

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1338 20th Street Santa Monica, CA 90404	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48026</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff wear identification (ID - a card that identifies a person/staff) badges while on the nursing floor providing nursing care to the residents.</p> <p>This deficient practice had the potential for:</p> <ol style="list-style-type: none"> Residents to decline nursing care from staff who they cannot identify causing residents to miss the nursing care they need. Residents to fear for their safety when staff did not have proper identification causing residents to feel unsafe while residing in the facility. <p>Findings:</p> <p>During an observation on 2/03/2025 at 10:29 AM, Certified Nursing Assistant (CNA) 3 was observed walking down the hallway near Nurse's Station 1 and not wearing an ID badge. CNA3 stated, I forgot (ID Badge). CNA3 stated it was necessary while working on the floor caring for facility residents so my patients know who is taking care of them. So they know I am here for them. CNA3 stated not wearing an ID badge will cause the residents to be afraid cuz they don't know who I am, why I am here.</p> <p>During an observation on 2/05/2025 at 2:59 PM, CNA5 was observed standing at the nurse's station 1. CNA5 was observed not wearing an ID badge. CNA5 stated I left it (ID Badge) somewhere. CNA5 was asked why it was important to wear an ID badge while working and caring for the residents, CNA5 stated so residents know my name and that I am taking care of them. CNA5 stated not wearing an ID badge may result in residents refusing care because they don't know who I am.</p> <p>During an interview with the Director of Nursing (DON) on 2/06/25 at 7:20 PM, DON was asked why it is important to wear an ID badge while working and providing care to the residents, DON stated, it's proper ID for the [residents], so if residents have concerns about the staff, they can easily identify the staff. DON stated staff not wearing ID their badges had the potential that an alleged abuser cannot be identified and for resident safety.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During record review, the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Identification Name Badges dated 11/21/2024, indicated, all personnel are required to wear ID badges during their work shift.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843</p> <p>Based on interview and record review, the facility failed to ensure the resident's clinical records were complete and updated concerning 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 four out of four sampled residents (Residents 72, 27, 65 and 114) by failing to maintain an accurate and current copy of the resident's advance directives in the resident's clinical record.</p> <p>This failure had the potential to cause conflict with a resident's wishes regarding health care.</p> <p>Findings:</p> <p>During record review, Resident 72's admission record, indicated Resident 72 was admitted to the facility (skilled nursing facility [SNF]) on 8/10/21, with diagnoses that included, hypertension (high or raised blood pressure), anxiety disorder (restlessness, worried, tense or afraid of what may happen in the future), and muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>During record review, of Resident 72's Minimum Data Set (MDS - resident assessment tool) dated 12/25/24, indicated Resident 72's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) was severely impaired. Resident 72 needed partial assistance with bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>During record review, Resident 27's admission record indicated Resident 27 was admitted to the facility on [DATE], with the diagnosis of, but not limited to, Type 2 Diabetes Mellitus (DM - a disease characterized by elevated levels of blood sugar), hypertension, muscle weakness.</p> <p>During record review, Resident 27's MDS dated [DATE], indicated Resident 27's cognition was moderately impaired. The MDS further indicated that the resident was independent and is able to complete activities of daily living (ADL - include bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>During record review, Resident 65's Admission Record indicated the resident was admitted to the facility on [DATE], with the diagnosis of, but not limited to, anxiety disorder, and depression (a constant feeling of sadness and loss of interest), dysphagia (difficulty swallowing).</p> <p>During record review, Resident 65's MDS dated [DATE], indicated Resident 65's cognition was severely impaired. The MDS indicated that the resident required supervision or touching assistance with activities of daily living (ADL's including bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During record review, Resident 114's admission record indicated the resident was admitted to the facility on [DATE], with the diagnosis of, but not limited to, dementia, (a condition characterized by progressive or persistent loss of intellectual functioning especially with loss of memory), Alzheimer's disease (progressive mental decline due to generalized breakdown of the brain), Acute Kidney Failure (AKF - A condition in which the kidneys suddenly can't filter waste from the blood).</p> <p>During record review, Resident 114's MDS dated [DATE], indicated Resident 114's cognition was severely impaired. The MDS further indicated that the resident required supervision or touching assistance with activities of daily living (ADL's including bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>During an interview on 10/3/24 at 0:06 am, Social Services Director (SSD) stated when a resident is unable to make life ending or medical decisions, the resident's representative will sign the acknowledgment for the advanced directive and not check the box. Once the resident representative signs the advance directive acknowledgment, then the form is signed the (SSD) and the resident's physician. If the form is not signed by the resident's representative it would be unclear as to the representative's wishes for the resident regarding end-of-life care.</p> <p>During a concurrent interview and record review on 02/04/25 at 12:21 pm with Licensed Vocational Nurse (LVN) 8, LVN8 stated, there are no advanced directive in any of the charts for Resident 72, 27, 65, and 114. LVN 8 stated without an advanced directive there will be confusion about the end of life care that the residents would like to have.</p> <p>During an interview on 02/04/25 at 12:36 pm the Social Services Director (SSD) stated that during the admission process a form is given to the residents and the residents are asked if they have an advanced directive. SSD stated that if the residents do not have an advanced directive then they are offered the opportunity to complete one. SSD stated that if the residents are unable to complete one, then the residents responsible party will be given the opportunity to complete one. SSD stated that if the resident or their representative decides not to complete an advanced directive then they will have to sign a form stated that they refuse to keep on file and advanced directive.</p> <p>During an interview on 02/05/25 at 12:17 pm Director of Nursing (DON) stated, the resident should always have an advanced directive in the chart, in case of emergencies. The DON stated the advanced directive is used to honor the resident's last wishes. DON stated if the family or the resident refuses an advanced directive a form stated that they have declined must be maintained in the chart.</p> <p>During record review, the facility's policy and procedures titled Advance Directives dated, 11/2024 indicated, Policy Statement The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with the state law and facility policy. Policy Interpretation and Implementation It further indicates prior to or upon admission of a resident, the social service director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directive.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</p> <p>Based on observation, interview, and record review the facility failed to reinforce the residents right to a safe and homelike environment for two of seven sampled residents (Resident 18 and Resident 118).</p> <ol style="list-style-type: none"> 1. For Resident 18 the facility failed to replace a scortched black mark on the wood floor near the foot of Resident 18's bed 2. For Resident 18 the facility failed to inventory the resident's personal belongings. 3. For Resident 118, the facility failed to repair damaged wall and paint the wall behind the resident's bed. <p>This failure resulted in the loss of Resident 18's personal checks, and Resident 118 feeling ashamed of living with damaged and unpainted walls. in the facility.</p> <p>Findings:</p> <p>a. During record review, Resident 18' s Admission Record indicated the facility initially admitted Resident 18 on 8/15/2023 and readmitted the resident on 11/28/24 with diagnoses that included, chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hearing loss.</p> <p>During record review, Resident 18's Minimum Data Set (MDS- resident assessment tool), dated 12/11/25, indicated Resident 18's cognition (ability to make decisions concerning care, alert to situation and oriented to place and time) was moderately impaired. Resident 18 required total to substantial assistance with Activities of daily Living (ADL - showering, toileting hygiene, dressing and personal hygiene).</p> <p>During a concurrent interview and observation on 2/3/25 at 8:28 AM at Resident 18's bedside an approximately 1.5 square foot section of the wood floor was scarred black. Resident 18 was using an over the counter hearing amplifier with headphones to communicate. Resident 18 stated it had been there for a while and it was not pleasant to look upon.</p> <p>During a concurrent interview and observation on 2/4/25 at 1:47 PM with the Maintenance Supervisor (MS), Resident 18's floor was observed. MS stated maintenance was not aware of the state of the floor. MS stated the resident should not have a burnt mark on their floor and stated if the facility was not able to strip the floor the wood would have to be removed.</p> <p>During a concurrent interview and observation on 2/4/25 at 2:00 PM at Resident 18's bedside, the Housekeeping Supervisor (HKS) stated the black stain on Resident 18's floor was there when HKS started to work in the facility in 8/2024. HKS stated< the black mark does not make a homelike environment and the floor should look nice.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/5/25 at 11:13 AM, the Administrator stated Resident 18's floor looked awful and that the floor was a home like environment issue.</p> <p>b. During record review, Resident 18's Inventory of Personal Effects form, dated 8/15/23, indicated</p> <p>During an interview on 2/3/25 at 11:16 AM, Resident 18's Friend (RF) 1 stated Resident 18 had a white bag which contained the resident's personal checks. RF1 stated the white bag and the resident's personal checks, keys and wallets and has been missing since 1/30/25. RF1 stated they (RF1 and Resident 18) told the Admissions Coordinator (AC) when RF1 and Resident 18 became aware that the items were missing.</p> <p>During record review, Resident 18's Theft/Loss Monitoring Report, dated 2/3/25, indicated the resident's checkbooks were missing.</p> <p>During record review on 2/4/24 at 10:10 AM, Resident 18's physical chart was reviewed. The physical chart indicated there was no inventory list in the chart for Resident 18. During a concurrent review of Resident 18's electronic medical record indicated the last Inventory of Personal effects form was last completed on 8/15/23.</p> <p>During an observation and interview on 2/6/25 at 10:29 AM, AC stated RF1 advised the facility that Resident 18 was missing items on 1/31/25 at around 6 PM. AC RF1 looked inside the facility's dumpster looking for Resident 18's missing items on 1/31/25. The AC further stated Resident 18 pays rent on the apartment monthly with the checks and has never been a problem. The AC also stated the facility inventories anything the resident brings into the facility on a log sheet to keep track of resident's property. The AC stated the log is mandatory in order to provide reassurance to the residents.</p> <p>During an interview on 2/6/25 at 10:55 AM, the Social Services Director (SSD) stated a theft and loss report was created on 2/3/25 for Resident 18's missing property. SSD stated Resident 18 was missing checkbooks. SSD stated Resident 18's inventory list was last updated on 8/15/23 and the inventory list did not include the resident's checks. SSD further stated the facility readmitted Resident 18 on 11/28/24 and the inventory log should have been updated at that time. SSD stated staff inventory new items during every admission in order to safekeep their items.</p> <p>During an interview on 2/06/25 at 1:59 PM, Resident 18 stated the bag with the resident's checks and personal papers were missing. Resident 18 stated they have incurred hundreds of dollars in late fees due to not being able to pay their bills. During a concurrent observation, the resident's bag or checks was not seen.</p> <p>During an interview 2/6/25 at 2:38 PM, the Director of Nursing (DON) stated the nurses complete the resident's personal belonging inventory log and update the log as necessary. The DON further stated it was important to update the inventory log when new items are brought in.</p> <p>During record review, the facility's policy and procedures titled, Personal Property, effective 11/21/24, indicated the resident's personal belongings and clothing are inventory and documented upon admission and updated as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During record review, the facility's policy and procedures titled, Identifying Exploitation, Theft and Misappropriation of Resident Property, dated 4/2021; indicated, exploitation, theft and misappropriation of resident property are strictly prohibited. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training.</p> <p>46843</p> <p>c. During record review, Resident 118's Admission Record indicated Resident 118 was admitted to the facility on [DATE], with medical diagnoses that included: Essential Hypertension (high blood pressure) and Diabetes Mellitus (DM - a disease characterized by elevated levels of sugar in the blood).</p> <p>During record review, Resident 118's MDS, indicated Resident 118's cognition was Intact, Resident 118 could make decisions regarding his daily care. Resident 118 required moderate assistance from staff with ADL (toileting, bathing, lower body dressing, and personal hygiene).</p> <p>During observation on 2/3/25 at 12:38 pm, Resident 118's room was damaged and the walls were unpainted, there were holes in the lower area of the wall behind the residents bed, plaster on the walls throughout the three bed resident room. Resident's room needed repairs primarily for the wall.</p> <p>During an interview on 2/3/25 at 12:38 pm, Resident 118 stated the wall in his room has been damaged and has looked this way since 12/10/2024 when he was admitted into the facility. Resident 118 stated he has been told it will be repaired, but nothing has been done about the room.</p> <p>During an interview on 2/3/25 at 12:38 pm, MS stated Resident 118's room was already on his (MS) list from his initial assessment of the facility. MS stated he has bought material it is only a matter of time when he is able to get to the room to perform repairs. The MS stated at this time it is not a home like environment.</p> <p>During an interview on 2/5/25 at 11:00 pm, the Administrator (ADM) stated the damage to the wall in (Resident 118's) room is not a homelike environment at this time. The ADM stated because we have just purchased the building, we have a list of needed repairs, and this room is on our list. We need to hire more assistance to the maintenance supervisor's staff and then the repairs will be completed much faster. However, currently it is not a homelike environment for the Resident in this room.</p> <p>During record review, the facility's policy and procedures titled, Homelike Environment - Quality of Life dated 11/21/2024 indicated,</p> <p>Policy Statement</p> <p>Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.</p> <p>Policy Interpretation and Implementation</p> <p>2 The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:</p> <p>c. inviting colors and decor;</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. personalized furniture and room arrangements;</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>44253</p> <p>Based on observation, interview, and record review the facility failed to follow the facility's Use of Restraints, policy and procedures for one of 23 sampled residents (Resident 12) by failing to:</p> <ol style="list-style-type: none"> 1. Execute an informed consent for restraints prior to administration 2. Conduct a pre-restraining assessment 3. Initiate a flow sheet documenting restraint site, observation, range of motion, and repositioning and every two-hour release of the physical restraint <p>These deficient practices have the potential to place the residents at risk for unnecessary prolonged use of restraints, a decline in physical functioning and skin injuries.</p> <p>Findings:</p> <p>During record review, Resident 12's Admission Record indicated the facility admitted the resident on 7/20/11, with diagnoses dementia (a progressive state of decline in mental abilities), atrial fibrillation (an irregular heartbeat that can lead to blood clots and increases the risk of stroke and other heart complications) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During record review, Resident 12's Devices care plan initiated on 11/4/24 indicated, the resident used hand mitten physical restraints. A review of the care plan indicated a goal was for the resident to not pull out the resident's g-tube. The care plan interventions indicated to monitor every shift for circulation and skin breakdown.</p> <p>During record review, Resident 12's Minimum Data Set (MDS - resident assessment tool) dated 11/8/24, indicated Resident 12 had severely impaired cognition (never/rarely made decisions).The MDS indicated the resident is dependent for eating, oral and toileting hygiene, showering/bathing, and personal hygiene.</p> <p>During record review, Resident 12's physician's orders dated 12/23/24 , indicated:</p> <ul style="list-style-type: none"> - to apply hand mittens due to a history of pulling out gastrostomy tubing [g-tube: a tube inserted through the belly that brings nutrition directly to the stomach]) and -to monitor frequently every shift for circulation and skin breakdown. <p>During record review, Resident 12's medical chart indicated there was no pre-restraining assessment and no informed consent form for the bilateral hand mitten restraints. A further review of the resident's medical chart also indicated there was no flow sheet to document restraint site observation, range of motion, and repositioning as indicated in the facility's Use of Restraint, policy and procedures.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/3/25 at 8:36 AM Resident 12 was observed in a low bed wearing bilateral hand mittens. Resident 12 was sleeping and was calm.</p> <p>During a concurrent interview and observation on 2/5/25 at 8:53 AM, Resident 12 was observed not wearing the bilateral mittens at Certified Nursing Assistant (CNA) 1 stated Resident 12 wears mitten restraints due to the resident's scratching. CNA1 stated Resident 12 does not wear the mittens at all times and it was the licensed vocational nurse responsibility to monitor the resident skin when wearing the mitten restraints.</p> <p>During a concurrent interview and record review on 2/5/25 at 11:27 AM, Resident 12's physical chart and electronic health record was reviewed with Registry Licensed Vocational Nurse (LVN) 3 stated the physician ordered Resident 12's bilateral mitten restraints on 12/23/24 and the order was discontinued today by the night nurse. LVN3 stated the order for bilateral mittens should be renewed because Resident 12 pulls at all of her devices. LVN3 also stated there was no informed consent for restraints or pre-restraint assessment in the medical record. LVN3 further stated that there was no monitoring of the resident's skin on the MAR.</p> <p>During an interview on 2/5/25 at 11:44 AM, Medical Records Assistant (MRA) stated there was no informed consent for restraints in Resident 12's physical or electronic health record.</p> <p>During a concurrent interview and record review on 2/6/25 at 2:24 PM with the Director of Nursing (DON), Resident 12's MARs, Nursing Assessments, and informed consent for restraint were reviewed. The DON stated prior to initiating Resident 12's mitten restraints, a pre-restraint assessment was not conducted and informed consent for restraint form was not executed. The DON further stated the resident's medical record did not indicate any monitoring, observation, range of motion and repositioning per the facility's policy and procedure was documented. The DON stated the resident could possibly have restricted blood flow to her hands if the restraints and the resident skin was not monitored while wearing the restraints.</p> <p>During record review, the facility policy and procedures titled, Use of Restraints, reviewed 11/21/24, indicated:</p> <ul style="list-style-type: none"> - Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. - When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. - Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. <p>6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12. The following safety guidelines shall be implemented and documented while a resident is in restraints:</p> <p>a. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident.</p> <p>b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used.</p> <p>c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record.</p> <p>d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed.</p> <p>e. Restrained residents must be repositioned at least every two (2) hours on all shifts.</p> <p>14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.</p> <p>15. Should a resident not be capable of making a decision, the surrogate or sponsor may exercise the right of the use or non-use of a restraint. (Note: The surrogate/sponsor may not give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.)</p> <p>16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.</p> <p>19. Documentation regarding the use of restraints shall include:</p> <p>a. Full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode</p> <p>b. A description of the resident's medical symptoms (i.e., an indication or a characteristic of a physical or psychological condition) that warranted the use of restraints;</p> <p>c. How the restraint use benefits the resident by addressing the medical symptom;</p> <p>d. The type of the physical restraint used;</p> <p>e. The length of effectiveness of the restraint time; and</p> <p>f. Observation, range of motion and repositioning flow sheets.</p>		

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NAME OF PROVIDER OR SUPPLIER Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1338 20th Street Santa Monica, CA 90404	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</p> <p>Based on observation, interview, and record review, the Facility failed to ensure a care plan was initiated for one out of 23 sampled residents (Resident 20) for amoxicillin (antibiotic - medication to treat infection/s) ordered for 120 days to treat oral lesions (abnormal cell growths or sores in the mouth that can be painful).</p> <p>This deficient practice had the potential to negatively affect the delivery of care and services and had the potential to result in complications from unnecessary medications such as resistance to antibiotics and a super bag infection (a microorganism/bacteria that has become resistant to antibiotics or antifungal medications).</p> <p>Findings</p> <p>During record review, Resident 20's admission record indicated Resident 20 was admitted on [DATE] with diagnoses that included heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), irritative hyperplasia of the oral mucosa (a condition where the mucous membrane in the mouth becomes enlarged due to chronic irritation) and hypothyroidism (a condition in which the thyroid gland(thyroid hormone producing gland) does not produce enough thyroid hormone).</p> <p>During record review, Resident 20's Minimum Data Set (MDS - resident assessment tool) dated 11/18/2024, indicated Resident 20 cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 20 independent with eating and oral hygiene.</p> <p>During a medication administration observation and interview on 2/4/2025 at 8:23 AM, Licensed Vocational Nurse (LVN) 7 administered Amoxicillin 500mg po (orally/by mouth) to Resident 20. LVN 7 stated Resident 20 was receiving Amoxicillin 500mg twice a day for oral lesions since 12/3/2024 and that the Amoxicillin order was to be administered for 120 days.</p> <p>During record review, Resident 20's Physician Order Summary Recap report dated 2/14/2025, indicated an order for Amoxicillin 500 milligrams (mg - unit dose) capsule, give 1 capsule daily orally two times a day for oral lesions.</p> <p>During record review, Resident 20's 12/2024 Electronic Medical Administration Record (eMAR) dated 2/6/2025, indicated, Resident 20 received Amoxicillin 500 mg medication for 66 days starting from 12/3/2024 to 2/6/2025.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During record review, the facility's policy and procedures titled Care Plans - Comprehensive Person-Centered, dated 11/21/2024, indicated, The comprehensive person-centered care plan includes measurable objective time frames, described the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being for each Resident. Policy further states Care plan interventions address the underlying source(s) of the problem area(s), symptoms and triggers, reflect treatment goals, timetables and objectives in measurable outcomes, reflects currently recognized standards of practice for problem areas and conditions.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>44253</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 5), who had limited range of motion (ROM - the extent of movement of a joint) in the right hand received Restorative Nursing Aide (RNA - assistant that help residents to maintain their function and joint mobility) services as ordered by the physician.</p> <p>This deficient practice put Resident 5 at risk for further decline and contracture formation.</p> <p>Findings:</p> <p>During record review, Resident 5's admission record indicated the facility originally admitted the resident on 10/10/12 and readmitted the resident on 6/8/24 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), multiple sclerosis (disabling disease of the brain and spinal cord that causes the nerves to deteriorate or become permanently damaged) and scoliosis (a condition in which the spine curves abnormally to the side, usually in an S or C shape).</p> <p>During record review, Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/24, indicated Resident 5's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision- were moderately impaired. The MDS also indicated Resident 5 required total to substantial assistance from staff with bed mobility, dressing, toileting and personal hygiene. The MDS further indicated the resident had functional limitation in range of motion in both arms and legs. The MDS further indicated Resident 5 did RNA services consisted of PROM exercises and assistance with a brace or a splint.</p> <p>During record review, Resident 5's Physician Order, dated 10/1/24 indicated Resident 5 to receive RNA program consisting of passive range of motion (PROM, movement at a given joint with full assistance from another person) to the left upper extremity five times a week with a left hand splint.</p> <p>During record review, Resident 5's alteration in musculoskeletal status care plan, initiated 10/25/24, indicated Resident 5 had carpal tunnel syndrome (a condition that causes numbness, tingling, and pain in the hand and forearm).</p> <p>During record review, Resident 5's Physician Order, dated 11/20/24, indicated the resident was to receive RNA with PROM to the resident's left and right lower extremities one time a day Monday through Friday.</p> <p>During record review, Resident 5's falls/injury care plan, initiated 12/18/24, indicated the goal was to safely promote the resident's functional ability. The interventions included RNA for PROM to bilateral lower extremities five times a week.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/3/25 at 8:30 AM, Resident 5 was observed sitting up in bed. Resident 5's right hand was folded and positioned under the resident's chin. When asked could the resident straighten the hand, Resident 5 used their left hand to unfold the right hand and straighten the right hand's fingers. During a concurrent interview, Resident 5 stated they hadn't received RNA services recently. Resident 5 stated they had not worn the brace for the right hand in over a month and Resident 5 stated they would like to have RNA services as it prevents contracture formation.</p> <p>During a concurrent interview and record review on 2/5/25 at 1:34 PM, Resident 5's RNA documentation was reviewed with Restorative Nurse Aide (RNA) 1. RNA 1 stated they were the only RNA employed by the facility for all 115 residents. RNA 1 stated at times they are pulled from RNA duties and used as a certified nursing assistant (CNA). RNA 1 stated when they are pulled to work as a CNA, they do not perform RNA services for the resident. RNA 1 further stated Resident 5 received passive range of motion (PROM, movement at a given joint with full assistance from another person) on her right hand and then we place a brace, however the brace has been missing since 1/31/25 (5 days). Upon review of Resident 5's RNA documentation, RNA 1 stated Resident 5 did not receive RNA services on 2/3/25 because RNA 1 did not work that day and Resident 5 did not receive RNA services on 2/4/25 because RNA 1 was working as a CNA that day. RNA 1 further stated Resident 5 missed 10 days (1/3/25, 1/6/25, 1/9/25, 1/10/25, 1/14/25, 1/15/25, 1/16/25, 1/24/25, 1/27/25 and 1/28/25). RNA 1 stated Resident 5's range of motion could deteriorate if the resident did not receives RNA services per physician orders.</p> <p>During an interview on 2/26/25 at 2:29 PM, the Director of Nursing (DON) stated there was only one RNA employed by the facility. The DON stated they were aware of residents not receiving RNA services in the building. The DON further stated RNA services are provided to maintain the resident's range of motion and the resident could develop a contracture from not receiving RNA services.</p> <p>During record review, the facility's policy and procedures (P&P) titled, Restorative Nursing Services - Rehabilitave and Restorative, reviewed 11/21/24, indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</p> <p>Based on observation, interview, and record review, the facility failed to ensure one out 23 sampled residents (Resident 277) was evaluated and demonstrated the ability to self-administer medication prior leaving medication at the Residents bedside.</p> <p>This deficient practice had the potential to result in an allergic reaction, poor patient outcomes and even death from accidental ingestion of unknown medication/substance.</p> <p>Findings:</p> <p>During record review, Resident 277 Admission Record indicated Resident 277 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included toxic encephalopathy (brain dysfunction caused by exposure to toxic substances), diabetes mellitus (metabolic disease characterized by abnormally high blood sugar (glucose) levels in the blood), dysphagia (swallowing difficulty), pneumonitis (lung inflammation) and depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities).</p> <p>During record review, Resident 277's the Minimum Data Set (MDS- resident assessment tool) dated 12/27/2024, indicated Resident 277's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. Resident 277 was dependent for eating and required substantial/maximum assistance with oral hygiene.</p> <p>During the initial tour on 2/3/25 at 9:06 AM, the top of Resident 277's bedside drawer was observed to have a powdered substance inside a medicine cup. During a concurrent interview with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the powdered substance in the medicine cup looked like nystatin or crushed medication. LVN6 stated the medication is not supposed to be left at bedside, LVN stated a confused wandering patient could ingest the medication which could lead to an adverse reaction, unnecessary hospitalization and even death.</p> <p>During an interview on 2/6/2025 at 6:45 PM, Director of Nursing (DON) stated medication should never be left at bedside if a Resident is severely mentally impaired and/or does not have capacity to self-administer. DON further stated the Resident would be incapable or reporting if they have an adverse reaction which could lead to poor patient outcomes, unnecessary hospitalization and even death.</p> <p>During record review, the facility policy and procedures (P&P) titled Self-Administration of Medications dated 11/21/2024 indicated, the interdisciplinary team (IDT) will assess each resident's cognitive and physical abilities to determine whether the self-administration of medications is safe and clinically appropriate for the Resident. Factors considered when determining self-administration of medications is safe and appropriate for the Resident:</p> <p>a. Medication is appropriate for self -administration</p> <p>b. Resident can read and understand medication labels</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. The resident can follow directions and tell time to know when to take the medications .</p> <p>d. Resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff.</p> <p>e. Resident has physical capacity to open medication bottles, remove medications from a contain and to ingest and swallow (or otherwise administer) the medication; and</p> <p>f. Resident can safely and securely store the medications.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident with an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) received catheter care as ordered by the physician for one of two sampled residents (Resident 55).</p> <p>This deficient practice had the potential to result in urinary tract infections (UTI- is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra) for Resident 1.</p> <p>Findings:</p> <p>A review of the Admission Record indicated the facility originally admitted Resident 55 on 4/28/2017 and was readmitted on [DATE] with diagnoses including acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), prostate cancer and a history of urinary tract infections (UTI- an infection in the bladder/urinary tract).</p> <p>A review of the Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 10/21/2024, indicated Resident 55's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 55 required total to substantial assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated the resident had an indwelling urinary catheter.</p> <p>A review of Resident 55's Physician Orders, dated 9/22/2024, indicated physician ordered:</p> <p>-A urinary catheter to bedside drainage due to diagnosis of urinary retention</p> <p>-urinary catheter care every shift</p> <p>During a concurrent interview and record review on 2/5/2025 at 1:18 PM with Licensed Vocational Nurse (LVN) 3, Resident 55's November 2024 Treatment Administration Record (TAR) was reviewed. LVN 3 stated Resident 55 did not receive the ordered urinary catheter care on 11 days out of 30 in the month of November 2024. LVN 3 stated urinary catheters are an invasive medical device and not providing the ordered catheter care could lead to a urinary tract infection.</p> <p>During a concurrent interview and record review on 2/6/2025 at 2:33 PM with Director of Nursing (DON), Resident 55's 11/2024 TAR was reviewed. The DON stated facility staff did not administer urinary catheter care to the resident on 11/2, 11/5, 11/9, 11/10, 11/11, 11/18, 11/19, 11/20, 11/25 and 11/26/2024. The DON further stated there is a risk for infection when catheter care is not provided.</p> <p>A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised 8/2022, the P&P indicated, To use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's P&P titled, Urinary Tract Infections (Catherter-Associated), Guidelines for Preventing, reviewed 11/21/2024, indicated the purpose of the procedure was to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs). It also indicated staff were to perform daily meatal hygiene with soap and water for residents with an indwelling catheter.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of three sampled residents (Resident 21 and Resident 39).</p> <p>1. Resident 39 the facility failed to administer two liters of oxygen continuously according to physician's order and failed to date the resident's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen).</p> <p>2. The facility failed to ensure Resident 21 received the correct therapeutic dose (of oxygen (a colorless, odorless gas that is essential for life and the proper functioning of the body) as ordered by the physician.</p> <p>This deficient practice placed Resident 21 at risk of oxygen poisoning (lung damage that happens from breathing in too much extra (supplemental) oxygen.) and had the potential to cause complications associated with oxygen therapy and negatively impact the Residents 21 and 39's health and well-being.</p> <p>Findings:</p> <p>1. A review of the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), cerebral infarction (a stroke in which an area of brain tissue dies due to a lack of blood flow) and asthma (a chronic lung disease that makes breathing difficult).</p> <p>A review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/26/2025, indicated Resident 39's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 3 required substantial assistance from staff for bathing, dressing and toileting.</p> <p>During an observation on 2/3/2025 8:02 AM, Resident 39 was observed in bed. Resident 39 was receiving oxygen at 1.5 liters per minute (lpm - unit of measurement) connected to a nasal cannula tubing and humidifier at bedside. Resident 39's nasal cannula was undated.</p> <p>During a concurrent interview and observation at Resident 39's bedside on 2/3/2025 at 8:07 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 39's nasal cannula was undated and Resident 39 was currently receiving 1.5 lpm of oxygen. LVN 1 stated the nasal cannula should be dated in order to know when it was placed. LVN 1 further stated staff are to change the nasal cannula weekly to prevent infection and LVN 1 doesn't know when the cannula was last changed. LVN 1 further stated the current lpm was incorrect and the physician order indicated Resident 39 should receive 2 lpm. LVN 1 further stated not receiving the correct lpm could lead to low blood oxygenation.</p> <p>A review of Resident 39's Order Summary Report as of 2/5/25, indicated on 1/16/25, the physician ordered the resident to receive oxygen 2 lpm as needed for an oxygen saturation less than 90%.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Director of Nursing (DON) on 2/6/25 at 2:35 PM the DON stated nasal cannula should be dated for infection control and physician orders should always be followed. The DON further stated a possible outcome of not receiving the correct lpm was poor oxygenation for the resident.</p> <p>A review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, reviewed 11/21/24, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P further indicated in preparing to administer oxygen staff were to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. The P&P further indicated staff were to, turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter) and adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</p> <p>45455</p> <p>2. A review of Resident 21's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, diabetes Mellitus (metabolic disease characterized by abnormally high blood sugar (glucose) levels in the blood) cardiomyopathy (a disease that affects the heart muscle), encephalopathy (a change in your brain function due to injury or disease), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time) and COPD.</p> <p>A review of Resident 21's the MDS dated [DATE], indicated Resident 21's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact.</p> <p>A review of Resident 21's history and physical (H&P) undated, indicated Resident 21 has the capacity to understand and make decisions.</p> <p>A review of Resident 21's Order Summary Report dated 2/6/2025 indicated physician's order for oxygen at two (2) liters per minute via nasal cannula continuously to keep oxygen saturation above 92%. Diagnosis (Dx)= shortness of breath (SOB) every shift for COPD.</p> <p>During an initial tour on 2/5/2025 at 8:19 AM, Resident 21 was observed awake in bed, an oxygen concentrator machine (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen) was observed at bedside flowing at 5 liters (unit measure) per minute (duration) -l/min flowing via the Resident's nasal cannula (a device used to deliver supplemental oxygen that should be placed directly on the resident's nostrils) Resident 21's was observed resting comfortably in bed with no distress and unlabored breathing.</p> <p>During an observation and a concurrent interview on 2/5/2025 at 8:25 AM Licensed Vocational Nurse (LVN) 6, stated Resident 21 is has an order for continuous oxygen at 2L/min, a nasal cannula for shortness of breath (SOB), LVN 6 was unable to answer when asked why Resident 21 was receiving 5 L/min instead of the physician's order of 2L/min. However, LVN 6 stated receiving oxygen at 5L/min with a diagnosis of COPD placed Resident 21 at risk for oxygen toxicity due to hyper-oxygenation and could cause lung paralysis and even death.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/6/2024 at 6:52 PM., the DON stated Resident 21 was at risk for lung collapse due to high amount of oxygen that can affect breathing due to over oxygenation which can cause the Resident to stop breathing and die.</p> <p>A review of the facility's P&P and procedure titled, Oxygen Administration, dated 11/21/2024, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The same P&P indicated, Verify that physicians order for oxygen and facility protocol for oxygen administration .unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 l/min.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>48026</p> <p>Based on observation, interview, and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Nursing staff and the certified nurse assistant (CNA) are competently wearing N95 masks (is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles) during an ongoing influenza outbreak in the facility. 2. The director of staff development (DSD), a licensed vocation nurse (LVN) had the skill set to train registered nursing staff concerning resident care and assessment for abuse reporting during in-service training. <p>These deficient practices had the potential to result in:</p> <ol style="list-style-type: none"> 1. Vulnerable residents to contract influenza causing a larger spread of influenza (Flu- viruses known to cause flu pandemics that infects people and has the ability to spread efficiently among people, and against which people have little or no immunity) outbreak. 2. Unsatisfactory training for the registered nursing staff. <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation of LVN 6 on 2/05/2025 at 2:04 PM, LVN 6 was observed sitting at the nurse's station 1 wearing N95 mask under the chin during an ongoing influenza outbreak in the facility. LVN 6 the importance of wearing the N95 properly was for infection control (measures taken to prevent or stops the spread of infections in the healthcare settings). LVN 6 further stated, We have several residents who are on transmission-based precautions (TBP - used when patients already have confirmed or suspected infections), they have the flu, the mask is to help the staff minimize transmission of the infection. LVN 6 further stated the potential risks for residents when staff do not wear the N95 mask inappropriately, was the risk of spreading infection and making the residents sicker. During an observation of CNA 4 on 2/05/25 at 2:10 PM, CNA 4 was observed sitting on a high stool on the second floor hallway wearing N95 mask under CNA 4's chin during an ongoing influenza outbreak in the facility. CNA 4 was observed moving the N95 mask from the chin to the face covering both the nose and mouth. CNA 4 stated the importance of wearing the N95 properly was to make sure we control the spread of infection. CNA 4 stated the potential risk of wearing the N95 mask inappropriately was to continue to spread of infection and the residents who are already sick may get sicker and other residents that are not sick, may get sick. During an interview with Infection Prevention (IP) nurse on 2/05/2025 at 3:55 PM, IP stated N95 masks are to be worn where the nose and mouth are completely covered to ensure transmission of infection is prevented. The IP nurse stated, when staff do not wear their N95 mask appropriately, there might be greater spread of infection causing residents to get sick or sicker. <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on 2/06/2025 at 4:44 PM, DON stated, all staff are expected to wear their N95 masks when they are in areas frequented by residents. DON also added residents may get sick and contract influenza when N95 masks are worn under their chin.</p> <p>During a review of the facility's policy and procedure (P&P) titled Competency of Nursing Staff dated 11/1/2024, the P&P indicated competency in skills and techniques necessary to care for residents' needs includes .infection control (measures taken to prevent or stops the spread of infections in the healthcare settings). The P&P further indicated facility and resident-specific competency evaluations will include demonstrated ability to use tools, devices, or equipment used to care for residents.</p> <p>46843</p> <p>b. During an interview and a concurrent record review, on 2/6/2025 at 11:20 pm, the DSD stated, she performed all the abuse training for the staff in the facility. The DSD stated she had trained the former DON of the facility, and the RN 1 on abuse reporting and prevention. The in-service documents were signed by the DON and the RN1, dated 11/27/2024, the signature of the trainer was the DSD. The DSD stated that part of her duty as DSD is to perform in-service education and training as needed to CNAs, License Vocational Nurses (LVNs), and to Registered Nurses (RNs) working for the facility. The DSD stated that she has the in-service lesson plans and attendance records of the previous lessons that she has taught the CNAs, LVNs, and RN staff on abuse, The DSD provided copies of the in-service sign in sheets and the lesson plans along with abuse policy. The sign-in sheets have listed as attendees a majority of staff members including registered nursing staff members. The DSD stated that she trains the registered nursing staff and all other staff on all subjects. DSD stated that she trains staff independently, depending on the need of the facility at the time.</p> <p>During an interview, on 2/6/25 at 11:25 pm, the DON stated the DSD/LVN should not be training an RN, because it was out of the scope of practice for the LVN. The DON further stated the RN does addition functions that the LVN may not be aware of and therefore would not be qualified to teach to an RN.</p> <p>During a review of the job description of the Director of Staff Development, the description states the following:</p> <p>Position Summary:</p> <p>the purpose of your job position is to oversee the development of staff at the facility.</p> <p>Essential Duties and Responsibilities</p> <p>Directly supervises the Certified Nurses Assistants and the Restorative Nurses Aids</p> <p>Conducts various in-services and educational presentations based off a regular schedule and on an as-needed basis</p> <p>During a review of the facility's P&P titled Competency of Nursing Staff, dated 11/21/2024, the P&P indicated,</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law.</p> <p>Policy Interpretation and Implementation</p> <p>7. Facility and resident-specific competency evaluations will include:</p> <p>e. Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</p> <p>Based on observation, interview, and record review the facility failed to ensure that one of 23 sampled residents (Resident 20) was free of unnecessary medication by failing to clarify the physicians order for Amoxicillin (a drug used to treat infections caused by bacteria and other microorganisms), to be administered orally (by mouth) for 120 days.</p> <p>This deficient practice resulted in Resident 20 receiving an excessive dose of antibiotics, for an excessive duration without adequate indication for prolonged use, rationale or monitoring and had the potential to result in adverse consequences such as antibiotic resistance, kidney, and liver failure.</p> <p>Findings:</p> <p>A review of Resident 20's admission record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), irritative hyperplasia of the oral mucosa (a condition where the mucous membrane in the mouth becomes enlarged due to chronic irritation) and hypothyroidism (a condition in which the thyroid gland(thyroid hormone producing gland) does not produce enough thyroid hormone).</p> <p>A review of Resident 20's the Minimum Data Set (MDS - a assessment tool) dated 11/18/2024, indicated Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 20 was independent with eating and oral hygiene.</p> <p>During a medication administration observation, On 2/4/2025 at 8:23 AM, Licensed Vocational Nurse (LVN) 7 stated Resident 20 was receiving Amoxicillin 500mg twice a day oral lesions for 120 day, LVN 7 stated Resident 20 had been receiving the medications since 12/3/2024.</p> <p>A review of Resident 20's medical chart and electronic medical administration record (eMAR) indicated no transcribed orders from Resident 20's Dentist (DST1).</p> <p>A review of Resident 20's 09/2024 Electronic Medication Administration Record (eMAR) dated 2/6/2025 indicated, an order for Doxycycline Hyclate (is an antibiotic that is commonly used to improve tooth attachment and reduce gum pockets in people who have a dental procedure) oral tablet 100milligram (mg-unit of measurement) by mouth two times a day for infection in dental implant for 10 days starting 9/7/2024. Doxycycline Hyclate 100mg was never administered to Resident 20 and was discontinued on the same day.</p> <p>A review of Resident 20's 10/2024 (eMAR) dated 2/6/2025 indicated, an order date of 9/19/2024 for Amoxicillin 500mg capsule give 1 capsule orally two times a day of oral lesion until 10/21/2024. Medication was administered for 21 days from 10/1/2024 to 10/21/2024</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 20's 11/2024 (eMAR) dated 2/6/2025 indicated, an order date of 11/1/2024 for Amoxicillin 500mg capsule give 1 capsule orally two times a day of gum irritation for 30 days. Medication was administered for 30 days from 11/1/2024 to 11/30/2024</p> <p>A review of Resident 20's 12/2024 (eMAR) dated 2/6/2025 indicated, an order date of 12/3/2024 for Amoxicillin 500mg capsule give 1 capsule orally two times a day of oral lesion for 120 days. Medication was administered for 66 days from 12/3/2024 to 2/6/2025 and discontinued by the medical director (MD) as antibiotic timeout after survey team initiated an investigation on unnecessary medication.</p> <p>During an interview on 2/6/2025 at 8:45AM, Registered Nurse (RN) stated he received a telephone order for the amoxicillin500mg x1 capsule two times a day for oral lesions for 120 on 12/3/2024 from Resident 20's personal dentist (DST1), RN stated DST1 is not a contracted dentist with the facility. RN stated he (RN) questioned DST1 about the 120-day antibiotic dose and DST1 confirmed the antibiotic duration as 120 days. RN stated he (RN) sent an electronic telephone message (text) to Resident 20's primary care provider (PCP) notifying him about the antibiotic order and duration of medication order, RN stated PCP did not respond to the text. RN stated he (RN) followed the order by transcribing the DST1's order in Resident 20's medical record under PCP's name since all non-contracted doctor's orders are entered through the PCP , the order was directly received and carried out by pharmacy. RN stated Resident 20 called DST1 directly by herself and stated she was having oral pain. RN stated DST1 did not come to the facility to examine Resident 20s oral pain prior to ordering the medication.</p> <p>During an interview on 2/6/2025 at 10:41AM, Director of Nursing (DON) stated licensed nurses taking a telephone order must from a non-contracted doctor must notify the Residents assigned Primary Care Physician and confirm their agreement with the treatment plan, DON stated the telephone order should not be carried out unless there is a written doctor confirmation of the agreement with the ordered medication. DON further stated the risk of prolonged antibiotic use could cause Resident to develop resistance to antibiotics, a Resident could develop a super bag infection (a microorganism that has become resistant to antibiotics or antifungal medications).</p> <p>During a telephone Interview on 2/6/2025 at 11:59 AM, facility Medical Director (MD) stated he was not aware Resident 20 had an antibiotic order for 120 days, MD stated I have seen doxycycline prescribed by doctors can place Residents on prophylaxis for 90 days or 150 days, however, every other day is more common. MD stated antibiotic treatment depends on the cite and type of infection, Resident's should be monitored for improvement and/or decline in treatment and Resident Kidney, endocrinology and liver function should be monitored. MD stated a non-contracted facility doctor must provide a physical prescription order and must go through the Resident's PCP to have their orders carried out, the admitting PCP was supposed to follow-up on the medications and laboratory results.</p> <p>A review of Resident 20's medical chart titled laboratory Results report indicated the last lab report was completed on 12/20/2024.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 2/6/2025 at 2:05PM, Pharmacy Consultant (PC) stated she completed a facility Medical Regimen Review (MRR) in November and instructed the licensed staff to clarify indication for the 11/1/2024 Amoxicillin oral tablet 500mg (Amoxicillin) 1 tab by mouth two times a day for gum irritation for 30 days. PC stated she was not aware of the new 12/3/2024 amoxicillin antibiotic order for 120 days. PC attempted to verify the order while with surveyors on the phone, PC stated she could not see an order for the amoxicillin antibiotic order 120 days, PC stated upon further investigation into discontinued medications, PC stated she could see that the amoxicillin order was discontinued on 2/6/2025 (today) at 10:50 AM for antibiotic timeout. PC stated antibiotic orders should be monitored and used appropriately, PC stated prolonged use of antibiotics could cause Resident 20 to develop resistance to antibiotics.</p> <p>A review of facility's policy and procedure (P&P) titled Administering Medications reviewed 11/21/2024, the P&P indicated, medications are administered in a safe and timely manner and as prescribed. If a dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences, the person preparing or administering the medication will contact the prescriber, the Resident's attending physician or the facility's medical director to discuss the concerns. The P&P further stated each nurses' station has a current physician's desk reference (PDR-a reference book that contains information about prescription drugs) and/or other medication reference, as well as a copy of the surveyor guidance for (pharmacy services).</p> <p>A review of the facility's P&P titled, Medication and Treatment Orders reviewed, 11/21/2024, the P&P indicated, verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date and the time of the order. Policy further states, verbal orders must be signed by the prescriber at his or her next visit.</p> <p>A review of facility's P&P titled, Verbal Orders, reviewed 11/21/2024, the P&P indicated, A telephone order is a verbal order given over the phone. Text messaging is not an acceptable method of communicating an order. The individual receiving the verbal order must write it on the physician's order sheet as v.o. (verbal order) or t.o (telephone order). Policy further states, the individual receiving the verbal order will: record the ordering practitioner's last name and his or her credentials (MD, NP, PA, etc.); and record the date and time of the order.</p> <p>A review of facility's P&P titled, Antibiotic Stewardship - Orders for Antibiotics, reviewed 11/21/2024, the P&P indicated, Appropriate indications for use of antibiotics include: Criteria met for clinical definition of active infection or suspected and sepsis; and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy began while culture is pending). The same P&P further indicated when antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45037</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen for 114 of 114 residents who received food from the kitchen. By failing to ensure:</p> <ol style="list-style-type: none"> 1. The Italian and ranch dressings were not unlabeled and undated, 2. The bacon slices was not uncovered and undated. 3. The leftover chicken and ground beef stored in the refrigerator had record of following the cool down method. 4. The 16 pre-packed sandwiches were not undated. 5. The meat slicer was uncleaned. <p>These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses and other toxins).</p> <p>Findings:</p> <p>During the initial tour of the facility on 2/03/2025 at 7:23 am, of the kitchen with Dietary Supervisor(DS), it was observed there was 16 prepackaged sandwiches without labels and no expiration dates on them, large container of Italian and ranch dressing, without an open date, expiration, or used by date on them noted with a grey bag with a monster drink in the refrigerator that belong to the kitchen staff that was brought in from the outside. It was was obseerved that there was a container of cooked ground beef and cooked chicken stored in the refrigerator with a date of 2/2/2025 and was not documented on the cooling monitoring form. It was also obseerved that the meat slicer was dirty. There was no cleaning log for the meat slicer.</p> <p>During an interview and a concurrent record review on 2/03/2025 at 7:48 am, the kitchens cooling monitoring form was reviewed. There was no record for the cooked ground beef and cooked chicken dated 2/2/2025. The DS confirmed the findings. The DS stated the staff was allowed to store cooked food in the refrigerator as long as they follow the reheating policy and the cool down policy. The DS stated meat slicer should be cleaned daily and after every use. The DS confirmed and stated that there was no cleaning log for the meat slicer. The DS further stated he did not know the last time the meat slicer was cleaned. The DS stated the staff is aware that they are never supposed to place personal food or drink items bought in from the outside in the kitchen refrigerator or freezer. The DS stated if staff bring in food from the outside and place it in the kitchen refrigerator and freezer it could contaminate the food for the residents and could cause the residents to get very sick.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedures titled Food Receiving and Storage dated 11/21/2024, the P&P indicated, All foods stored in the refrigerator or freezer are covered, labeled and dated (used by date) .7. Refrigerated foods are labeled, dated and monitored so they are used by their used by date, frozen, or discarded.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1.Ensure staff did not placed their personal monster energy drink in the refrigerator in the kitchen. 2. Staff performed hand hygiene after leaving the patient's room that was on isolation and after disposing of dirty linen from a resident's room. 3. Ensure standard infection control practices were followed for four (2) out of 23 sampled residents (Residents 21 and 227) by: <ol style="list-style-type: none"> a. Failing to ensure oxygen nasal cannula tubing (a device used to deliver supplemental oxygen placed directly on a resident's nostrils) were off the floor for Resident 21. b. Failing to ensure nebulizer (nebulizer is a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) was securely wrapped in a clear plastic cover and not touching the bedside table for Resident 227. <p>These deficient practices had the potential to result in pathogen (germ) exposure for Residents 21 and Resident 227 and placed both residents at risk for respiratory infections, serious medical complications and unnecessary hospitalization and even death.</p> <p>4. The facility failed to ensure nursing staff and the certified nurse assistant (CNA) are competently wearing N95 masks (is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles) during an ongoing influenza outbreak in the facility.</p> <p>This deficeint practice had the potential to result in exposing residents to harmful bacteria and viruses, and for vulnerable residents to contract influenza causing a larger spread of influenza outbreak.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the initial tour of the kitchen on 2/03/2025 at 7:23 am, with Dietary Supervisor (DS), it was observed that there was a grey bag with a monster drink in the refrigerator that belonged to the kitchen staff. <p>During an interview on 2/3/2025 at 7:45 am, Dietary Supervisor stated if staff brought in food from the outside and placed it in the kitchen refrigerator and freezer it could contaminate the food for the residents and could cause the residents to get very sick.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1338 20th Street Santa Monica, CA 90404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. During an observation and a concurrent interview on 2/3/2025 at 10:00 am, Certified Nurse Assistant (CNA) 1 was observed carrying a dirty linen in her hands without gloves on from room [ROOM NUMBER] to room [ROOM NUMBER]. CNA 1 placed the dirty linen in the dirty linen barrel and did not provide hand hygiene. CNA 1 stated she was aware that she was supposed to wear gloves when carrying dirty linen. CNA 1 stated she should have placed a dirty linen barrel outside of her resident's room. CNA 1 stated if she does not follow the infection control policy other residents can get infected and really get sick.</p> <p>During an observation and a concurrent interview on 2/3/2025 at 10:35 am, CNA 2 was observed coming out of room [ROOM NUMBER] who was on droplet precaution with a blue isolation gown on, he was not wearing an N95 mask, and no gloves. CNA 2 doffed his blue isolation gown in the hallway and placed it in the trash in the nurses' station, and did not provide hand hygiene. CNA 2 confirmed the findings and stated he did not wear a mask or shield in the isolation room where the resident was placed on droplet precaution. CNA 2 stated he was much aware that he was supposed to wear a mask in an isolation room, and doff his isolation gown as he was exiting the resident's room. CNA 2 further stated he should have performed hand hygiene immediately after exiting the residents' rooms. CNA 2 stated if he does not follow the infection control policy, other staff and resident could be infected with bacteria and viruses.</p> <p>During a concurrent record review and interview with the Infection Prevention Nurse (IPN), on 02/03/25 at 2:25 pm, CNAs 1 and 2 employee files were reviewed. There was no infection control training provided to him upon hire, with his hire date of 1/13/2025 for CNA 2. The IPN stated stated all registry nurse's competencies are completed with the registry prior to the nurses coming to the facility to work. IPN stated she does not have the completed certificates of completed competencies by CNA 2 on file. The IPN stated if the nurses perform hand hygiene the residents could be put at risk for infections.</p> <p>A review of the facility's policy and procedures (P&P) titled Infection Prevention and Control Program, dated 11/21/24, the P&P indicated, An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>A review of the facility's P&P titled Personal Protective Equipment dated 11/21/24, the P&P indicated, .4. A supply of protective clothing and equipment is maintained at each nurses' station. PPE required for transmission-based precautions is maintained outside and inside the resident's room, as needed.</p> <p>A review of the facility's P&P titled Handwashing/Hand Hygiene dated 11/21/24, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections . Practices to Promote Hand Hygiene: .1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encouraged (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility.</p> <p>45455</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3a. A review of Resident 21's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, diabetes Mellitus (metabolic disease characterized by abnormally high blood sugar (glucose) levels in the blood) cardiomyopathy (a disease that affects the heart muscle), encephalopathy (a change in your brain function due to injury or disease), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time) and chronic obstructive pulmonary disease (COPD- lung disease marked by permanent damage to tissues in the lungs)</p> <p>b. A review of Resident 277 Admission Record indicated Resident 277 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included toxic encephalopathy (brain dysfunction caused by exposure to toxic substances), diabetes mellitus (metabolic disease characterized by abnormally high blood sugar (glucose) levels in the blood), dysphagia (swallowing difficulty), pneumonitis (lung inflammation) and depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities).</p> <p>A review of Resident 21's the Minimum Data Set (MDS-a resident assessment tool) dated 1/31/2025, indicated Resident 21's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact.</p> <p>A review of Resident 277's the MDS dated [DATE], indicated Resident 277's cognition was severely impaired (a person's mental or physical abilities are significantly limited, making it hard for them to function in daily life).</p> <p>During an initial tour on 2/3/2025 at 8:19 AM, Resident 21 was observed awake in bed, Resident 21's nasal cannula tubing was observed on the floor. Resident 21 stated the nasal cannula has been on the floor the whole night.</p> <p>During a concurrent interview and record review on 2/3/2025 at 8:25 AM Licensed Vocational Nurse (LVN) 6, stated Resident 21 has an order for continuous oxygen at 2L/min, a nasal cannula for shortness of breath (SOB). LVN 6 further stated, the nasal cannula tubing should not be on the floor because it is a fire hazard, the tubing gets contaminated while on the floor and if re-used would expose Resident 21 to respiratory infections.</p> <p>During an interview and a concurrent observation on 2/3/2025 at 9:25AM, Resident 227's nebulizer equipment was observed uncovered. LVN 6 stated Resident 227's nebulizer equipment should be placed in clear plastic bag to prevent potential pathogen exposure and for infection control.</p> <p>During an interview on 2/6/2025 at 6:45PM, Director of Nursing (DON) stated Resident 21's Nasal cannula should not be touching the floor due to infection control, DON stated inhalation from a contaminated nasal cannula could expose Resident 21 to respiratory illness. DON further stated Resident 277's Nebulizer should be in a plastic bag for infection control and to prevent Resident exposure to bacteria and viruses that cause respiratory illnesses from inhalation of dirty equipment which could result in unnecessary hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the facility's P&P titled, Infection Prevention and Control Program (IPCP) dated 11/24/2024, indicated: An IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for Residents .Policy further states, important facets of infection prevention include following established general .guidelines such as those of the Centers for Disease Control (CDC).</p> <p>48026</p> <p>4. During an observation of LVN 6 on 2/05/2025 at 2:04 PM, LVN 6 was observed sitting at the nurse's station 1 wearing N95 mask under the chin during an ongoing influenza outbreak in the facility. LVN 6 the importance of wearing the N95 properly was for infection control (measures taken to prevent or stops the spread of infections in the healthcare settings). LVN 6 further stated, We have several residents who are on transmission-based precautions (TBP - used when patients already have confirmed or suspected infections), they have the flu, the mask is to help the staff minimize transmission of the infection. LVN 6 further stated the potential risks for residents when staff do not wear the N95 mask inappropriately, was the risk of spreading infection and making the residents sicker.</p> <p>During an observation of CNA 4 on 2/05/25 at 2:10 PM, CNA 4 was observed sitting on a high stool on the second floor hallway wearing N95 mask under CNA 4's chin during an ongoing influenza outbreak in the facility. CNA was observed moving the N95 mask from the chin to the face covering both the nose and mouth. CNA 4 stated the importance of wearing the N95 properly was to make sure we control the spread of infection. CNA 4 stated the potential risk of wearing the N95 mask inappropriately was to continue to spread of infection and the residents who are already sick may get sicker and other residents that are not sick, may get sick.</p> <p>During an interview with Infection Prevention (IP) nurse on 2/05/2025 at 3:55 PM, IP stated N95 masks are to be worn where the nose and mouth are completely covered to ensure transmission of infection is prevented. The IP nurse stated, when staff do not wear their N95 mask appropriately, there might be greater spread of infection causing residents to get sick or sicker</p> <p>During an interview with the DON on 2/06/2025 at 4:44 PM, DON stated, all staff are expected to wear their N95 masks when they are in areas frequented by residents. DON also added residents may get sick and contract influenza when N95 masks are worn under their chin.</p> <p>During a review of the facility's P&P titled Competency of Nursing Staff dated 11/1/2024, the P&P indicated competency in skills and techniques necessary to care for residents' needs includes .infection control (measures taken to prevent or stops the spread of infections in the healthcare settings). The P&P further indicated facility and resident-specific competency evaluations will include demonstrated ability to use tools, devices, or equipment used to care for residents.</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>46843</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe homelike environment by not equipping corridors with firmly secured handrails on each side.</p> <p>This deficient practice had the potential to result in a fall causing injury to a resident using the unsafe railing.</p> <p>Findings:</p> <p>During an observation on 2/4/2025 at 1:44 pm the hallway railing on the third floor was broken at the metal area that is attached to the wall making the railing unstable for resident use. The rail was not attached securely to the wall and had the possibility of braking away from the wall if pressure is applied to the unsecured railing.</p> <p>During an interview on 2/4/2025 at 1:46 pm, the Maintenance Supervisor (MS) stated he was not aware of the railing being lose from the wall in this area of the third floor in the hallway. The MS stated no one informed him and he did not see it during his initial assessment. The MS stated he will get it fixed immediately. The MS confirmed and stated that it was the facility's responsibility to provide a safe and homelike environment for the residents.</p> <p>During an interview on 2/5/25 at 10:52 am the Administrator (ADM) confirmed and stated the damage to the railing on the third-floor hallway was a potential safety hazard and someone could fall.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Homelike Environment - Quality of Life, dated 11/21/2024, the P&P indicated,</p> <p>Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. 4. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment.</p>