, who was busy, but the charting did not include the name or title of the person who provided the care. The DON also stated she documented the COC based on information provided by the charge nurse, but the entry was written as if she herself had performed the procedures, when it was the charge nurse who implemented the interventions. The DON stated that she should have included the charge nurse ' s name and title in both instances to accurately reflect who provided the care. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 2017, indicated: Documentation of procedures and treatments will include care-specific details, including: The date and time the procedure/treatment was provided; (continued on next page)

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	555787	A. Building B. Wing	11/07/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The name and title of the individual(s) who provided the care; The assessment data and/or any unusual findings obtained during the procedure/treatment; How the resident tolerated the procedure/treatment; Whether the resident refused the procedure/treatment; Notification of family, physician or other staff, if indicated; and The signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50012 Based on observation, interview, and record review, the facility failed to follow the facility ' s infection control policy and procedure for three of 3 sampled residents (Resident 11, 16, and 19) by failing to: Ensure that Enhanced Barrier Precautions (EBP-a set of infection control measures that use personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs) were implemented by Certified Nursing Assistant (CNA 1, and 2) for three of 3 sampled Residents (Resident 11, 16, and 19) who all have indwelling catheter (a medical device that remains inside the body and provides a direct path for pathogens [any organism that causes disease] to enter the body and cause infection) and were at risk for Multi-Drug Resistant Organisms (MDRO, disease causing organism that have become resistant to certain antibiotics). These deficient practices had the potential to result in the spread of diseases and infections among the residents, visitors and staffs. Findings: During an observation on 11/4/2024 at 2 PM, a Stop sign on the door indicated all who enter the Enhanced Barrier Precautions room should clean their hands and wear Personal Protective Equipment (PPE), (gown and gloves), and wash hands with soap and water. The sign also indicated to Do not wear the same gown and gloves for the care of more than one person. During an observation on 11/4/2024 at 2 PM, Certified Nursing Assistant (CNA) 1 and CNA 2 were observed donning (putting) on gloves and into Resident 16 ' s room to reposition Resident 16. During an observation on 11/4/2024 at 2:05 PM, CNA 1 and CNA 2 were observed sanitizing hands and donned new gloves. CNA 1 and CNA 2 did not change isolation gown and proceed to repositioning Resident 11 with the same gown. During an interview on 11/4/2024 at 2:15 PM with the CNA 2, CNA 2 stated he should not wear the same gown and should have change the isolation gown because it was important for preventing infection from spreading. During an interview on 11/4/2024 at 2:16 PM with the CNA 1, CNA 1 stated I should have changed my isolation gown in between residents to prevent possible spread of infection. During an observation on 11/5/2024 at 8:45 AM, License Vocational Nurse (LVN) 1, LVN 1 was observed administering medications for Resident 19 via Gastrostomy-Tube (G-tube, a tube that is inserted through the abdominal wall and into the stomach to provide nutrition and medication) without donning an isolation gown. During an interview on 11/5/2024 at 8:45 AM License Vocational Nurse 1 (LVN), LVN 1 stated she should have put on an isolation gown to administer medications, because it is important to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/2024 at 1:45 PM, the Infection Preventionist (IP) Nurse stated the IP ' s expectation was for all staff to wear proper PPE, such as a gown, during medication administration via G-tube due to the high potential risk of bodily fluid exposure. The IP Nurse stated EBP ensures staff reduce the risk of MDRO transmission. The IP Nurse stated the facility should have ensured that all staff members have a clear knowledge of EBP practices and are in accordance with the Center for Disease Control and Prevention (CDC) EBP guidelines. The IP nurse stated the facility tries to keep up with CDC guidelines and always seek guidance from the Los Angeles County Department of Public Health regarding changes in Infection Prevention and Control practices and guidelines.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident for fourteen (14) out of sixteen (16) resident rooms (room [ROOM NUMBER],2,3,4,5,6,7,8,10,12,13,15 and 16). This deficient practice had the potential to negatively impact the quality-of-care and the ability of the nursing care to safely provide care and privacy to the residents. Findings: During the entrance conference interview with the Administrator (ADM) on 11/6/2024 at 9:06 AM, the ADM stated there were fourteen rooms (room [ROOM NUMBER],2,3,4,5,6,7,8,10,12,13,15 and 16) in the facility that did not meet the federal regulation [a regulation that the Long-Term Facilities was required to follow to meet federal requirement of by Centers for Medicare & Medicaid Services (CMS)] to ensure at least 80 square feet of space per resident in each room. The ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year. During a concurrent observation and interview on 11/5/2024 at 11:10 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 2 beds, each bed had their own drawers. Resident 23 stated, he had no concern with the room size, and stated, the facility staffs and him were able to move around freely. During an observation on 11/6/2024 at 9 AM, Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, and 16 had adequate space, provide privacy, comfort, and nursing care to the residents. The residents residing in the affected rooms were observed to have enough space for the residents to move freely inside the rooms. Each resident inside the affected rooms had beds an During a concurrent observation and interview on 11/6/2024 at 9:40 AM in room [ROOM NUMBER], Certified Nurse Assistant 2 (CNA 2) stated he had no concern with the room size, and stated, he can perform task such as transferring residents with a Hoyer lift (is a mobility tool designed to help individuals with mobility challenges) from the bed to the wheelchair without any issues. and is able to move around freely. During a review of the facility ' s request letter for room waiver, dated 11/6/2024, indicated the following resident bedrooms were: room [ROOM NUMBER] (2 beds) 146.52 sq ft 73 sq. ft. room [ROOM NUMBER] (2 beds) 146.52 sq ft 73 sq. ft. room [ROOM NUMBER] (2 beds) 143.88 sq ft 71.5 sq. ft. room [ROOM NUMBER] (2 beds) 143.88 sq ft 71.5 sq. ft. room [ROOM NUMBER] (2 beds) 149.16 sq ft 74.5 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (2 beds) 141.21 sq ft 70.5 sq. ft. room [ROOM NUMBER] (2 beds) 119.92 sq ft 59.96 sq. ft. room [ROOM NUMBER] (2 beds) 119.92 sq ft 59.96 sq. ft. room [ROOM NUMBER] (2 beds) 147.84 sq ft 73.5 sq. ft. room [ROOM NUMBER] (2 beds) 147.84 sq ft 73.5 sq. ft. room [ROOM NUMBER] (2 beds) 147.84 sq ft 73.5 sq. ft. room [ROOM NUMBER] (2 beds) 119.92. sq ft 59.96 sq. ft. room [ROOM NUMBER] (2 beds) 119.92 sq ft 59.96 sq. ft. room [ROOM NUMBER] (2 beds) 147.84 sq ft 73.5 sq. ft. The room waiver indicated; the facility will ensure: That the approval of the waiver will not adversely affect the health, safety, and welfare of each resident that we care for as the waiver is in accordance with meeting the special needs of each resident.

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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** 50958 Based on observation, interview, and record review, the facility failed to ensure the call light was in good functioning condition for one of sixteen sampled residents (Resident 23). This failure had the potential for Resident 23 not being able to call for assistance especially during emergency that could result in fall and injury. Findings: During a concurrent observation and interview on 11/4/2024 at 10:25 AM, in Resident 23's room, Resident 23 stated the call light system was not working then pressed the call light button to show the call light was not working. The call light did not make an audible sound and the call light above Resident 23's door did not turn on. During a concurrent observation and interview on 11/4/2024 at 10:45 AM with Certified Nursing Assistant (CNA) 1, in Resident 23's room, CNA 1 pressed the call light, but the call light did not make an audible sound and the light above Resident 23's door did not turn on. CNA 1 stated the call light was not working due to a loose plug on the wall, and she would report to the charge nurse and the maintenance. CNA 1 stated if the call light was not working the resident would not be able to call for assistance and accident like fall could happen. During a concurrent interview and record review on 11/4/2024 at 10:58 AM with Licensed Vocational Nurse (LVN) 1, the Maintenance Repair Log Sheet for October and November 2024 were reviewed. The Maintenance Repair Log Sheet indicated Resident 23's call light had no sound on 10/14/2024 at 10 AM and was repaired. LVN 1 stated the facility should make sure the call light was functioning. LVN 1 stated the charge nurse should inform maintenance if they found the call light was not working, and the maintenance should fix it right away. LVN 1 stated the facility should ensure the residents were able to call for help at all times to help prevent accidents like falls. During an interview on 11/6/2024 at 10:41 AM with Maintenance Supervisor (MS), the MS stated Resident 23's call light was not functioning because the call light plug on the wall was loose, and he fixed it on 11/4/2024 after the nurse reported the call light was not working. The MS stated every morning he checked the Maintenance Repair Log Sheet and made rounds to ensure the call lights were functioning to ensure to residents' needs were met. During an interview on 11/6/2024 at 11:47 AM with the Director of Nursing (DON), the DON stated it was important to ensure the call light was working and ensure resident get assistance on time to meet resident's needs. (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 review of Resident 23's Admission Record (Face Sheet), the Face Sheet indicated that Resident 23 was admitted on [DATE] with diagnoses including left ankle, right ankle, left knee, and right knee contracture (a stiffening or shortening at any joint, that reduces the joint's range of motion), muscle weakness, dysphagia (difficulty swallowing), benign prostatic hyperplasia (a condition in which the prostate gland grows larger than normal), primary hypertension (high blood pressure), depression, bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior), anxiety disorder (a mental illness that causes people to experience excessive and uncontrollable feelings of fear or anxiety), schizophrenia (a mental illness that is characterized by disturbances in thought), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 23's History and Physical (H&P), dated 1/29/2024, the H&P indicated Resident 23 could make needs known but could not make medical decisions. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool) dated 8/20/2024, the MDS indicated Resident 23 had moderate impairment in cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated Resident 23 needed partial/moderate assistance (another person provided less than half of the effort) to complete the activities including oral hygiene, roll left and right, sit to lying, and lying to sitting on side bed. The MDS indicated Resident 23 was dependent and needed two or more helpers do all the effort for the resident to complete the toileting hygiene, personal hygiene, shower/bathe, lower body dressing, and bed to chair transfer activity. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated revised December 2009, the P&P indicated the Maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the paging system in good working order. During a review of the facility's P&P titled, Answering the Call Light, dated 2001, revised October 2010, the P&P indicated the facility should ensure to respond to the resident's request and needs. The facility should ensure that the call light be plugged in at all times and report all defective call lights to the nurse supervisor promptly.