STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555791	A. Building B. Wing	05/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens Healthcare Center	17650 Devonshire Street Northridge, CA 91325

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44309 Based on observation, interview, and record review, the facility failed to ensure a resident's urinary catheter bag (device used to collect urine drained from the bladder via a urinary catheter [a hollow tube inserted into the bladder to drain or collect urine]) was covered with a privacy bag (also known as a dignity bag - device used to cover the contents of a urinary catheter bag) for one of three sampled residents (Resident 29) reviewed under the dignity care area. This deficient practice had the potential to negatively affect the resident`s psychosocial wellbeing and dignity. Findings: During a review of Resident 29's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/27/2025, with diagnoses including retention of urine (a condition in which urine cannot empty from the bladder), urinary tract infection (UTI- an infection in the bladder/urinary tract), and history of falling. During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 4/30/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 29 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated that Resident 29 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene and personal hygiene. The MDS further indicated that Resident 29 had an indwelling catheter. During a review of Resident 29's Physician Order Summary Report dated 4/27/2025, the Order Summary Report indicated to check the placement of the indwelling catheter during every shift. During a concurrent observation and interview on 5/10/2025 at 8:30 a.m. with Registered Nurse 1 (RN 1) inside Resident 29`s room, RN 1 stated that Resident 29`s urinary catheter bag was not covered with a privacy bag. RN 1 stated that urinary collection bags are required to be covered with a privacy bag to promote dignity. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 5/11/2025 at 2:10 p.m. with the Director of Nursing (DON), the DON stated that urinary catheter bags are required to be covered with a privacy bag. The DON stated that Resident 29`s urinary catheter bag was not covered with a privacy bag and the potential outcome is the lack of promotion of a resident`s dignity. During a review of the facility's Policy and Procedure (P&P) titled Quality of Lift-Dignity, last reviewed on 1/20/2025, the P&P indicated that residents shall be treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity is prohibited. Staff should promote dignity and assist residents as needed by helping the residents to keep urinary catheter bags covered.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. 44309 Based on observation, interview, and record review, the facility failed to ensure that the call light (an alerting device for nurses to assist a patient when in need) was within a resident`s reach while in bed for one of one sampled resident (Resident 18) reviewed under the environment task.  This deficient practice had the potential to result in a delay in care, and Resident 18`s inability to ask for assistance. Findings: During a review of Resident 18's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/30/2025, with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and history of falling. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 5/3/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 18 required substantial/maximal assistance (helper does more than half of the effort) from staff for toileting hygiene, showering, bathing, lower body dressing, and putting on/talking off footwear. The MDS further indicated that Resident 18 required partial/moderate assistance (helper does less than half of the effort) from staff for eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 18's care plan (written guide that organizes information about the resident's care) for high risk for falls and injuries initiated on 4/30/2025, the care plan indicated a goal that the resident`s risk factors will be managed to minimize falls and injuries through the next review. The care plan interventions were to explain care and procedure to the resident, and to place the resident`s call light and other common personal belongings within her reach. During a concurrent observation and interview on 5/10/2025 at 8:26 a.m. inside Resident 18`s room, the resident was observed lying on her bed with her call light on the floor. Resident 18 stated that there is a button she presses when she needs help, and she started searching for it. Resident 18 was not able to locate or reach the call light. During a concurrent observation and interview on 5/10/2025 at 8:27 p.m. with Certified Nursing Assistant 1 (CNA 1) inside Resident 18`s room, CNA 1 stated that Resident 18's call light was on the floor, not within the resident's reach. CNA 1 stated the call light should always be within a resident's reach so she can call for help. During an interview on 5/11/2025 at 2:04 p.m. with the Director of Nursing (DON), the DON stated a residents call light is required to be accessible to the resident at all times. The DON stated that the potential outcome of the staff not placing the call light within a resident`s reach is the inability of the resident to call for help when they need it. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's Policy and Procedure (P&P) titled, Resident Call System: Answering the Call Light, last reviewed on 1/20/2025, the P&P indicated that call light shall be accessible and within easy reach while the resident is in his/her bed or other sleeping accommodations within the resident`s room. Call light systems are to be checked for functionality on a regular interval.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure the residents' clinical records were updated about advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for one out of the three sampled residents (Resident 147) by failing to maintain a current copy of the resident's advance directives in the resident's active clinical record. This deficient practice had the potential to cause conflict with Resident 147's wishes regarding health care. Findings: During a review of Resident 147's Admission Record, the Admission Record indicated the facility admitted Resident 147 to the facility on [DATE] and readmitted the resident on 5/3/2025, with diagnoses including normal pressure hydrocephalus (a build-up of fluid in the cavities deep within the brain), type two (2) diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a serious mental illness that can cause a persistent low mood, loss of interest, and other symptoms that affect how a person feels, thinks, and acts). During a review of Resident 147's History and Physical (H&P), dated 5/5/2025, H&P indicated Resident 147 had the capacity to understand and make decisions. During a review of Resident 147's Minimum Data Set (MDS - a resident assessment tool), dated 5/7/2025, indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) and the resident was dependent on facility staff or required moderate to maximal assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review, with the Director of Social Services (SSD), on 5/10/2025, at 10:17 a.m., Resident 147's clinical record was reviewed and the SSD stated that the resident's Advance Directive Acknowledgement Form indicated Resident 147 had an advance directive. The advance directive was not found in Resident 147's clinical record. The SSD stated the resident's advance directive was not in the chart. During an interview, with the SSD, on 5/10/2025, at 11:22 a.m., the SSD stated a copy of Resident 147's advance directive should have been kept in the resident's active chart to provide guidance to the facility staff about the resident's wishes. During an interview, with the Director of Nursing (DON), on 5/11/2025, at 2:42 p.m., the DON stated that a copy of Resident 147's advance directive should have been kept in the resident's active chart to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's policies and procedures (P&P) titled, Advance Directives, reviewed 1/20/2025, the P&P indicated if the resident or resident's representative has executed an advanced directive, a copy of the document is obtained and maintained in the same section of the resident medical record and are readily retrievable by any facility staff.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to develop a complete baseline care plan within 48 hours of a resident`s admission to the facility by failing to address a resident`s indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) for one of one sampled resident (Resident 9) reviewed under the catheter care area. This deficient practice had the potential for Resident 9 to not receive the appropriate care and treatment in the facility. Findings: During a review of Resident 9's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 9/10/2023 and readmitted on [DATE], with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), obstructive uropathy (a blockage in the urinary tract that prevents urine from draining normally), reflux uropathy (when urine flows backward into the kidneys) and benign prostatic hyperplasia (BPH- a condition in men where the prostate gland grows larger than normal). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 9 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene and showering/bathing. The MDS indicated that Resident 9 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene, upper body dressing, and personal hygiene. The MDS further indicated that Resident 9 had an indwelling catheter. During a review of Resident 9's physician Order Summary Report dated 4/29/2025, the Order Summary Report indicated an order to provide indwelling catheter care: cleanse the area during every shift and monitor for redness, irritation, swelling and sign and symptoms of urinary tract infection (UTI- an infection in the bladder/urinary tract) during every shift. During a concurrent interview and record review on 5/11/2025 at 1:00 p.m. with MDS Coordinator 1 (MDSC 1), Resident 9`s baseline care plan was reviewed. MDSC 1 stated that Resident 9 was readmitted to the facility on [DATE] with an indwelling catheter. MDSC 1 stated that Resident 9`s baseline care plan initiated on 4/21/2025, did not indicate that the resident had an indwelling catheter. MDSC 1 stated that residents` baseline care plans must address all of the residents' care areas. MDSC 1 stated that the potential outcome of not thoroughly completing a resident`s baseline care plan is the inability to meet the resident`s immediate care needs and lack of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/11/2025 at 2:18 p.m., with the Director of Nursing (DON), the DON stated a resident`s baseline care plan is required to be completed within 48 hours of the resident`s admission to the facility. The DON stated that upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident addressing problem areas and all the necessary nursing interventions. The DON stated that he (DON) developed Resident 9`s baseline care plan on 4/21/2025. The DON stated that Resident 9`s baseline care plan was not completed thoroughly because the baseline care plan did not address the resident`s indwelling catheter. The DON stated the potential outcome of not completing a baseline care plan is the inability to meet the resident`s immediate care needs related to the indwelling catheter. During review of the facility`s Policy and Procedure (P&P) titled Baseline Care Plan Summary, last reviewed on 1/20/2025, the P&P indicated that the facility is required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. This means that baseline care plan should strike a balance between conditions and risks affecting the resident`s health and safety. The baseline care plan must reflect the resident`s goals and objectives and include interventions that address his or her current needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44309 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for one of one sampled resident (Resident 30) by failing to develop and implement a comprehensive person-centered care plan addressing Resident 30`s use of a continuous glucose monitoring system (CGM-a system that provides glucose readings every minute, allowing users to see their glucose levels in real-time, anytime, and anywhere. It uses a sensor that's worn on the back of the arm for up to 14 days and wirelessly sends glucose data to a smartphone application or reader). This deficient practice had the potential to result in Resident 30`s inadequate care. Findings: During a review of Resident 30's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/11/2025, with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool) dated 4/16/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS further indicated that Resident 30 was taking hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood) medication which was considered a high-risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration). During a review of Resident 30's physician Order Summary Report (physician order) dated 4/11/2025, the Order Summary Report indicated to apply a CGM sensor transdermally (through the skin) in the morning, every 14 days on the back of the resident`s upper arm.  During a concurrent interview and record review on 5/10/2025 at 2:00 p.m., with MDS Coordinator 1 (MDSC 1), Resident 30`s care plans were reviewed. MDSC 1 stated that Resident 30`s physician ordered to apply a CGM sensor transdermally every 14 days on the back of the resident`s upper arm for continuous blood sugar monitoring. However, licensed nurses did not develop a comprehensive care plan with person-centered interventions for the use of this sensor. MDSC 1 stated there should have been a person-centered care plan developed with goals and interventions to address how the facility is going to monitor Resident 30`s CGM sensor. MDSC 1 stated the potential outcome of not developing a care plan for a resident who has a CGM sensor is the absence of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/11/2025 at 2:06 p.m., with the Director of Nursing (DON), the DON stated licensed nurses did not develop a care plan with goals and interventions for Resident 30`s CGM sensor. The DON stated licensed nurses are using Resident 30`s CGM sensor blood sugar reading and it is required to monitor the sensor to ensure it is applied properly and functioning. The DON stated the potential outcome of not developing a person-centered care plan for a resident who has a CGM sensor is the lack or inadequate care for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/20/2025, the P&P indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to furnish to attain or maintain the resident`s highest practicable physical, mental, and psychosocial well-being and incorporate identified problem areas.

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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 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. 44309 Based on interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of one sampled resident (Resident 30) by failing to: 1. Monitor Resident 30`s continuous glucose monitoring system (CGM-a system that provides glucose readings every minute, allowing users to see their glucose levels in real-time, anytime, and anywhere. It uses a sensor that's worn on the back of the arm for up to 14 days and wirelessly sends glucose data to a smartphone app or reader) and ensure that the sensor patches are available in the facility for application. 2. Complete Resident 30`s Admission/Readmission Screen and Baseline Care Plan form accurately upon his admission to the facility. These deficient practices had the potential to result in ineffective management of Resident 30's type 2 diabetes ((DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing) diagnosis. Findings: During a review of Resident 30's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/11/2025, with diagnoses including type two diabetes mellitus, hypertension (HTN-high blood pressure), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool) dated 4/16/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS further indicated that Resident 30 was taking hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood) medication which was considered a high-risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration). During a review of Resident 30's physician Order Summary Report (physician order) dated 4/11/2025, the Order Summary Report indicated to apply the CGM sensor transdermally (through the skin) in the morning, every 14 days on the back of the resident`s upper arm. (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 review of Resident 30`s physician Order Summary Report dated 4/11/2025, the Order Summary Report indicated an order to administer insulin lispro (a rapid-acting insulin: a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar (BS) from going too high) subcutaneously (SQ- injecting in the fatty layer of the skin) as per sliding scale (the increasing administration of the insulin dose based on the blood sugar level) before meals for DM 2: if the resident`s blood sugar level is 70-150 mg/dl, administer 0 unit of insulin (a unit of measurement for insulin), BS 151-200 mg/dl=1 unit, BS 201-250 mg/dl=2 units, BS 251-300 mg/dl= 3 units, BS 301-350 mg/dl=4 units, and BS 351-400 mg/dl=5 units of insulin. During a review of Resident 30's physician Order Summary Report dated 4/11/2025, the Order Summary Report indicated an order to administer insulin Glargine solution (a long-acting insulin injected once daily that provides a consistent, steady level of insulin throughout the day), 100 units per milliliters (unit/ml, a unit of fluid volume), inject 10 units SQ at bedtime for hyperglycemia (a condition where there is an abnormally high level of sugar in the bloodstream). During a review of Resident 30`s Self Administration of Medication form dated 4/11/2025, the form indicated that the resident did not request self-administration of any medication.  During a review of Resident 30`s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/11/2025-4/31/2025, the MAR indicated that licensed nurses documented that CGM sensors were not available for application on 4/12/2025 and 4/26/2025. During an observation of the medication administration on 5/10/2025 at 9:37 a.m., Licensed Vocational Nurse 1 (LVN 1) was observed preparing Resident 30`s morning medications. LVN 1 stated that Resident 30`s CGM sensor is due for application today (5/10/2025). However, sensor patches are not available in the medication cart for application. LVN 1 looked for the patches in the facility`s medication room as well and did not find one.  During a concurrent interview and record review on 5/10/2025 at 11:00 a.m., with the Director of Nursing (DON), Resident 30`s physician orders and MAR for April 2025 were reviewed. The DON stated that Resident 30`s physician ordered to apply a CGM sensor transdermally on the back of the resident`s upper arm every 14 days. However, the facility does not have the patches available for the nurses to apply on Resident 30`s upper arm. The DON stated licensed staff documented that the patches were not available in the facility for application on 4/12/2025 and 4/26/2025. The DON stated licensed nurses did not inform him that Resident 30 is using a CGM sensor. The DON stated that he is unsure if Resident 30 currently has a sensor patch on his arm. During a concurrent observation and interview on 5/10/2025 at 11:40 a.m. with the DON and Resident 30 inside Resident 30`s room, the DON stated that Resident 30 did have a sensor patch on his left upper arm. Resident 30 stated that he has been placing the CGM patch every 14 days on his own without the assistance of a facility staff member and was aware that the sensor patch is due to be changed today (5/10/2025). Resident 30 stated that the CGM sensor was never applied by staff. Resident 30 stated that he is capable of changing his patches. (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 concurrent interview and record review on 5/10/2025 at 1:40 p.m., with MDS Coordinator 1 (MDSC 1), Resident 30`s Admission/Readmission Screen and Baseline Care Plan form was reviewed. MDSC 1 stated a licensed nurse initiated Resident 30`s Admission/Readmission Screen and Baseline Care Plan form on 4/11/2025. However, the nurse who completed the assessment did not lock the assessment and the assessment is therefore not signed and considered incomplete. MDSC 1 stated Resident 30`s Admission/Readmission/Readmission Screen and Baseline Care Plan form did not address that the resident uses a CGM system. MDSC 1 stated that licensed staff are required to thoroughly assess the residents upon admission, complete their assessment forms and sign the forms with the time and date the assessment was completed. MDSC 1 stated the potential outcome of an incomplete admission assessment form is the lack of care and delivery of necessary services to the resident. During a concurrent interview and record review on 5/10/2025 at 2:00 p.m., with MDS Coordinator 1 (MDSC 1), Resident 30`s care plans were reviewed. MDSC 1 stated that Resident 30`s physician ordered to apply the CGM sensor transdermally every 14 days on the back of the resident`s upper arm for continuous blood sugar monitoring. However, licensed staff did not develop a comprehensive care plan with person-centered interventions for this sensor. MDSC 1 stated it is required to develop a person-centered care plan with goals and interventions to address how the facility is going to monitor Resident 30`s CGM sensor. MDSC 1 stated the potential outcome of not developing a care plan for a resident who has a CGM sensor is the absence of care.  During a concurrent interview and record review on 5/11/2025 at 1:25 p.m., with Registered Nurse 3 (RN 3), Resident 30`s physician orders were reviewed. RN 3 stated that she received and processed Resident 30`s physician order for application of the CGM sensor transdermally on the back of the resident`s upper arm every 14 days on his admission. RN 3 stated she (RN 3) did not call the physician and did not obtain an order for monitoring the CGM sensor. RN 3 stated that licensed nurses should have monitored the placement and functionality of Resident 30's CGM system. RN 3 further stated that Resident 30`s self-administration of medication form dated 4/11/2025 indicated that the resident did not request self-administration of medication, however, Resident 30 was applying the CGM sensor patches. RN 3 stated the resident should have been assessed to determine whether the self-administration of the CGM patch sensor was appropriate. RN 3 also stated that the facility should ensure that they have the sensor patches readily available for the resident's use. During review of the facility`s Policy and Procedure (P&P) titled Resident Examination and Assessment, reviewed 1/20/2025, the P&P indicated that the purpose of this procedure is to examine and assess the resident for any abnormalities in health status which provides a basis for the care plan. Review the resident`s admission assessment and/or preliminary care plan to assess for any special situation regarding the resident`s care.  During review of the facility`s Policy and Procedure (P&P) titled Charting and Documentation, reviewed 1/20/2025, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional pr psychosocial conditions shall be documented in the resident`s medical record. Documentation in the medical record will be objective, complete and accurate. (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 review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/20/2025, the P&P indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to furnish to attain or maintain the resident`s highest practicable physical, mental, and psychosocial well-being and incorporate identified problem areas.

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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. 44309 Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards and implement interventions to prevent accidents when Licensed Vocational Nurse 1 (LVN 1) left a bottle of Vitamin C unattended and easily accessible to other residents on top of the medication cart while LVN 1 was inside Resident 30`s room to administer Resident 30's medications. This deficient practice placed other residents at risk to gain access to Vitamin C without staff knowledge resulting in the accidental ingestion possibly causing harm to the residents. Findings: During a review of Resident 30's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/11/2025, with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool) dated 4/16/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 30 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, upper body dressing, and personal hygiene. The MDS further indicated that Resident 30 was dependent on staff (helper does all of the effort) for toileting hygiene, lower body dressing and putting on/taking off footwear. During a review of Resident 30's physician Order Summary Report (physician orders) dated 4/24/2025, the Order Summary Report indicated to administer vitamin C (Ascorbic Acid-a type of supplement) 500 milligrams (mg-a unit of measure of mass) by mouth two times a day for 30 days. During an observation of the medication administration on 5/9/2025 at 9:27 a.m., Licensed Vocational Nurse 1 (LVN 1) was observed preparing Resident 30`s morning medications. LVN 1 removed a bottle of vitamin C from the cart drawer, took one tablet, placed it in a cup and closed the bottle with its cart. LVN 1 did not place the bottle inside the medication cart and left it on top of the cart. LVN 1 entered Resident 30`s room to administer Resident 30's medications. During a concurrent observation and interview on 5/10/2025 at 9:40 a.m., LVN 1 observed the unattended bottle of Vitamin C left on top of her medication cart. LVN 1 stated that she (LVN 1) left the vitamin C bottle outside the medication cart, unsecured, and easily accessible to other residents in the hallway. LVN 1 stated that medications should never be left outside of the medication cart drawers unattended. LVN 1 stated the potential outcome of leaving medication outside of medication cart drawer is that other residents can easily access the medication, and consume medication not prescribed for their specific condition which may cause injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/11/2025 at 2:17 p.m. with the Director of Nursing (DON), the DON stated that the bottle of Vitamin C should not have been left on top of the medication cart in the hallway because it placed other residents at risk of being able to easily access medications without the supervision of a licensed staff member. During review of the facility`s Policy and Procedure (P&P) titled Medication Storage in The Facility, reviewed 1/20/2025, the P&P indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer`s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. During review of the facility`s Policy and Procedure (P&P) titled Storage of Medications, reviewed 1/20/2025, the P&P indicated that the nursing staff shell be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drugs shall be stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44309 Based on interview and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 29) with an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) received proper care and services by failing to provide indwelling catheter care to the resident as ordered by the physician. This deficient practice had the potential to result in Resident 29 receiving inadequate care and supervision at the facility. 2. Provide a bowel/bladder retraining program (a set of strategies and interventions aimed at helping individuals regain or maintain control over their bowel and bladder functions) for two of two sampled residents (Resident 7 and 21) reviewed under the care area bladder and bowel incontinence (inability to control the flow of urine from the bladder or the escape of stool from the rectum). This deficient practice had the potential for Residents 7 and 21 to not receive the proper and necessary care to maintain regain some control of their incontinence. Findings: 1. During a review of Resident 29's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 4/27/2025, with diagnoses including retention of urine (a condition in which urine cannot empty from the bladder), urinary tract infection (UTI- an infection in the bladder/urinary tract), and history of falling. During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 4/30/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 29 required staff substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated that Resident 29 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS further indicated that Resident 29 had an indwelling catheter. During a review of Resident 29's physician Order Summary Report dated 4/29/2025, the Order Summary Report indicated to provide indwelling catheter care: cleanse the area and monitor for redness, irritation, swelling and sign and symptoms of UTI during every shift. During a review of Resident 29's care plan for indwelling catheter initiated on 4/27/2025, the care plan indicated a goal that the resident will be free from sign and symptoms of UTI through the next review date. The care plan interventions were to provide catheter care daily and as needed, and to observe and notify the physician of any sign and symptoms of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's Treatment Administration Record (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) from 5/1/2025 to 5/10/2025, the TAR did not indicate any evidence that licensed nurses provided indwelling catheter care for Resident 29 or monitored the catheter area for redness, irritation, swelling and sign and symptoms of UTI on 5/4/2025 and 5/6/2025 during the 3 p.m.-11p.m. shift and on 5/8/2025 during the 11 p.m.-7 a.m. shift. During a concurrent interview and record review on 5/10/2025 at 12:50 p.m., with MDS Coordinator 1 (MDSC 1), Resident 29`s physician orders and TAR for May 2025 were reviewed. MDSC 1 stated that Resident 29`s physician ordered to provide indwelling catheter care during every shift. However, there is no documentation that a licensed nurse provided catheter care to Resident 29 on 5/4/2025 and 5/6/2025 during the 3 p.m. -11 p. m. shift and on 5/8/2025 during the 11 p.m. -7 a.m. shift. MDSC 1 stated that licensed nurses are required to implement physician orders and provide catheter care and monitoring for Resident 29 as ordered by his physician. MDSC 1 stated that the potential outcome of not providing catheter care for a resident with an indwelling catheter is infection. During an interview on 5/11/2025 at 2:14 p.m., with the Director of Nursing (DON), the DON stated that licensed nurses are required to provide catheter care to residents who have an indwelling catheter as ordered by their physicians and document that the care was provided. The DON stated licensed staff did not document in the Resident 29`s chart that they provided catheter care to the resident on 5/4/2025 and 5/6/2025 during the 3 p.m. -11p.m. shift and on 5/8/2025 during the 11 p.m. -7 a.m. shift. The DON stated the potential outcome of not providing care for a resident with an indwelling catheter is the risk of infection and the inability to provide appropriate care and services to the resident. During review of the facility`s Policy and Procedure (P&P) titled Urinary Catheter, last reviewed on 1/20/2025, the P&P indicated that the purpose of this policy is to prevent catheter-associated urinary tract infections. Review the resident`s care plan to assess any special needs of the resident. The following information should be recorded in the resident`s medical record: the date and time that catheter care was given, the name and title of the individual giving the catheter care, all assessment data obtained when giving catheter care, how the resident tolerated the procedure and if the resident refused the procedure, the reason why and the interventions taken. 49947 2. a. During a review of Resident 7's Admission Record, the Admission Record indicated the facility admitted Resident 7 on 4/17/2025 with diagnoses that included, but not limited to dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), urinary tract infection (UTI- an infection in the bladder/urinary tract) During a review of Resident 7's History and Physical (H&P), dated 5/11/2025, the H&P indicated Resident 7 was able to makes needs known but not able to make decisions and her decision maker is a family member. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/20/2025, the MDS indicated Resident 7 was able to make herself understood but was forgetful and was dependent on staff for activities such as toileting, showering and dressing. The MDS further indicated Resident 7 did not have a trial toileting program nor was she considered for the bowel retraining program. During a review of Resident 7's Bowel and Bladder Assessment form dated 4/17/2025, the date the resident was admitted , the assessment indicated Resident 7 was a candidate for the bladder and bowel retraining program. The Bowel and Bladder Assessment further indicated Resident 7 can comprehend and follow through with instructions. During a concurrent interview and record review on 5/11/2025 at 9:03 am with Minimum Data Set Coordinator (MDSC1), MDSC1 reviewed Resident 7's MDS and Bowel and Bladder Assessment. MDSC 1 stated when a resident is new, for the first 72 hours every two hours, the charting system tasks the Certified Nursing Assistants to check with the new resident the status of their bladder and bowel and if they need assistance to either be changed or assisted to the restroom. MDSC1 further explained the need for bladder and bowel retraining program is determined after 72 hours from the CNA's documentation along with the initial Bladder and Bowel Assessment. For Resident 7, MDSC1 stated she forgot to consider the Bladder and Bowel Assessment when determining the need for the retraining program. During an interview with Registered Nurse 3 (RN 3) on 5/11/2025 at 11:33 am, RN 3 stated the Bladder and Bowel Assessment form should have been reviewed when determining the resident's need for a bladder and bowel retraining program because without starting the program, the resident has the potential to develop urinary tract infections, continued incontinence and skin breakdown. During a review of the facility provided Policy and Procedure (P&P) titled, Bowel and Bladder Program last reviewed on 1/20/2025, the P&P indicates it is the policy of the facility that the bowel and bladder assessment of the residents will be preformed to attain and maintain the highest bowel and bladder function and to establish a toileting program within 4 days of admission. b. During a review of Resident 21's Admission Record, the Admission Record indicated the facility admitted Resident 21 on 3/27/2025 with diagnoses that included but not limited to acute respiratory failure (a sudden inability of the respiratory system to meet the oxygenation, needs of a person) with hypoxia (low levels of oxygen in your body tissues), muscle weakness and dysphagia (difficulty swallowing). During a review of Resident 21's History and Physical (H&P), dated 3/18/2025, the H&P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS - an assessment and care screening tool) dated 3/30/2025, the MDS indicated Resident 21 was able to understand others and make himself understood, but forgetful with moderately poor orientation and recall. The MDS indicated Resident 21 was frequently incontinent of urine, but not always and a trial toileting program has not been attempted. During a review of Resident 21's Bowel and Bladder Assessment form dated 3/27/2025, the date the resident was admitted , the assessment indicated Resident 21 was a candidate for the bladder and bowel retraining program. The Bowel and Bladder Assessment further indicated Resident 21 can comprehend and follow through with instructions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/11/2025 at 9:15 am with Minimum Data Set Coordinator (MDSC1), MDSC 1 reviewed Resident 21's MDS and Bowel and Bladder Assessment. MDSC1 stated when a resident is new, for the first 72 hours every two hours, the charting system tasks the Certified Nursing Assistants to check with the new resident the status of their bladder and bowel and if they need assistance to either be changed or assisted to the restroom. MDSC1 further explained the need for bladder and bowel retraining program is determined after 72 hours from the CNA's documentation along with the initial Bladder and Bowel Assessment. For Resident 21, MDSC1 stated she forgot to consider the Bladder and Bowel Assessment when determining the need for the retraining program. During an interview with Registered Nurse 3 (RN 3) on 5/11/2025 at 11:33 am, RN 3 stated the Bladder and Bowel Assessment form should have been reviewed when determining the resident's need for a bladder and bowel retraining program because without starting the program, the resident has the potential to develop urinary tract infections, continued incontinence and skin breakdown. During a review of the facility provided Policy and Procedure (P&P) titled, Bowel and Bladder Program last reviewed on 1/20/2025, the P&P indicates it is the policy of the facility that the bowel and bladder assessment of the residents will be performed to attain and maintain the highest bowel and bladder function and to establish a toileting program within 4 days of admission.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49947 Based on interview and record review, the facility failed to follow a physician's order by failing to conduct a weekly weight for one of one sampled resident (Resident 24). This deficient practice had the potential for a delay in care and services and undetected weight loss. Findings: During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted Resident 24 initially on 3/26/2025 and readmitted the resident on 4/21/2025 with diagnoses that included but not limited to type two (2) diabetes (a chronic condition that affects the way the body processes blood glucose [sugar]), muscle weakness, and metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood). During a review of Resident 24's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 4/24/2025, the H&P indicated Resident 24 did not have the capacity to understand make decisions. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool) dated 4/24/2025, the MDS indicated Resident 24 was able to understand others and make himself understood, but forgetful with poor recall and dependent on staff for activities such as toileting bathing and dressing. During a review of Resident 24's Order Summary Report, the Order Summary Report indicated an order for weekly weights x4 every day shift, every seven (7) days for weight monitoring for 30 days, ordered 4/21/2025. During a review of Resident 24's weights, Resident 24's weights indicated the following: - 4/22/2025: 151 pounds (lbs. - unit of measurement) - 5/4/2025: 151 lbs. There was no weight recorded on 4/29/2025, seven (7) days after the weight on 4/22/2025. During a concurrent interview and record review on 5/10/2025 at 2:12 p.m., with the Director of Staff Development (DSD), reviewed Resident 24's weights. The DSD stated the second week's weight on 4/29/2025 should not have been missed to ensure the resident is not continuing to lose weight. The DSD stated she oversees the weight log accuracy. During an interview on 5/11/2025 at 2:46 p.m., with the Director of Nursing (DON), the DON stated licensed nurses must follow physician's orders and it was unacceptable for licensed nurses to miss a week of weights. The DON further stated without weighing every week, how else will the facility know if the resident is continuing to lose weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Weighing and Measuring the Resident, last reviewed on 1/20/2025, the P&P indicated the purpose of the P&P is to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status of the resident.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 49947 Based on interview and record review the facility failed to provide care and services that meet professional standards of quality by failing to assess the continued need for a peripheral intravenous (IV-into or within the vein, a small tub is inserted) catheter (a thin, flexible tube that is inserted into a vein to draw blood and give treatments including IV fluids, drugs, or blood transfusions) if not being used for IV fluids or medications for one of one sampled resident (Resident 198). This deficient practice had the potential for Resident 198 to develop an infection from a prolonged IV that she did not need. Findings: During a review of Resident 198's Admission Record, the Admission Record indicated the facility admitted Resident 185 on 5/8/2025 with diagnoses that included, but not limited to muscle weakness, fusion of the spine (a procedure that permanently joins two or more vertebrae [the individual bones that make up the spinal column, also known as the spine] in the spine to eliminate movement between them), spinal stenosis (a condition where the spaces in the spine become narrower, putting pressure on the nerves and spinal cord) and depression (a persistent low mood, loss of interest or pleasure in most activities, and other symptoms that interfere with daily life). During a review of Resident 198's History and Physical (H&P), dated 5/9/2025, the H&P indicated Resident 198 was admitted from a general acute care hospital (GACH) on 5/8/2025 after having spinal fusion surgery. During a review of Resident 198's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/11/2025, the MDS indicated Resident 198 was able to understand others and make herself understood, but forgetful with moderately poor orientation and recall. During a review of Resident 185's Skin Evaluation Admission/Readmission (Upon Return of the Facility within 72 Hours) on 5/9/2025 dated 5/8/2025 did not indicate Resident 185's had an IV. During an observation on 5/8/2025 at 7:45pm in Resident 185's room, Resident 185 had an IV on the back side of her right lower arm. Resident 185 stated she did not know why the nurses did not remove it at the hospital or at the facility since she does not need it anymore. Resident 185 stated the IV did not hurt but was very annoying. During a concurrent interview and record review with Registered Nurse 2 (RN 2) on 5/8/2025 at 8:50 pm, RN 2 looked through Resident 185's electronic medical record and stated Resident 185 did not have an indication or order for an IV. During a concurrent observation and interview 5/8/2025 at 8:55 pm with RN 2 in Resident 185's room, RN 2 pointed to Resident 185's right arm and stated the GACH should have removed the IV and because they did not, the admitting nurse should have seen it and removed it to prevent pain or infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON), the DON stated the licensed nurses should have identified the IV upon admission and remove it. The DON stated Resident 185 did not have a need for the IV and prolonged placement of the IV could cause bleeding, swelling or an infection. During a review of the facility's policy lastt reviewed on 1/20/2025, titled, General Policies for IV Therapy, the policy indicated physician orders are required for initiating intravenous therapy. All orders must include name. dose, frequency, duration of therapy, route of administration and dignosis.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47883 Based on observation, interview, and record review, the facility failed to ensure residents receive necessary respiratory care and services that is in accordance with professional standards of practice for one of two sampled residents (Resident 4) investigated under the respiratory care area when Resident 4's nasal cannula (a medical device that delivers supplemental oxygen therapy to people with low oxygen levels) oxygen tubing was touching the floor and the tubing cannula (a small flexible tube with two prongs that fit inside the nostrils, used to deliver extra oxygen) was not attached to the resident. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 4/23/2025 with diagnoses including fracture of right femur (a break of thighbone), aphasia (a condition that makes it hard for a person to speak, understand, read or write language), and urinary tract infection (an infection in any part of the urinary system). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2024, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. During a review of Resident 4's History and Physical (H&P - a comprehensive assessment of a resident's health, performed by a doctor during an initial visit), dated 4/25/2025, the H&P indicated that the resident could make needs known but cannot make medical decisions. During a review of Resident 4's Physician's Orders, dated 5/9/2025, the Physician's Orders indicated an order to administer oxygen at two (2) liters (a unit of measure for volume) per minute (LPM) via nasal cannula continuously every shift. During a concurrent observation and interview, on 5/9/2025, at 7:22 p.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 4's room, Resident 4's nasal cannula tubing was on the floor and the tubing cannula was under Resident 4's body, not connected to the resident's nose. The other end of the tubing connected to an oxygen concentrator (a medical device that extracts oxygen from ambient air and delivers a concentrated stream of oxygen to residents who need supplemental oxygen). LVN 2 verified that a portion of the tubing was on the floor. LVN 2 stated that the tubing was already contaminated and can introduce infection to the resident. LVN 2 stated this deficient practice had the potential for Resident 4 to desaturate (a decrease in the oxygen saturation of the blood) and risk of transmission of bacteria that can lead to infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/11/2025, at 2:42 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to implement physician orders for the administration of oxygen to residents. The DON stated the potential outcome of oxygen tubing touching the floor is development of respiratory infection in Resident 4. The DON stated that if the nasal canula was not attached to Resident 4, there is potential for Resident 4 to desaturate. During a review of the facility`s policy and procedure (P&P) titled, Oxygen Administration, last reviewed on 1/03/2025, the policy statement indicated, The nasal canula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. During a review of the Centers for Disease Control (CDC) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, last updated April 2023, the source material indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.

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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. 47883 Based on observation, interview, and record review, the facility failed to ensure that staffing information was posted and placed in a visible and prominent place daily. As a result, the total number of staff and the actual hours worked by the staff were not readily accessible to residents and visitors. Findings: During a concurrent observation and interview, on 5/11/2025, at 9:05 a.m., with the Director of Staff Development (DSD), at the nursing station, the posted facility staffing information contained information about the projected staffing for 5/11/2025. The DSD confirmed and stated the facility staffing information posted at the nursing station contained only information about projected staffing for 5/11/2025. During a concurrent interview and record review, on 5/11/2025, at 9:05 a.m., with the DSD, the Census and Direct Care Service Hours Per Patient Day (DHPPD), dated 5/9/2025 and 5/10/2025, were reviewed and the DSD stated the daily staffing information for 5/9/2025 and 5/10/2025 did not include information about the actual staffing. The DSD stated that she did not post the actual staffing for 5/9/2025 and 5/10/2025. During an interview, on 5/11/2025, at 10:22 a.m., the Director of Nursing (DON) stated the facility staff place the daily staffing at the nursing station. The DON stated that the residents, family, and visitors can ask the staff about the number of nursing personnel responsible for providing direct care to residents. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Staffing Numbers, last reviewed in 1/20/2025, the P&P indicated, Within two hours of the beginning of each shift , the number of Licensed Nurses (RN [registered nurses], LPN [licensed practical nurses], LVN [licensed vocational nurses]) and the number of unlicensed nursing personnel (CNA [certified nursing assistant]) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors and in a clear and readable format .Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care for each shift. The information recorded on the form shall include: A. The name of the facility B. The date for which the information is posted C. The resident census at the beginning of the shift for which the information posted D. Twenty-four hours shift schedule operated by the facility E. The shift for which the information is posted. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Type(RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff. G. The actual time worked during that shift for each category and type of nursing staff H. Total number of licensed and non-licensed staff working for posted shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49947 Based on observation interview, and record review the facility failed to: 1. Ensure the disposal of medications in a manner that was not retrievable, in one of one inspected Medication Rooms (Medication Room Station 1.) 2. Include three disposed medications with verifying signatures of two licensed nurses on the Medication Disposition Record/Pass Log. As a result, control and accountability of discontinued medications and medications awaiting final disposition (process of returning and/or destroying unused medications) did not follow federal regulations and facility policy and procedures. These deficient practices increased the opportunity for medication diversion (the transfer of a medication from a lawful to an unlawful channel of distribution or use,) and increased the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization . Findings: During a concurrent observation and interview on 05/11/25 08:32 am, with Registered Nurse 3(RN 3), in Medication Room Station 1, the pharmaceutical waste bin was observed to contain a mixture of unopened and unused medications in their original manufacturer packaging, as well as a couple intact (not damaged or impaired in any way) loose medication tablets and capsules out of their manufacturer packaging. RN 3 stated the pharmaceutical waste bin contained medications that were disposed of in original manufacture packaging and as loose tablets and capsules. RN 3 stated, per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact (unchanged from original form) by pouring liquid over them. RN 3 stated that the pharmaceutical bin did not contain liquid poured over the medications, and the medications remained in a form that could be easily retrieved and re-used. RN 3 stated when medications are not disposed of properly there could be the potential for accidental misuse and diversion. During a concurrent record review and interview on 5/11/25 at 8:48 am, with RN 3, in Medication Room Station 1, RN 3 reviewed Medication Disposition Record/Pass records between 5/1/25 and 5/10/25. RN 3 stated she was unable to locate the entry and witness signatures of licenses nurses on three medications: Vancomycin oral suspension (used to teat infections caused by bacteria); Nystatin powder (used to treat fungal infections) 100 milligrams (ml-unit of measurement) and Naloxone spray (used to treat opioid [class of drugs used to reduce moderate to severe pain] over dose) found in the pharmaceutical waste bin. RN 3 stated that licensed nurses failed to follow the policy of entering all medication in the logs by a witness when disposing medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 5/11/25 at 10:54 am, with the Director of Nursing (DON,) the DON reviewed the three medications found the pharmaceutical waste bin against the Medication Disposition Record/Pass Log records. The DON stated he was unable to locate the medications and witness signatures on the logs dated between 5/1/25 and 5/10/25. The DON stated licensed nurses failed to log the medications and include the signatures of witnesses when destroying medications. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. Review of the Policy and Procedures (P&P) titled Disposal of Medication and Medication related supplies last reviewed 1/20/25, the P&P indicated all medications are placed in the proper waste container per facility policy. The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form with date, resident's name, name and strength of the medication, prescription number, amount of medication destroyed and signatures of witnesses.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 47883 Based on observation, interview, and record review, the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses (also called food poisoning, illness caused by eating contaminated food) when one of five sampled residents (Resident 147) had leftover food that was not removed from the resident's bedside after four hours. These deficient practices had the potential for Resident 147 to ingest (consume) contaminated leftover food and lead to foodborne illness. Findings: During a review of Resident 147's Admission Record, the Admission Record indicated the facility admitted Resident 147 to the facility on [DATE] and readmitted the resident on 5/3/2025, with diagnoses including normal pressure hydrocephalus (a build-up of fluid in the cavities deep within the brain), type two (2) diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a serious mental illness that can cause a persistent low mood, loss of interest, and other symptoms that affect how a person feels, thinks, and acts). During a review of Resident 147's History and Physical (H&P), dated 5/5/2025, H&P indicated Resident 147 had the capacity to understand and make decisions. During a review of Resident 147's Minimum Data Set (MDS - a resident assessment tool), dated 5/7/2025, indicated the resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) and the resident was dependent on facility staff or required moderate to maximal assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview, on 5/9/2025, at 7:44 p.m., inside Resident 147's room, with Resident 147, Resident 147's bedside table had a baked custard covered with plastic wrap on the table surface. Resident 147 asked to remove the baked custard and stated that the baked custard was in the room for last couple days. During a concurrent observation and interview, with Registered Nurse (RN) 2, on 5/9/2025, at 7:50p.m., inside Resident 147's room, RN 2 confirmed and stated the baked custard on top of Resident 147's table was served for lunch on 5/9/2025, between 12 p.m. to 1 p.m. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 5/10/2025, at 4:41 p.m., with the Dietary Supervisor (DS), the menu for the week of May 4, 2025 to May 9, 2025 was reviewed and the menu indicated baked custard was served during lunch on May 9,2025. The DS stated that the facility does not allow residents to store leftover food from their meal trays for more than four hours. The DS stated yesterday (5/9/2025), baked custard was served to Resident 147 during lunch time. The DS stated that lunch time in the facility is from 12 p.m. to 1p.m. The DS stated that leftover food had to be discarded after four hours as it is no longer safe for the resident to consume beyond that time and may cause foodborne illnesses. During a review of the facility's P&P titled, Meal Service, last reviewed 1/20/2025, indicated Nursing will remove the tray when the resident completes the meal and placed all trays and tray cart and returns to the cart to the [Food and Nutrition Service] Department. Note that food on trays is no longer being temperature controlled- trays must not be kept past [four] hours in rooms, despite a resident's inquiry.

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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** 49947 Based on interview and record review, the facility failed to ensure the pre and post dialysis (the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) assessments were completed accurately for two of two sampled residents (Resident 6 and 24). This deficient practice placed the residents at risk of not receiving appropriate care due to inaccurate resident medical care information and the potential to result in confusion in the care and services for Resident 6 and Resident 24. Findings: a. During a review of Resident 6's Admission Record, the Admission Record indicated the facility admitted Resident 6 on 4/17/2025 with diagnoses that included but not limited to type two (2) diabetes (a chronic condition that affects the way the body processes blood glucose [sugar]), dependence on renal (kidney) dialysis, muscle weakness, and end state renal disease (chronic irreversible kidney failure). During a review of Resident 6's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 4/21/2025, the H&P indicated Resident 6 did have the capacity to make needs known but did not have the capacity to make decisions. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2025, the MDS indicated Resident 6 was able to understand others and make himself understood, but forgetful with poor recall and dependent on staff for activities such a bathing and dressing. The MDS further indicated Resident 6 receives dialysis. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated an order for Permacath (a medical device used for accessing the bloodstream for dialysis with a long, flexible tube inserted into a large blood vessel, typically in the neck or chest) on right upper chest; monitor for pain, redness, swelling and signs and symptoms of infection every shift, ordered 4/17/2025. During a review of Resident 6's Post-Dialysis Assessment, the Post-Dialysis Assessment indicated the following: - 4/25/2025: Thrill (vibration of blood passing through the access site)/Bruit (sound of blood passing through the access site) was checked off as present. - 4/28/2025: Thrill/Bruit was checked off as present. - 4/30/2025: Thrill/Bruit was checked off as present. - 5/7/2025: Thrill/Bruit was checked off as present. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/9/2025: Thrill/Bruit was checked off as present. During a concurrent interview and record review on 5/10/2025 at 1:03 p.m., with Registered Nurse 3 (RN 3), reviewed Resident 6's Post-Dialysis Assessment forms dated 4/25/2025-5/9/2025. RN 3 stated licensed nurses should have never checked off that thrill and bruit were present because Permacaths do not have thrills or bruits. RN 3 stated residents must be assessed accurately before and after dialysis to prevent complications such as bleeding and swelling at the access site. During an interview on 5/11/2025 at 2:35 p.m., with the Director of Nursing (DON), the DON stated licensed nurses must be accurate with their charting and thrill and bruit should never be marked as present for Permacaths because it would be inaccurate, and charting must be accurate in order to provide the best care for the residents. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, last reviewed on 1/20/2025, the P&P indicated all documentation concerning dialysis and care of the dialysis resident will be maintained in the resident' medical record, including the Pre/Post Dialysis form. b. During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted Resident 24 initially on 3/26/2025 and readmitted the resident on 4/21/2025 with diagnoses that included but not limited to type two (2) diabetes, muscle weakness, and metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood). During a review of Resident 24's H&P dated 4/24/2025, the H&P indicated Resident 24 did not have the capacity to understand and make decisions. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 was able to understand others and make himself understood, but forgetful with poor recall and dependent on staff for activities such as toileting bathing and dressing. The MDS further indicated Resident 24 receives dialysis. During a review of Resident 24's Order Summary Report, the Order Summary Report indicated an order for Permacath on right upper chest; monitor for pain, redness, swelling and signs and symptoms of infection every shift, ordered 4/23/2025. During a review of Resident 24's Pre-Dialysis Assessment, the Pre-Dialysis Assessment indicated the following: - 4/25/2025: Thrill/Bruit was checked off as present. - 4/28/2025: Thrill/Bruit was checked off as present. - 5/2/2025: Thrill/Bruit was checked off as present. - 5/5/2025: Thrill/Bruit was checked off as present. - 5/10/2025: Thrill/Bruit was checked off as present. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's Post-Dialysis Assessment, the Post-Dialysis Assessment indicated the following: - 4/25/2025: Thrill/Bruit was checked off as present. - 4/28/2025: Thrill/Bruit was checked off as present. - 4/30/2025: Thrill/Bruit was checked off as present. - 5/2/2025: Thrill/Bruit was checked off as present. - 5/5/2025: Thrill/Bruit was checked off as present. During a concurrent interview and record review on 5/10/2025 at 1:08 p.m., with Registered Nurse 3 (RN 3), reviewed Resident 24's Post-Dialysis forms dated 4/25/2025-5/5/2025. RN 3 stated licensed nurses should have never checked off that thrill and bruit were present because Permacaths do not have thrills or bruits. RN 3 stated residents must be assessed accurately before and after dialysis to prevent complications such as bleeding and swelling at the access site. During an interview on 5/11/2025 at 2:39 p.m., with the DON, the DON stated licensed nurses must be accurate with their charting and thrill and bruit should never be marked as present for Permacaths because it would be inaccurate and charting must be accurate in order to provide the best care for the residents. During a review of the facility's P&P titled, Dialysis Care, last reviewed on 1/20/2025, the P&P indicates all documentation concerning dialysis and care of the dialysis resident will be maintained in the resident' medical record, including the Pre/Post Dialysis form.