STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 50387 Based on observation, interview, and record review, the facility failed to ensure the protection and promotion of resident rights for two of two sampled residents (Resident 22 and Resident 89) by: a. Not providing eye level positioning while assisting Resident 89 with eating. b. Not ensuring privacy curtain was closed exposing Resident 22's left buttock . These deficient practices resulted in residents not being treated with dignity and respect, and not receiving care in a manner that promotes quality of life. Findings: a. During a review of Resident 89's Admission Record, the Admission Record indicated, the facility admitted Resident 89 on 7/22/2016 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental health condition where a person experiences symptoms of both schizophrenia [a chronic mental illness that causes a break with reality] and a mood disorder) and iron deficiency anemia (a condition where the body does not have enough iron to produce healthy red blood cells). During a review of Resident 89's Minimum Data Set (MDS- a resident assessment tool), dated 3/20/2025, the MDS indicated, Resident 89's cognitive (to think, pay attention, process information, and remember things) skills for daily decision making were moderately impaired. The MDS indicated, Resident 89 required moderate assistance (helper does less than half the effort to complete the task) with eating. During a review of Resident 89's Order Summary Report, orders as of 5/6/2025, the Order Summary Report indicated a diet order dated 4/26/2024 of no added salt (NAS- avoid adding salt to food when cooking or while eating) for Resident 89. During a review of Resident 89's care plan for self-care deficit, revised on 7/24/2023, the care plan indicated that staff should assist with meals as needed. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/6/2025 at 12:26 p.m., in the main dining room, Certified Nurse Assistant (CNA) 3 was assisting Resident 89 to eat lunch. CNA 3 was standing on the right side of Resident 89 who was seated. CNA 3's eye level remained higher than the resident's eye level. CNA 3 confirmed that he did not sit next to the resident while feeding the resident. During an interview on 5/8/2025 at 12:08 p.m., with the director of nursing (DON), the DON stated that providing eye level positioning is important while assisting them with eating for the resident's dignified experience. During a review of the facility's policy and procedure (P&P) titled, assistance with meals, revised 7/2017, the P&P indicated, residents who cannot feed themselves will be fed with attention to safety, comfort and dignity for example: not standing over residents while assisting them with meals. b. During a review of Resident 22's Face Sheet (admission record), the Face Sheet indicated the facility admitted Resident 22 on 5/13/1999 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and muscle weakness. During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 had severe cognitive impairment (never/rarely made decisions), had unclear speech, rarely/never makes herself understood and was dependent (helper does all the effort) on the staff for eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting on side of bed, and chair/bed to chair transfer. During a concurrent observation and interview on 5/5/2025 at 2:22 p.m. in Resident 22's room, Resident 22 was awake lying partially on her back, on the right side of the bed. Resident 22 was unable to verbally answer questions or follow commands. Certified Nursing Assistant (CNA) 4 entered the room and uncovered Resident 22 without pulling privacy curtain closed and with the door wide open. Resident 22 had incontinent pad (adult diaper) partially pulled down with left buttock exposed. CNA 4 stated, I should have closed the privacy curtain for resident's dignity and privacy, I always do but did not this time and should have. During an interview on 5/8/2025 at 12:16 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, providing privacy was important while a resident's body was exposed to maintain dignity. During an interview on 5/8/2025 at 12:25p.m. with the Director of Nursing (DON), the DON stated, a resident's dignity would be compromised if privacy was not provided while a resident's body was exposed. During a review of the facility's policy and procedure(P&P) titled, Quality of Life-Dignity dated August 2009, the P&P indicated, Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-worth. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote, maintain and protect resident privacy, including bodily privacy .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 51310 Based on interview and record review, the facility failed to obtain a completed psychotropic medication (drugs that are used to treat a variety of mental health conditions) consent (a document that legally and ethically records an individual's agreement to participate in a specific treatment, ensuring they understand the potential risks and benefits involved) for one of six sampled residents (Resident 119). This failure had the potential for escalation of symptoms due to delay or failure initiating needed treatment due to lack of consent and can lead to worsening psychiatric (relating to mental illness) symptoms. Findings: During an interview on 5/5/25 at 12:38 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated psychotropic medication consents need the name of the resident, medication, dosage, route and signed by the doctor. During an interview on 5/5/25 at 12:40 p.m. with LVN 2, LVN 2 stated psychotropic medication consents need to have the resident name, medication, dose, route, and frequency. During an interview on 5/8/25 at 11:03 a.m. with Registered Nurse (RN) 1, RN 1 stated the responsible party should be informed of the medication including the name, dose, and the frequency. During a review of Resident 119's record, titled Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 119 on 11/22/2021 with a diagnoses of gastrostomy tube (g-tube - a surgically placed tube that provides direct access to the stomach for feeding, hydration, or medication administration, often used when someone has difficulty swallowing or cannot meet their nutritional needs orally), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 119's record, titled Minimum Data set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated the resident's cognition was severely impaired and was dependent on staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of the Resident 119's record, titled Physician Order's, dated 4/29/25, the Physician Order's indicated, Zyprexa Zydis (medication used to treat mental health conditions) 5mg via gastric tube once a day and Zyprexa Zydis 15mg via g-tube once an evening. During a review of Resident 119's record, titled Medication Administration Record (MAR - document that tracks all medications administered to a patient), dated 5/1/25 thrpugh 5/31/25, the MAR indicated Zyprexa Zydis 5 milligrams (mg- unit of measure) via g-tube has been given daily in the morning and Zyprexa Zydis 15 mg via g-tube given daily in the evening. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 119's record, titled Facility Verification of Resident Informed Consent (document that indicates the health care provider educated a resident or responsible party about the risks, benefits, and alternatives of a medication that affect the mind or brain), dated 1/3/25, the consent indicated, Zyprexa Zydis to be given for schizoaffective disorder was missing the dosage and frequency. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, undated, the P&P indicated, The following material information should be presented to the resident by the physician prior to obtaining an informed consent: B. The nature of the procedure to be used in the proposed treatment including their probable frequency and duration.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51310 Based on observation, interviews, record review, the facility failed to ensure the call light was within reach for one of six sampled residents (Resident 94). This failure had the potential for increased risk of falls, delayed response to emergencies, and unmet basic needs of Resident 94. Findings: During a concurrent observation and interview on 5/5/25 at 9:27 a.m. with Activities Aide (AA) 1, in Resident 94's room, Resident 94 was asleep in bed with the call light on the floor behind the dresser. AA 1 stated the call light was not within reach but should have been within reach. During an interview on 5/5/25 at 11:08 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the call light should be within reach. LVN 1 stated if call light is not within reach it can lead to falls. During an interview on 5/6/25 at 9:54 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the call light should be in resident's reach. CNA 1 stated anything can happen like falls if needs are not met . During an interview on 5/8/25 at 1:35 p.m. with the Director of Nursing (DON), the DON stated the call light should be on the pillowcase within the resident's reach. The DON stated the residents can roll out of bed and fall if they cannot reach the call light. During a review of Resident 94's record, titled Face Sheet (Admission record), dated 2/14/24, the Face Sheet indicated Resident 94 was admitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities), difficulty walking, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), cerebral vascular accident (CVA - stroke, loss of blood flow to a part of the brain). During a review of Resident 94's record, titled Minimum Data Sheet (MDS - a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 94's cognitive skills for daily decision making is severely impaired and requires partial or moderate assistance with personal hygiene. During a review of Resident 94's records, titled Care Plan (CP), dated 3/17/25, the CP indicated, Ensure call light is within easy reach. During a review of the facility's policy and procedure (P&P) titled, Call Lights, undated, the P&P indicated, Ensure that all residents (even those who are confused) have access to the call signal at all times and know how to use it.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview, and record review, the facility failed to implement less restrictive restraints (to limit, restrict, or keep under control) before the use of a Geri-chair (a specialized large, padded chair with wheeled base to enable transport, designed to recline and to assist residents with limited mobility) with a lap tray (a detachable tray that attaches to most chairs) and provide ongoing monitoring for the continued use of the restraint to keep one of two sampled residents from falling (Resident 134). This deficient practice had the potential to place Resident 134 at risk for decline in physical functioning, and potential for unwanted behaviors when there was no monitoring for continued use of the lap tray. Findings: During a review of Resident 134's Admission Record, the Admission Record indicated Resident 134 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), and convulsions (involuntary, violent shaking or twitching of the body, often accompanied by loss of consciousness). During a review of Resident 134's History and Physical (H/P), dated 6/8/2024, the H/P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 134's Minimum Data Set ([MDS], a resident assessment tool), dated 3/20/2025, the MDS indicated Resident 134 was severely impaired in cognitive (thinking process) skills for daily decision making and required maximal assistance (helper does more than half the effort) on self-care abilities with eating, required moderate assistance (helper does less than half the effort to complete the task) with upper body dressing, and was dependent (helper does all of the effort) with oral hygiene, personal hygiene, toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 134 required maximal assistance with mobility with rolling left and right, sitting to lying position, lying to sitting on side of bed, sitting to stand position, bed to chair transfers, and shower transfers. During a review of Resident 134's Physician Order Report, dated 5/1/2025 to 5/31/2025, the Physician Order Report indicated Geri-chair with lap tray that was ordered on 6/6/2024. During a review of Resident 134's Resident Care Plan, no date, the Resident Care Plan indicated Resident 134 required a Geri-chair with a lap tray with goals that Resident 134 would not develop any complications due to the use of Geri-chair with lap tray daily and the next three months with the plan to assess resident for the use of Geri-chair with lap tray, monitor and maintain vigilance while resident is up in Geri-chair with lap tray, assess for possible restraint use discontinuation. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 134's Physical Restraint Assessment for the Initial Restraint Order, dated 6/6/2024, the Physical Restraint Assessment indicated non-restrictive alternatives can be attempted at first and that the current interventions were effective. During an observation on 5/5/2025 at 11:53 a.m., with Resident 134 in the dining room, Resident 134 was sitting in a Geri-chair with a tray table on his lap. Resident 134 could not tell surveyor what the tray table was on his lap that was attached to the Geri-chair. The Certified Nursing Assistant (CNA) 10 (the action of a person feeding another person who cannot otherwise feed themselves) sitting near Resident 134 stated Resident 134 sits in a Geri-chair with a lap tray so he does not fall trying to get up. During a concurrent interview and record review on 5/7/2025 at 3:34 p.m., with Registered Nurse (RN) 1, Resident 134's physical restraint assessment dated [DATE] was reviewed. RN 1 stated a restraint was anything that may restrict movement such as side rails, lap tray, and non-self-release lap band. RN 1 stated the Geri-chair with lap tray was considered a restraint and that there were no interventions started that were less restrictive for Resident 134 before the Geri-chair with lap tray was implemented. RN 1 stated there was no monitoring done for Resident 134 with lap tray. RN 1 stated staff are monitoring residents on the non-self-release lap band (a safety device that secures a person in a chair to prevent falls or other accidents, but the person cannot easily release the belt themselves) restraints but not monitoring residents with lap trays. RN 1 stated there was no care plan developed of interventions for reducing or eventually discontinuing the use of the lap-tray restraint for Resident 134. RN 1 stated if staff are not monitoring the use of the lap tray, residents can get restless and can feel trapped when they can't move the restraint away. During an interview on 5/8/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated a restraint was anything that prevents residents from getting up out of bed and/or removing any medical devices. The DON stated a physical restraint can be a lap tray, a non-self-release lap band, or mittens. The DON stated the lap tray was considered at the higher end of physical restraints because residents cannot remove the lap tray themselves. The DON stated that she was not aware of any less restrictive interventions done for Resident 134 before the lap tray was introduced. The DON stated restraints restrict resident's movement and should not be used unless there was a medical necessity and documentation for that necessity. During a review of the facility's policy and procedure (P/P) titled, Use of Restraints, revised April 2017, indicated, restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully .restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls 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 physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body 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 .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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to accurately complete the minimum data set (MDS - a resident assessment tool) assessment Section I (active diagnoses), dated 3/10/25, by failing to include a diagnosis of schizophrenia (a mental illness characterized by hearing or seeing things that are not there) per information in the medical record for one of five residents sampled for unnecessary medications (Resident 92.) This deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Resident 92 may not have received care planning and treatment according to his needs possibly leading to a decline in his overall health and well-being. Findings: During a review of Resident 92's Admission Record (a record containing diagnostic and demographic resident information), dated 5/7/25, indicated he was admitted to the facility on [DATE] with diagnoses including schizophrenia. During a review of Resident 92's History and Physical (H&P - a record of a comprehensive physician's assessment) dated 3/8/25, indicated he had fluctuating capacity to understand and make decisions. During a review of Resident 92's psychiatric note (a medical progress assessment written by a psychiatric care provider) dated 12/20/24, indicated Resident 92's primary psychiatric diagnosis is schizophrenia with known behaviors confabulation - believing he is an Olympic athlete and multimillionaire when he is not and uncontrollable yelling at staff and peers. During a review of Resident 92's Order Summary Report (a summary of all current physician orders), for May 2025, indicated Resident 26's attending physician prescribed Zyprexa (a medication used to treat schizophrenia) 10 milligrams (mg - a unit of measure for mass) by mouth daily for schizophrenia on 8/11/23. During a review of Resident 92's MDS assessment Section I, dated 3/10/25, indicated he did not have an active diagnosis of schizophrenia. During an interview on 5/7/25 at 10:04 AM with the Director of Nursing (DON), the DON stated Resident 92's MDS assessment dated [DATE] Section I is inaccurate as it is missing the diagnosis of schizophrenia as it is reflected on the psychiatric progress note dated 12/20/24. The DON stated this was likely an oversight by the MDS coordinator who completed the assessment. The DON stated the MDS assessments are crucial to creating accurate care plans to address residents' individual needs. The DON stated Resident 92's inaccurate MDS assessment could have led to a care plan that did not address his specific diagnosis of schizophrenia or other related needs possibly resulting in a diminished quality of life. During a review of the facility's policy Resident Assessments, revised October 2023, indicated .Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy MDS - Accuracy Assessments, indicated The assessment must accurately reflect the resident's status . The MDS is a standardized assessment tool used to collect data about residents' health, functional capacity, and needs. F641 focuses on ensuring that this data is accurate and reflects the resident's current status.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview, and record review, the facility failed to complete the Preadmission Screening and Resident Review (PASARR - resident screening to ensure those with severe mental illness or intellectual disability are receiving services according to their needs) Level 1 for one of three sampled residents (Resident 40) pre admission or soon there after. This deficient practice had the potential to result in an inappropriate placement and delay of the residents' needed services. Findings: During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing), hypertension ([HTN], high blood pressure). During a review of Resident 40's History and Physical (H/P), dated 3/4/2025, the H/P indicated Resident 40 had confusion and could not make medical decisions. During a review of Resident 40's Minimum Data Set ([MDS], a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 40 was rarely/never understood. Resident 40 required moderate assistance (helper does less than half the effort) on self-care abilities with eating, oral hygiene, and upper body dressing, was supervision assistance (helper provides verbal cues as resident completes the activity) with toileting hygiene, was maximal assistance (helper does more than half the effort) with shower/bathe self, lower body dressing, and putting on/taking off footwear, and was dependent (helper does all of the effort) with personal hygiene. The MDS also indicated Resident 40 required supervision assistance with rolling left and right and walking 10 feet ([ft], a unit of measurement), required moderate assistance with sit to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, and toilet transfers and was maximal assistance with shower transfers. The MDS also indicated Resident 40 had psychiatric diagnosis of schizophrenia and was taking an antipsychotic and antidepressant medication. During a review of Resident 40's Physician Order Report, dated 5/1/2025 to 5/31/2025, the physician order report indicated Clozaril (Clozapine, medication primarily used to treat schizophrenia in patients who haven't responded to other treatments) tablet (pill) 400 milligram ([mg], a unit of measurement) one tablet for schizophrenia manifested by auditory hallucination (experiencing sounds, voices, or noises that are not actually present) at bedtime at 9:00 p.m. ordered on 4/19/2025. During a review of Resident 40's Preadmission Screening and Resident Review (PASARR) Level 1 Screening, dated 5/8/2025 (completed on the same date of the record review), the PASARR Level 1 Screening indicated Resident 40 was positive for serious mental illness but negative for intellectual disability/developmental disability/related condition and Level 2 screening needed to be done. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 11:17 a.m., with the Social Service Director (SSD), Resident 40's medical record was reviewed. The SSD stated a PASARR Level 1 should have been completed when Resident 40 was admitted to the facility. During an interview on 5/8/2025 at 2:37 p.m. with Director of Nursing (DON), the DON stated PASARR Level 1 screening should be done before residents are admitted to the facility and will not admit residents who do not have PASARR Level 1 done. The DON stated the importance of PASARR Level 1 to be completed so the residents are being placed in the correct facility for the right level of care. The DON stated if PASARR Level 1 was not done or updated if there was a change in condition to the residents, the staff would not know how to care for the residents with a new mental illness diagnosis and the care plan would not reflect the residents. During a review of the facility's policy and procedure (P/P) titled, Preadmission Screening and Resident Review, dated July 1, 2023, indicated, preadmission screening and resident review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that Medicaid-certified nursing facilities: 1. evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID) . 2. offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings).3. provide all applicants with the services they need in those settings.

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Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 46537 49573 Based on observation, interview, and record review, the facility failed to develop and implement person centered care plans ((a document that outlines a resident's care needs, diagnosis, and treatment goals) for five out of five sampled residents (Resident 95,120,396, 93 and 5), by failing to: A.Implement care plan interventions for elopement risk for Resident 95. B.Implement a comprehensive care plan for Resident 120 who had a diagnosis of post-traumatic stress disorder ([PTSD], a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). C. Develop a baseline smoking care plan for Resident 93, Resident 396, and Resident 5 who smoke. These deficient practices had the potential for the residents' care needs not to be addressed and the lack of ability to identify the residents' ongoing needs. Findings: During a review of Resident 95's Admission Record, the Admission Record indicated, Resident 95 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), alcohol dependence, and heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 95's History and Physical (H&P), dated 9/26/2024, the H&P indicated, Resident 95 did not have capacity (ability) to understand and make decisions. During a review of Resident 95's Minimum Data Set ([MDS]-a resident assessment tool), dated 3/27/2024, the MDS indicated Resident 95 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for eating, toileting hygiene, dressing, bed mobility, transfer, and walking. The MDS section E (Behavior) indicated, Resident 95 had hallucination (perceptual experiences in the absence of real external sensory stimuli). The MDS section E indicated, Resident 95 had wandering (to move around or go to different places usually without having a particular purpose or direction) behavior that occurred daily. During an interview on 5/5/2025, at 11:27 a.m., with Resident 95 in the activity room, Resident 95 stated, he wanted to leave the facility, and he would escape the facility if the staff did not let him leave. Resident 95 stated, he could walk without assistance and would have no problem leaving. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/6/2025, at 2:24 p.m., with Licensed Vocational Nurse (LVN) 6, Resident 95's Elopement Risk Assessment (ERA), dated 9/11/2024 and 3/10/2025 were reviewed. The ERA dated 9/11/2024 indicated, Resident 95 was at risk for elopement. The ERA dated 9/11/2024 indicated, Resident verbally expressed the desire to leave the facility, had a history of wandering/eloping. The ERA dated 3/10/2025 indicated, Resident 95 was at risk for elopement and verbally expressed the desire to leave the facility. The ERA dated 3/10/2025 indicated, Resident 95 wandered without a sense of purpose. LVN 6 stated, Resident 95 should have been considered a high risk for elopement per the assessments and should have been monitored frequently. During a concurrent interview and record review on 5/6/2025, at 2:30 p.m., with LVN 6, Resident 95's untitled Resident Care Plan (RCP), revised 3/2025 was reviewed. The RCP concerns indicated, Resident 95 was at risk for elopement due to the history of wandering and verbalizing desire to leave the facility. The RCP Approach Plan (Interventions) indicated, provides constant monitoring of whereabouts. LVN 6 stated Resident 95 was not on the list for hourly rounds, and she did not know the reason why. LVN 6 stated, Resident 95 should be on the list for hourly monitoring rounds to prevent actual elopement as care plan indicated. LVN 6 stated, Resident 95 would be seriously injured if he eloped. LVN 6 stated, the care plan should be implemented as indicated, because it was the resident's plan of care. During a review of the facility's Hourly Rounds, dated from 4/2025 to 5/6/2025, the Hourly Rounds indicated, there was no monitoring documented for Resident 95. During an interview on 5/8/2025, at 2:16 p.m., with the Director of Nursing (DON), the DON stated, the care plan should be followed through and the interventions implemented as indicated because interventions were formulated through the Interdisciplinary Team (IDT- a group of healthcare professionals from complementary fields who work in tandem to treat a resident) meetings and assessments. The DON stated, Resident 95 was at risk for elopement and needed constant monitoring to prevent elopement as the care plan indicated. B. During a review of Resident 120's Admission Record, the Admission Record indicated Resident 120 was originally admitted on [DATE] with a re-admitted [DATE] with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), vascular dementia (a progressive state of decline in mental abilities), and PTSD. During a review of Resident 120's History and Physical (H/P), dated 9/14/2024, the H/P indicated the resident can make needs known but cannot make medical decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 120's MDS dated [DATE], the MDS indicated Resident 120 was moderately impaired in cognitive (thinking process) skills for daily decision making and required supervision assistance (helper provides verbal cues as resident completes activity) on self-care abilities with eating, toileting hygiene, required moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, personal hygiene, shower/bathe, upper and lower body dressing, and required maximal assistance (helper does more than half the effort) with putting on/taking off footwear. The MDS also indicated Resident 120 required supervision assistance with mobility with rolling left and right, sitting to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, toilet transfers and walking 10 to 150 feet (a unit of measurement) and required moderate assistance with shower transfers. The MDS also indicated Resident 120 had a mood disorder of depression and PTSD. During a review of Resident 120's physician order report, dated 5/1/2025 to 5/31/2025, the physician order report indicated trazadone (a medication used in the management and treatment of major depressive disorder) tablet (pill) 50 milligram ([mg], a unit of measurement of mass) one tablet for insomnia manifested by inability to sleep at bedtime at 9:00 p.m. ordered on 9/29/2024. The physician order report also indicated escitalopram oxalate (a medication primarily used to treat depression and generalized anxiety disorder) tablet 10 mg half a tab for 5 mg for depression manifested by depressed mood once a day at 9:00 a.m. ordered on 9/25/2023. During a review of Resident 120's undated comprehensive care plan, the comprehensive care plan did not have PTSD as a concern or problem with no goals and interventions in place. During a concurrent interview and record review on 5/7/2025 at 3:52 p.m., with Registered Nurse (RN) 1, Resident 120's Admission Record and comprehensive care plan were reviewed. RN 1 stated she was not aware that Resident 120 had PTSD and that there was no care plan for PTSD in his plan of care. RN 1 stated the importance of having a comprehensive care plan was that it was how staff would provide appropriate care for residents. RN 1 stated a care plan was a plan of care for residents and there should have been the care plan for Resident 120 's diagnosis of PTSD. RN 1 stated if there was no care plan for PTSD, the facility staff would not know how to care for the residents appropriately. During an interview on 5/8/2025 at 2:17 p.m. with the DON, the DON stated a care plan was a guideline on how to care for residents. The DON stated there was no care plan for PTSD but there should have been one for Resident 120. The DON stated the care plan should have been respectful to the residents and how to not re-trigger the residents that will cause more stress for the residents. The DON stated if there was no care plan in place for PTSD, the facility staff would not know how to care with residents with trauma and can re-trigger the trauma and cause more stress to the residents. During a review of the facility's policy and procedures (P/P) titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated 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 care planning process will: a. Facilitate resident and/or representative involvement; b. Include an assessment of the resident's strengths and needs; and c. Incorporate the residents' personal and cultural preferences in developing the goals of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled, Care of a Resident with PTSD, no date, indicated The Interdisciplinary Team (IDT, a structured gathering of healthcare professionals from different disciplines to discuss a patient's care and treatment plan) will: identify known triggers or stressors (e.g., loud noises, isolation, physical touch), develop specific interventions such as redirection, soft communication, and routine-building, coordinate with the resident, family, or legal representative to align with the resident's preferences. During a review of the facility's P/P titled Trauma-Informed Care Policy, no date, indicated during the admission process and care planning, staff will assess for any known history of trauma, if trauma is identified, it will be documented in the care plan with appropriate interventions . the interdisciplinary team will create a person-centered care plan that: reflects the resident's past experiences, avoids known emotional or environmental triggers, and includes supportive interventions to promote comfort and trust. C1. During a review of Resident 93's Admission Record, the Admission Record indicated the facility originally admitted Resident 93 on 1/24/2019 with diagnoses including schizophrenia, unspecified (a disorder that affects a person's ability to think, feel, and behave), chronic obstructive disease (an ongoing lung condition caused by damage to the lungs) , unspecified and bronchopneumonia (a lung infection, that affects the airways in the lung). During a review of Resident 93's MDS, dated [DATE], the MDS indicated the resident's cognition (ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 93 required supervision or touching assistance (helper provides verbal cues and or touching/ steadying and or contact guard assistance as resident completes the activity) with Oral hygiene, toilet hygiene, upper and lower body dressing. During a review of Resident 93's Smoking Safety Evaluation (SSE), dated 4/24/2025, the SSE indicated Resident 93 continued to partake in supervised smoke breaks up to three times a day following safe smoking guidelines. C2. During a review of Resident 396's Admission Record, the Admission Record indicated the facility originally admitted Resident 396 on 11/14/2022 with diagnoses including psychotic disturbance (a state when a person experience a break from reality characterized by having abnormal thoughts), hyperlipidemia (increased fat in the blood), unspecified and acute kidney failure (when the kidneys suddenly cant filter waste from the blood). During a review of Resident 396's MDS, dated [DATE], the MDS indicated the resident's cognition was moderately impaired. The MDS indicated Resident 396 required supervision or touching assistance (helper provides verbal cues and or touching/ steadying and or contact guard assistance as resident completes the activity) with eating, oral hygiene, toilet hygiene, and upper and lower body dressing. During a review of Resident 396's Smoking Safety Evaluation (SSE), dated 4/24/2025, the SSE indicated Resident 396 attends supervised smoke break up to three times daily following safe smoking guidelines. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 5/8/2025 at 10:55 a.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated I do the care plans for the residents who smoke . The MDSC stated it is important to have a care plan because there are some residents who have impaired cognitive function and nursing staff need to have the interventions to follow to care for them. During an interview on 5/8/2025 at 11:00 a.m., with the DON , the DON stated every smoker should have a care plan so there would be a plan of action and staff will know the safety rules and policies for a safe smoker. C3.During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted Resident 5 initially on 3/26/2013 and readmitted Resident 5 on 1/3/2025, with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and residents), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), tardive dyskinesia (a movement disorder characterized by involuntary, abnormal, and repetitive movements, often affecting the face, limbs, and other body parts) and pneumonitis (inflammation of the lungs). During a record review of Resident 5's H&P, dated 4/8/2025, the H&P indicated, Resident 5 did not have the capacity (ability) to understand and make decisions. During a record review of Residents 5's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/25, the MDS indicated Resident 5's cognitive (ability to think, remember, and reason) skills for daily decision making were moderately impaired (poor decision making requiring cues and supervision). During a record review of the facility's Smokers List, Resident 5 was not identified as being a smoker. During an interview on 5/6/2025 at 12:55 p.m. with the Activities Director (AD), the AD stated every resident who smoked was required to have a care plane initiated and updated as needed. The AD stated every resident who smoked needed to be added to the smoking list after the care plan had been initiated. The AD stated having a smoking car was important to be able to know the residents' capabilities, limitations and needs while smoking. During an observation in the smoking patio on 5/6/2025 at 1:02 p.m., Resident 5 was observed sitting in a wheelchair smoking. During a concurrent interview and record review on 5/7/2025 at 10:29 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated a care plan was very important because the care plans tells the staff how to take care of a resident. LVN 3 stated a smoking care plan could not be found in the Resident 5's medical record (chart). LVN 3 stated all care plans were located in residents' charts and no where else. During an interview on 5/8/2025 at 1:35 p.m. with the Director of Nursing (DON), the DON stated care plans were important because care plans give directions on how to care for a resident. The DON stated residents who smoked or want to start smoking should always have a care plan initiated and revised as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, 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. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated, Policy Statement: 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. Policy Interpretation and Implementation: The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Assessment and the Care Delivery Process, revised 12/2016, the P&P indicated, Policy Statement: Comprehensive assessments will be conducted to assist in developing person-centered care plans. Policy Interpretation and Implementation: 1. Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to provide treatments and services to improve, prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) to one of eight sampled residents (Resident 109) who was identified as having ROM limitations in the right hand, right wrist, and left ankle. This deficient practice had the potential to cause Resident 109 to have a decline in ROM leading to contractures (loss of motion of a joint associated with stiffness and joint deformity) and have a decline in physical functioning such as the ability to eat, dress, and walk. Findings: During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including muscle weakness, chronic fracture (broken bone) and osteomyelitis (bone infection) of the left tibia (one of the bones of the leg that connects the knee to the ankle joint) and left fibula (smaller of the two bones of the lower part of the leg between the knee and the ankle), and contracture of the right wrist. During a review of Resident 109's Minimum Data Set (MDS, - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 109 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 109 required supervision or touching assistance for rolling to both sides and sit to stand transfers, partial/moderate assistance for eating, oral hygiene, toilet hygiene, dressing, and walking, and substantial/maximal assistance for bathing and personal hygiene. The MDS indicated Resident 109 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand). During a review of Resident 109's Annual Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 3/27/2025, the JMA indicated Resident 109 had severe (zero to 25 percent available ROM) ROM limitations in the right wrist and right hand/fingers, minimal (75 to 100 percent available ROM) ROM limitations in the left hip and left knee, and moderate/severe (25 to 50% available ROM) in the left ankle. The Problem Summary indicated no changes in ROM and indicated Resident 109 had right hand, fingers, and wrist contractures. During a review of Resident 109's Physician Order Report, the Physician's Order Report indicated a physician's order, dated 2/4/2025, for the Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) to apply a hand roll (rolled up towel) to Resident 109's right arm for up to five hours, seven times a week. During an observation on 5/5/2025 at 11:04 am, in Resident 109's room, Resident 109 was lying in bed. Resident 109's right arm was positioned with the elbow bent, the wrist bent full downwards, and the hand in a fist with a thin towel roll placed in the palm of Resident 109's hand. Resident 109 actively moved the right wrist upwards minimally and was unable to move the fingers. Resident 109 moved the left ankle upwards and downwards minimally and stated the left ankle felt sore and stiff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of an RNA session and interview on 5/7/2025 at 9:08 am, Resident 109 was lying in bed. Restorative Nursing Aide 1 (RNA 1) assisted Resident 109 into a sitting position, walked Resident 109 to the bathroom holding onto both of Resident 109's hands, opened Resident 109's hand and fingers, and cleaned Resident 109's right hand with soap and water. Resident 109's right wrist was fully bent downwards, the fingers were bent, and the thumb was resting against the pointer finger and hyperextended (the extension of a body part beyond its normal limits) at the middle joint. RNA 1 rolled up a small washcloth and placed it in Resident 109's hand. RNA 1 stated she only assisted with Resident 109's hand hygiene and application of a hand roll to keep the right hand open because there were no RNA orders for ROM of the arms and/or legs. RNA 1 stated Resident 109 would benefit from ROM exercises, particularly to the right arm because Resident 109 had contractures of the right wrist and right hand. RNA 1 stated she told the unit manager in the past that Resident 109 would benefit from ROM exercises to the right arm but was unsure what happened and why it was never ordered. During an interview on 5/7/2025 at 9:59 am, Licensed Vocational Nurse 4 (LVN 4) stated she was one of facility's unit managers. LVN 4 stated RNA must report any changes, refusals, and need for any modifications of the RNA program to one of the unit managers who in turn would notify the physician and consult therapy services who would reassess the resident and modify the RNA order as needed. LVN 4 stated Resident 109 had contractures of the right hand and right wrist. LVN 4 stated she was never informed by RNA that Resident 109 would have benefitted from ROM exercises. LVN 4 stated Resident 109 should be receiving services for ROM to prevent ROM decline since she had contractures and ROM limitations. During a concurrent interview and record review on 5/7/2025 at 2:47 pm, the Minimum Data Set Coordinator (MDSC) reviewed Resident 109's clinical record. The MDSC confirmed Resident 109 was identified as having ROM limitations of the right arm on the MDS, dated [DATE]. The MDSC confirmed Resident 109 was identified as having ROM limitations of the right wrist, right hand/fingers, and left leg on the JMA, dated 3/27/2025. The MDSC confirmed there were no interventions in place to improve and/or prevent a decline in ROM of Resident 109's right arm and left leg. The MDSC stated Resident 109 should have received skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant) or RNA to address Resident 109's limited ROM and contractures but did not. The MDSC stated if residents who had ROM limitations did not receive the appropriate services to improve or maintain ROM, it could lead to contracture development. During an interview on 5/8/2025 at 1:27 pm, the Director of Nursing (DON) stated residents who had ROM limitations and/or contractures should receive RNA and/or therapy services to improve or maintain ROM while in the facility. The DON stated if residents who required treatment and services to improve or maintain ROM did not receive them, it could result in contracture development and ROM decline. During a review of the facility's Policy and Procedure (P/P) titled, Resident Mobility and ROM, revised 7/2017, the P/P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive the treatment and services to increase and/or prevent a further decrease in ROM. The P/P indicated the care plan would include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to monitor and document hourly rounds to prevent elopement (an unauthorized departure of a patient from an around-the-clock care setting without the facility's knowledge and supervision) for one of three sampled residents (Resident 95) who was at risk for elopement. This failure had the potential to result in Resident 95 potentially eloping the facility and being put at risk for accidental injury or death. Findings: During a review of Resident 95's Admission Record, the Admission Record indicated, Resident 95 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), alcohol dependence, and heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 95's History and Physical (H&P), dated 9/26/2024, the H&P indicated, Resident 95 did not have capacity (ability) to understand and make decisions. During a review of Resident 95's Minimum Data Set ([MDS]-a resident assessment tool), dated 3/27/2024, the MDS indicated Resident 95 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for eating, toileting hygiene, dressing, bed mobility, transfer, and walking. The MDS indicated, Resident 95 had hallucination (perceptual experiences in the absence of real external sensory stimuli and had wandering (to move around or go to different places usually without having a particular purpose or direction) behavior that occurred daily. During an interview on 5/5/2025, at 11:27 a.m., with Resident 95 in the activity room, Resident 95 stated he wanted to leave the facility, and he would escape the facility because he could walk without assistance and would have no problem leaving. During a concurrent interview and record review on 5/6/2025, at 2:24 p.m., with Licensed Vocational Nurse (LVN) 6, Resident 95's Elopement Risk Assessment (ERA), dated 9/11/2024 and 3/10/2025 were reviewed The ERA dated 9/11/2024 indicated, Resident verbally expressed the desire to leave the facility, had a history of wandering/eloping. The ERA dated 3/10/2025 indicated, Resident 95 was at risk for elopement and verbally expressed the desire to leave the facility. LVN 6 stated, Resident 95 should have been considered as a high risk for elopement per assessment and should have monitored frequently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/6/2025, at 2:30 p.m., with LVN 6, Resident 95's Untitled Resident Care Plan (RCP), revised 3/2025 was reviewed. The RCP concerns indicated, Resident 95 was at risk for elopement due to the history of wandering and verbalizing desire to leave the facility. The RCP Approach Plan (Interventions) indicated, provides constant monitoring of whereabouts. LVN 6 stated, Resident 95 was not on the list for hourly rounds, and she did not know the reason why. LVN 6 stated, Resident 95 should be on the list for hourly rounds to prevent actual elopement. LVN 6 stated, Resident 95 would be seriously injured if he eloped due to lack of monitoring. LVN 6 stated, the care plan should be implemented . During an interview on 5/8/2025, at 10:49 a.m., with Director of Staff Development (DSD), DSD stated, all care plan interventions should be followed and implemented as indicated. DSD stated, Resident 95's care plan indicated constant monitoring for safety. DSD stated, if Resident 95 was not monitored, he might be eloped and get injured. During an interview on 5/8/2025, at 2:16 p.m., with Director of Nursing (DON), DON stated, the care plan should be followed through and implement the interventions as indicated because interventions were formulated through Interdisciplinary Team (IDT- a group of healthcare professionals from complementary fields who work in tandem to treat a resident) and assessment. DON stated, resident who was at risk for elopement needed constant monitoring to prevent elopement. During a review of the facility's Hourly Rounds, dated from 4/2025 to 5/6/2025, the Hourly Rounds indicated, there was no monitoring documented for Resident 95. During a review of the facility's Policy and Procedure (P&P) titled, Wandering, Unsafe Resident, revised 8/2014, the P&P indicated, Policy Interpretation and Implementation: 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 49)'s nasal cannula was labeled with a date to ensure it was changed timely. This failure had the potential to place Resident 49 at risk of infections and health complications due to use of the same nasal cannula for an unknown prolonged period of time Findings: During a review of Resident 31's Admission Record, the Admission Record indicated, the facility admitted Resident 31 on 2/18/2018 and readmitted on [DATE] with diagnoses including acute respiratory failure (your lungs are struggling to get enough oxygen into your blood or to remove enough carbon dioxide, leading to serious problems with your body's functions) and Chronic Obstructive Pulmonary Disease (COPD-a lung disease that makes it difficult to breath). During a review of Resident31's Minimum Date Set (MDS-a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 31's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 31 was dependent (helper does all of the effort) with toileting hygiene, showering, required maximal assistance (helper does more than half the effort to complete task) with oral hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear, personal hygiene and moderate (helper does less than half the effort to complete the task) assistance with eating. During a review of Resident 31's Physician Order Report, orders as of 5/5/2025, the Order Summary Report indicated there was an order on 3/26/2025 to place oxygen at 2-3liters per minute (LPM-a unit that expresses flow rate) via (through) nasal cannula (a simple, comfortable device used to deliver extra oxygen to people who need it) for shortness of breathing as needed. During an observation on 5/5/2025 at 10:56 a.m., in Resident 31's room, the resident was observed receiving oxygen 2LPM though a nasal cannula. There was no date (indicating when the nasal cannula was replaced) marked on the nasal cannula. During a concurrent observation and interview on 5/5/2025 at 12:47 p.m., with Licensed Vocational Nurse (LVN) 2, in Resident 31's room, LVN 2 assessed Resident 31's nasal cannula and stated that there was no date marked on it, and he could not tell when it was changed. LVN 2 stated that he did not assess Resident 31's oxygen care that morning due to lack of time. LVN 2 also stated that checking and dating nasal cannula is important to prevent the spread of infection. LVN 2 stated he was not sure how often the tubing should be changed. LVN 2 stated that overused nasal cannulas can allow bacteria to grow, increasing the risk of infection for Resident 31. During an interview on 5/8/2025 at 12:08 p.m. with the Director of Nursing (DON), the DON stated that dating on a nasal cannula while in use was important, staff should replace undated nasal cannular with a new one for the infection control, when not done properly and overusing nasal cannular without dating on it is a substandard of practice. (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 5/8/2025 at 3:04 p.m. with the administrator, the administrator stated that the facility needed to develop a policy to give staff guidance about indicating the start of use date on nasal cannulas, and when the nasal cannula should be changed. During a review of the facility's policy and procedure (P&P) titled, Respiratory Care, on 5/8/2025 at 12:34 p.m. , Medical Record stated that they do not have P&P regarding the dating on a nasal cannula.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 120), who was diagnosed with post-traumatic stress disorder ([PTSD], a mental health condition that can develop after someone experiences or witnesses a traumatic event), received trauma informed care (a model that aims to provide effective mental health services by taking into account a person's past experiences with trauma). This deficient practice had the potential to result in Resident 120's re-traumatization and can be detrimental for the resident's psychosocial well being. Findings: During a review of Resident 120's Admission Record, the Admission Record indicated Resident 120 was originally admitted on [DATE] with a re-admitted [DATE] with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and PTSD. During a review of Resident 120's History and Physical (H/P), dated 9/14/2024, the H/P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 120's Minimum Data Set ([MDS], a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 120 was moderately impaired in cognitive (thinking process) skills for daily decision making and required supervision assistance (helper provides verbal cues as resident completes activity) on self-care abilities with eating, toileting hygiene, required moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, personal hygiene, shower/bathe, upper and lower body dressing, and required maximal assistance (helper does more than half the effort) with putting on/taking off footwear. The MDS also indicated Resident 120 required supervision assistance with mobility with rolling left and right, sitting to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, toilet transfers and walking 10 to 150 feet and required moderate assistance with shower transfers. The MDS also indicated Resident 120 had a mood disorder of depression and PTSD. During a concurrent interview with record review on 5/7/2025 at 3:52 p.m., with Registered Nurse (RN) 1, RN 1 stated she was not aware that Resident 120 had PTSD. RN 1 stated the facility did not provide any specific type of care or services for residents with PTSD. RN 1 stated if staff are not providing trauma informed care, it can affect the residents and make the residents fall deeper into their mood disorder. RN 1 stated it can cause more stress to the residents by not addressing the problems or issues the residents have. During an interview on 5/8/2025 at 2:26 p.m., with Director of Nursing (DON), the DON stated the importance of providing trauma informed care was to make sure the residents are being care for appropriately and the staff caring for them prevent the residents from going through more stress. DON stated if staff are not providing safe, trauma informed care, staff can re-trigger the resident's trauma which can cause more harm to the residents. (continued on next page)

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F 0699 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 of a Resident with PTSD, no date, indicated to ensure residents with Post-Traumatic Stress Disorder (PTSD) receive safe, person-centered care that reduces the risk of emotional distress and supports overall well-being upon admission and during quarterly reviews, residents will be assessed for behavioral health history, including PTSD .any known or suspected PTSD diagnoses will be documented in the medical record and care plan. During a review of the facility's P/P titled, Trauma-Informed Care Policy, no dated, indicated to ensure that all residents at this facility who are survivors of trauma receive trauma-informed, person-centered care that promotes dignity, safety, and emotional well-being .this facility will provide care that recognizes and responds to the effects of trauma. Residents who have experienced past trauma will receive services in a way that avoids re-traumatization and supports their emotional and psychological health staff will promote a care environment that is: safe and predictable, supportive of emotional needs, respectful of resident boundaries, preferences, and choices.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39085 Based on interview and record review, the facility failed to ensure staff were in-serviced (educated) for post-traumatic stress disorder ([PTSD], a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) and trauma informed care for one of three sampled residents (Resident 120) who had a diagnosis of PTSD. This deficient practice had the potential to negatively affect all residents that reside in the facility with diagnosis of PTSD due to staff not being aware of and how to care for the residents with PTSD. Findings: During a review of Resident 120's Admission Record, the Admission Record indicated Resident 120 was originally admitted on [DATE] with a re-admitted [DATE] with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and PTSD. During a review of Resident 120's History and Physical (H/P), dated 9/14/2024, the H/P indicated the resident could make needs known but could not make medical decisions. During a review of Resident 120's Minimum Data Set ([MDS], a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 120 was moderately impaired in cognitive (thinking process) skills for daily decision making and required supervision assistance (helper provides verbal cues as resident completes activity) on self-care abilities with eating, toileting hygiene, required moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, personal hygiene, shower/bathe, upper and lower body dressing, and required maximal assistance (helper does more than half the effort) with putting on/taking off footwear. The MDS also indicated Resident 120 required supervision assistance with mobility with rolling left and right, sitting to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, toilet transfers and walking 10 to 150 feet and required moderate assistance with shower transfers. The MDS also indicated Resident 120 had a mood disorder of depression and PTSD. During a review of the facility's In-Service Topics Binder for facility staff, dated 2024 and 2025, the In-Service Topics Binder indicated there was no in-service for PTSD or Trauma Informed Care for facility staff for the year 2024 and 2025. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/7/2025 at 3:52 p.m., with Registered Nurse (RN) 1, the in-service topic binder for 2024 and 2025 was reviewed. RN 1 stated no in-service for PTSD and trauma informed care was done for staffing. RN 1 stated staff have not been provided with training on how to care for residents with PTSD, and/or trauma informed care. RN 1 stated if staff are not providing trauma informed care for residents, it can affect the residents and make the residents fall deeper into their mood disorder. RN 1 stated it can cause more stress to the residents by not addressing the problems or issues the residents have. During an interview on 5/8/2025 at 2:45 p.m. with the Director of Nursing (DON), the DON stated the facility did not provide in-service for staff for PTSD and/or trauma informed care. The DON stated the importance of staff being in-service for PTSD and trauma informed care was to help staff not trigger residents and cause the residents more stress. The DON stated residents may go through stress from the trauma that may be triggered because residents who have PTSD are more sensitive and need certain care and services. During a review of the facility's policy and procedure (P/P) titled, Competency of Nursing Staff, revised May 2019, indicated, all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law .In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: participate in a facility-specific, competency-based staff development and training program; and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care . the following factors are considered in the creation of the competency-based staff development and training program: an evaluation of the current program to ensure basic nursing competencies; any gaps in education or training that may be contributing to poor outcomes; specialized skills or training needed based on the resident population; a method to track, assess, plan, implement and evaluate the effectiveness of training; and a method to evaluate critical thinking skills and management of care in complex environments with multiple interruptions. During a review of the facility's P/P titled Trauma Informed Care Policy, no date, indicated, staff will receive annual training on trauma-informed care, including: how trauma may affect behavior or communication, how to respond in a supportive and respectful way, how to identify and reduce possible triggers.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Two medication errors out of 26 total opportunities contributed to an overall medication error rate of 7.69 % affecting one of four residents observed for medication administration (Resident 21.) The medication errors noted were as follows: 1. Attempted early administration of multivitamin (a vitamin supplement) 2. Attempted early administration of vitamin D (a vitamin supplement) These deficient practices of failing to administer medications in accordance with the physician's orders increased the risk that Resident 21 may have experienced medical complications possibly resulting in hospitalization . Findings: During a review of Resident 21's Admission Record (a document containing diagnostic and demographic information), dated 5/7/25, indicated he was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a mental illness characterized by seeing or hearing things that are not there.) During a review of Resident 21's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 5/1/24, indicated he had fluctuating capacity to understand and make decisions. During a review of Resident 21's Order Summary Report (a monthly summary report of all active physician orders), for May 2025, indicated Resident 21's attending physician prescribed the multivitamin and vitamin D 1000 IU to be given by mouth once daily at 12:00 PM. During an observation of medication administration on 5/6/25 at 8:27 AM with the Licensed Vocational Nurse (LVN 7), LVN 7 was observed preparing the following medications for Resident 25: 1. One multivitamin tablet 2. One tablet of vitamin D 1000 International Units (IU - a dosage unit for vitamins) During an observation on 5/6/25 AM at 8:31 AM, LVN 7 was observed offering the multivitamin and vitamin D tablets to Resident 21. Resident 21 was observed refusing the medications and stated he was not supposed to receive those until later. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 10:19 AM with LVN 7, LVN 7 stated the multi-vitamin and vitamin D for Resident 21 were scheduled to be given at 12:00 PM. LVN 7 stated she made a mistake by offering them to Resident 21 today at 8:30 AM. LVN 7 stated the earliest they could be offered would be 11 AM as it is one hour before the scheduled time in the physician's order. LVN 7 stated it is important to give medications at the time they are scheduled to ensure the residents do not experience any complications due to medications being dosed irregularly. LVN 7 stated that giving certain medications too closely together or too far apart could cause medical complications possibly leading to a decline in quality of life or hospitalization . During a review of the facility's undated policy Medication Administration, indicated Medication and treatments shall be administered only as prescribed . Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review the facility failed to: 1. Label one opened vial of Humulin R (a type of insulin used to control blood sugar) with an open date affecting Resident 6 in one of three inspected medication carts (Station A Medication Cart.) 2. Remove one expired vial of Humulin R opened on [DATE] from the medication cart affecting Resident 104 in one of three inspected medication carts (Station A Medication Cart.) These deficient practices of failing to store or label medications per the manufacturers' requirements increased the risk that Residents 6 and 104 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 11:45 AM of Station A Medication Cart with the Licensed Vocational Nurse (LVN 1), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One opened vial of Humulin R for Resident 6 was found without a labeled open date. According to the product labeling, Humulin R should be used or discarded within 31 days of opening or storage at room temperature. 2. One opened vial of Humulin R for Resident 104 was found labeled with an open date of [DATE]. According to the product labeling, Humulin R should be used or discarded within 31 days of opening or storage at room temperature. During a concurrent interview, LVN 1 stated the Humulin R for Resident 6 is open but not labeled with an open date. LVN 1 stated the Humulin R for Resident 4 is open and the open date reads [DATE]. LVN 1 stated Humulin R expires 31 days after opening it so labeling it with an open date once open is how staff will know when it expires. LVN 1 stated since Resident 6's Humulin R is not labeled with an open date; it is not clear when it expires and there is a risk it could be given to Resident 6 once it is expired. LVN 1 stated the Humulin R for Resident 104 has already expired and should have been removed from the cart. LVN 1 stated giving expired insulin to Residents 6 or 104 increased the risk they may experience medical complications from poor blood sugar control which could possibly lead to hospitalization . (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 record review of the facility's policy Storage of Medications, revised [DATE], indicated The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . the facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview and record review, the facility failed to follow proper sanitation and food handling practices by: 1.Failing to label open bag of pancake mix with an open date. 2.Failing to place a lid on an open container of breadcrumbs 3.Failing to close the lid on macaroni noodles and egg noodles 4.[NAME] to clean stationery can opener when it was found with a black tarry substance on it. These deficient practices had the potential to result in using pancake mix beyond its expiration date causing vulnerable residents to get sick. Pests, dust and other airborne particles that can contaminate the food items, and a potential for food contamination from the tarry substance on the can opener. During an initial observation of the kitchen on 5/5/2025 at 8:10 a.m., with the Dietary [NAME] (DC) 1 in the dry food area, on the shelf there was one bag of opened buttermilk pancake mix and no open date. On another shelf there was one large plastic container of breadcrumbs with no lid, one large container of macaroni noodles and one large container of egg noodles both with lids partially off. During an observation and interview on 5/5/2025 at 9:00 a.m., with DC 1, DC 1 stated she was in a hurry and forgot to close the macaroni and egg noodles. DC 1 stated it was important to keep lids on the dry food to prevent pests from getting in the containers and to prevent moisture . DC 1 stated she opened the buttermilk pancake mix on 5/4/2025 and should have dated it then. DC 1 stated the importance of labeling the pancake mix with an open date so other cooks can know when it was opened and when to throw out the pancake mix. During a revisit to the kitchen on 5/5/2025 at 11:30 a.m., with DC 1, DC 1 observed the stationary can opener with a black tarry substance and stated the can opener should be cleaned after use, she stated this is an infection control issue. During an interview on 5/6/2025 at 11:45 a.m., with the Dietary Supervisor (DS), the DS stated the lids are to stay closed on food items like macaroni noodles, egg noodles and breadcrumbs to prevent pests from crawling into the containers and cross contamination with open bins because residents who eat food from the kitchen could get sick. The DS stated when opening pancake mix the bag must be dated immediately so everyone will know when it was opened, she stated everything must be labeled and dated. The DS stated the Can opener must be cleaned daily for infection control . During a review of the facility's undated policy titled Labeling and Dating Food Policy , undated indicates all food items must be clearly dated with: (continued on next page)

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Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date of preparation or opening During a review of the facility's policy revised July 2014, titled Food Receiving and Storage indicates food services, or other designated staff, will maintain clean food storage areas at all times.

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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** 44055 Based on interview and record review the facility failed to ensure two of five sampled residents' (Resident 91 and 96) pneumococcal vaccination (medication that helps protect against serious illnesses like pneumonia [lung infection]) status was documented in Resident 91 and 96's medical records. This deficient practice had the potential to result in inaccurate depiction of resident health status. Findings: During a review of Resident 91's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 91 was admitted to the facility on [DATE], with the diagnoses including dementia (a progressive state of decline in mental abilities) and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 91's Minimum Data Set (MDS), a resident assessment tool, dated 2/21/2025, the MDS indicated Resident 91's cognition was severely impaired and the MDS indicated Resident 91 needed substantial assistance (helper does more than half the effort to complete the task) when eating and was dependent (helper does all the effort) on staff with oral hygiene, toileting hygiene, showering, dressing, and personal hygiene. During a review of Resident 96's face sheet, the face sheet indicated Resident 96 was admitted to the facility on [DATE], with the diagnoses including dementia and hypertension (high blood pressure). During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96's cognition was severely impaired and the MDS indicated Resident 96 needed supervision (verbal cues) when eating, partial assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, and substantial assistance with showering and personal hygiene. During a review of Resident 91 and 96's medical records, Resident 91 and 96's pneumococcal vaccination status was not in the medical records. During an interview with the Infection Prevention Nurse (IPN) on 5/07/2025 10:20 a.m., the IPN stated Resident 91 and 96's pneumococcal vaccination status was not documented in the medical records. During an interview with the Director of Nursing (DON) on 5/8/2025 at 2:17 p.m., the DON stated medical records need to be accurate and complete. During a record review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, the P&P indicated documentation in the medical record will be objective, complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation. interview and record review, the facility failed to implement infection control measures by failing to: A. Ensure implementing Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) for Resident 54 who had gastrostomy tube (G-tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placed. B. Implement the water management plan (comprehensive plan aimed at preventing waterborne illnesses by controlling germs in the water). C. Implement EBP interventions when Licensed Vocational Nurse 1 (LVN) 1 provided direct care for Resident 119. D. Perform hand hygiene between Resident care for Resident 77, Resident 90 and Resident 137. E. Ensure Maintenance/ Laundry ML staff (ML) did not let clean sheets touching the floor while folding them. F. Ensure ML used PPE (PPE- specialized clothing or gear worn to minimize exposure and prevent the spread of germs) when handling dirty linen. G. Ensure ML did not take off and place his personal hat on a shelf next to the clean linen H. Implement EBP for Resident 22 who had G-tube placed. I. Implement contact isolation precautions for Resident 31's entire room while the resident was being treated for scabetic rashes (skin rashes caused by tiny mites called scabies mites). These failures had the potential to result in compromised infection control measures to prevent the potential spread of infection among residents, staff, and visitors. Findings: A. During a review of Resident 54's Admission Record, the Admission Record indicated, Resident 54 was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), dysphagia (difficulty swallowing) with G-tube placement, sepsis (a life-threatening blood infection), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 54's History and Physical (H&P), dated 5/11/2024, the H&P indicated, Resident 54 did not have the capacity (ability) to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 54 required maximal assistance (Helper does more than half the effort) from one staff for bed mobility, transfer, dependent assistance (Helper does all of the effort) from two or more staff for eating, hygiene, and dressing. During a concurrent observation and interview on 5/6/2025, at 3:14 p.m., with Licensed Vocational Nurse (LVN) 8 in Resident 54's room, there was no EBP signage placed and there was no isolation cart. LVN 8 stated, Resident 54 had G-tube, but she did not know what EBP was. LVN 8 stated, she had never received in-service for EBP. During an interview on 5/8/2025, at 10:29 a.m., with Infection Preventionist Nurse (IPN), IPN stated, she did not provide any in-service regarding EBP to nursing staff. IPN stated, she would start in-service and order the EBP signage as soon as possible. IPN stated, Resident 54 had G-tube that was an indwelling device (a device that is left inside the body) and was required to have EBP. IPN stated, implementing EBP was important to prevent spreading of infection and protect vulnerable residents. During a review of the facility's Policy and Procedures (P&P) titled, Infection Prevention: Enhanced Barrier Precautions (EBP) Policy Regulatory Reference, dated 2022, the P&P indicated, Purpose: To reduce the transmission of multidrug-resistant organisms (MDROs) at ICC by using Enhanced Barrier Precautions (EBP) for high-risk residents during specific care activities. Policy: ICC will implement Enhanced Barrier Precautions for residents who are either: o Colonized or infected with a MDRO (e.g., MRSA, ESBL, CRE), OR o At high risk for MDRO colonization, including residents with wounds, indwelling devices (e.g., catheters, feeding tubes), or those recently hospitalized . When EBP Is Required: EBP applies during high-contact care activities, such as: oWound care, o Device care (e.g., central line, urinary catheter), oShowering or bathing, oAssistance with toileting, Dressing changes, Transferring or repositioning the resident in bed. Precautions Used: During these activities, staff must wear: Gloves, Gown (disposable or reusable). Implementation Steps: 1.Resident list: The Infection Preventionist (IP) or DON will maintain an up-to-date list of residents requiring EBP. 2. Signage: Clear, respectful signage (e.g., Enhanced Barrier Precautions in Place) will be posted inside the room or curtain area. 3. PPE Supplies: Gloves and gowns will be stocked and accessible outside each applicable resident room. 4. Staff Training: All staff will be trained on when and how to use EBP, with annual refreshers and ongoing audit B. During an interview on 5/7/2025 at 10:45 a.m. with the Maintenance Director (MD)1, MD 1 stated the facility did not have any logs indicating water management plan was implemented. MD 1 stated he only checked water for chlorine (chemical element). During an interview on 5/07/2025 at 2:30 p.m. with the administrator (admin), the admin stated the facility's water management program has not been implemented and there were no logs indicating water quality was checked weekly and that the plan was implemented. During a review of the facility's Water management Plan and Legionella Prevention Program, dated 4/11/2023, the plan indicated the facility would monitor water systems for Legionella bacteria through regular testing and keep detailed records of testing results and maintenance activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. During a review of Resident 119's Admission Record, the Admission Record indicated the facility admitted Resident 119 on 11/22/2021 with diagnoses of gastrostomy tube (g-tube - a surgically placed tube that provides direct access to the stomach for feeding, hydration, or medication administration, often used when someone has difficulty swallowing or cannot meet their nutritional needs orally), and dysphagia (difficulty swallowing). During an observation on 5/6/2025 at 10:54 a.m. in Resident 119's room, Licensed Vocational Nurse 1 (LVN 1) did not put on a gown while administering a g-tube feeding for Resident 119. During an interview on 5/6/2025 at 3:14 p.m., with LVN 1, LVN 1 stated, facility staff did not practice EBP at the facility. During an interview on 5/6/2025 at 3:52 p.m., with the Infection Preventionist (IPN - healthcare professional who works to prevent the spread of infections in the healthcare setting), the IPN stated that staff had not been educated yet on EBP but should be following EBP in the facility. D.During a review of Resident 77's Admission Record, the Admission Record indicated the facility originally admitted Resident 77 on 11/18/2013 with a diagnosis including essential (primary) hypertension (high blood Pressure), acute respiratory disease (when lung swelling causes fluid to build up in the lungs), and schizophrenia (a disorder that affects a persons ability to think, feel, and behave). During a review of Resident 77's MDS a resident assessment tool, dated 5/7/2025, the MDS indicated the resident's cognition was severely impaired. The MDS indicated Resident 77 required partial moderate assistance (helper lifts, hold, or supports trunk or limbs, but provides less than half the effort) in sit to stand and tub/ shower transfer. During a review of Resident 90's Admission Record, the Admission Record indicated the facility originally admitted Resident 90 on 7/29/2019 with a diagnosis including essential (primary) hypertension (high blood Pressure), hyperlipidemia, unspecified (elevate levels of fat in the blood without a specific underlying cause), and type 2 diabetes mellitus (elevated sugar in the blood) without complications. During a review of Resident 90's MDS, dated [DATE], the MDS indicated the resident's cognition was moderately impaired. The MDS indicated Resident 90 requires supervision or touching assistance (helper provides verbal cues and or touching/ steadying and or contact guard assistance as resident completes the activity) with sit to stand, lying to sitting on the side of the bed and chair/bed-to-transfer. During a review of Resident 137's Admission Record, the Admission Record indicated the facility originally admitted Resident 137 on 2/21/2024 with a diagnosis including essential hypertension, siogren syndrome, unspecified (a condition where your eyes and mouth are dry), and seizures (a disruption of normal brain activity that cause changes in behavior, movements or feelings). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 137's MDS dated [DATE], the MDS indicated the resident's cognition was moderately impaired. The MDS indicated Resident 137 requires supervision or touching assistance (helper provides verbal cues and touching/ steadying and or contact guard assistance as resident completes the activity) with sit to stand, lying to sitting on the side of the bed and chair/bed-to-transfer. During an observation on 5/5/2025 at 10:48 a.m., Certified Nurse Assistant 2 (CNA 2), while wearing isolation gloves assisted Resident 90 with putting on her socks .CNA 2 took the isolation gloves off placed the two gloves in her right hand and proceeded to resident 137's wheelchair pushing the resident into the activity room. CNA 2 left the activity room holding the isolation gloves and proceeded to push resident 77 into the activity room . CNA 2 left the activity room and placed her gloves in the trash can of resident 90's room. During an observation on 5/5/2025 at 10:48 a.m., Certified Nurse Assistant 2 (CNA 2), while wearing isolation gloves assisted Resident 90 with putting on her socks. CNA 2 took the isolation gloves off placed the two gloves in her right hand and proceeded to resident 137's wheelchair pushing the resident into the activity room. CNA 2 left the activity room holding the isolation gloves and proceeded to push resident 77 into the activity room . CNA 2 left the activity room and placed her gloves in the trash can of resident 90's room. During an interview on 5/5/2025 at 11:00 a.m., CNA 2 stated I usually use hand sanitizer when going from one resident to another, CNA 2 stated she was in a hurry to take her break and forgot to wash her hands, she stated that is how you can spread infection. During an interview on 5/8/2025 at 8:00 a.m., with LVN 4, LVN 4 stated when working between residents you must take the isolation gloves off clean your hands with hand sanitizer, before, after and in between residents to keep from transferring bacteria between Residents. During an interview on 5/8/2025 at 12:30 p.m., with the IPN, the IPN stated when putting on socks for a resident you must wear gloves and when you are finished with a resident remove the gloves, wash your hands before helping another resident. The DSD stated gloves cannot protect you 100 % from infectious organisms so you need to wash your hands also. D.During an observation on 5/6/2025 at 9:50 a.m., ML was observed holding a clean flat sheet that was touching ML's clothes. ML was observed not wearing PPE while taking dirty laundry out of a plastic bag and placing it in the washing machine. ML took off his hat and placed it on the shelf next to the clean folded sheets. During an interview on 5/6/2025 at 10:00 a.m., with ML, ML stated he was never told that laundry should not touch the floor. ML stated he did not know what PPE was and no one ever told him to wear PPE when handling dirty clothes . ML stated he did ML stated he could spread infection by placing his hat next to the clean laundry. During an interview on 5/7/2025 at 08:48 a.m., with Facility Aide (FA), FA stated when folding clothing and sheets you should never let it touch the floor the laundry becomes dirty, and you can spread germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/8/2025 at 11:a.m with the Director of Nursing (DON), the DON stated when folding sheets, the sheets should never touch the floor when this happens, it becomes dirty and must be washed again. The DON stated the linen should be away from your clothing while folding you can spread germs. The DON stated personal belongings should not be kept or mised in with the clean linen this can contaminate clean laundry and when working with dirty laundry you start with clean to dirty and PPE must be worn to prevent the spread of germs. During a review of the facility's policy and procedure (P&P) titled, Handwashing/ Hand Hygiene dated August 2019 the P&P indicated all personal shall be trained and regularly in-serviced on the importance of hand-hygiene in preventing the transmission of healthcare- associated infection. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively , soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after direct contact with residents. During a review of the facility's policy and procedure (P&P) titled, How We Keep Our Residents Safe updated June 2024, the P&P indicated availability of hand hygiene and PPE supplies at points of care. H. During a review of Resident 22's Admission Record, the Admission Record indicated the facility readmitted Resident 22 on 7/29/2024 with diagnoses including dysphagia (swallowing difficulties) and G-Tube status. During a review of Resident 22's History and Physical Examination (H&P), dated 2/8/2025, indicated, Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 22's MDS, dated [DATE], indicated Resident 22's cognitiion was severely impaired. The MDS indicated Resident 22 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 22's care plan for risk for infection at G-tube site, dated 2/28/2025, the care plan goal indicated Resident 22 would have no infection at G-tube site. During a review of Resident 22's care plan for impaired skin integrity related to tube site, dated 2/28/2025, the approach plan indicated that staff would provide good infection control during treatment. During a concurrent observation and interview on 5/6/2025 at10:50 a.m., with CNA 5 and CNA 6 at the door of Resident 22's room, CNA 5 and CNA 6 were observed wearing masks while opening the curtains around Resident 22's bed, they did not wear any other PPE such as gowns and gloves. Both staff members stated that they did not wear PPE when repositioning the residents, because there was no signage indicating the need for precautions. They stated that had there been a posted sign indicating required any precaution, they would have worn full PPE before making contact with the residents in order to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/6/2025 at 3:02 p.m., with the IPN, the IPN stated that Resident 22 had a G-tube and required EBP due to a higher risk of bacterial exposure and infection. The IPN stated that an EBP sign should have been posted both on the resident's door and inside the room to alert staff and EBP supplies should have been readily available to ensure proper implementation of precautions. During an interview on 5/8/2025 at 12:08 p.m., with the DON, the DON stated that wearing proper PPE while providing care to a resident, who is EBP for G-tube is important to prevent infections to the resident and a sign should be posted to communicate among staff. During a review of the facility's policy and procedure P&P) titled, Enhanced Barrier Precautions (EBP) Policy Regulatory Reference: CDC guidance, dated 2022, indicated that EBP should be implemented for resident who are at high risk for MDRO colonization, including residents with wounds, indwelling devices, such as feeding tubes. The P&P also stated that EBP applies during high-contact care activities, such as repositioning the resident in bed and staff must wear gloves and gown. The P&P indicated that clear, respectful signage must be posted inside the room or curtain area. I.During a review of Resident 31's Admission Record, the Admission Record indicated, the facility admitted Resident 31 on 2/18/2018 and readmitted on [DATE] with diagnoses including acute respiratory failure (your lungs are struggling to get enough oxygen into your blood or to remove enough carbon dioxide, leading to serious problems with your body's functions) and atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery). During a review of Resident31's Minimum Date Set (MDS-a resident assessment tool), dated 3/31/2025, indicated Resident 31's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 31 was dependent (helper does all of the effort) with toileting hygiene, showering, required maximal assistance (helper does more than half the effort to complete task) with oral hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear, personal hygiene and moderate (helper does less than half the effort to complete the task) assistance with eating. During the review Resident 31's telephone orders (TO), dated 4/21/2025, the TO indicated, an order to treat the resident with Elamite 5% (percent-out of 100) cream (a brand name for Permethrin cream, a medication used to treat scabies) neck down to toes at night, leave on for 12 hours then wash off in the morning and repeat same treatment in one week for prophylaxis. The TO also indicated to have the dermatology consult. During the review of Resident 31's progress notes-Dermatology, dated 5/2/2025, the progress notes indicated that Resident 31 has had rashes all over body for a few weeks and consistent with scabetic rash. During the review Resident 31's physicians' orders, dated 5/2/2025, indicated an order to treat the resident with Ivermectin (used to treat parasitic infections) 9 milligrams (mg-unit dose) orally once, repeat in one week, two does only, and contact precautions for one week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 5/6/2025 at 8:07 a.m. with LVN 5 at the door of Resident 31's room, Residents 31, 22, and 8 were observed lying in their beds in the same shared room. A contact precautions sign was posted at the door, indicating the precautions applied only to Resident 31 from 5/2/2025 to 5/9/2025. LVN 5 stated that Resident 8 typically eats meals in the dining room, including on the morning of the observation, despite sharing a room with Resident 31, who was under contact precautions. During a concurrent observation and interview on 5/6/2025 at 12:42 p.m. with Activity 2, at the door of Resident 31, 22 and 8's room, Activity 2 was observed not wearing a gown or gloves while inside the resident room and later exited the room holding a radio. Activity 2 stated that she had been sitting next to Resident 22's bed for a while as part of an activity. Activity 2 stated that there was no sign posted indicating that Resident 22 required any precautions, and that the only contact precautions sign present was for Resident 31. During an interview on 5/6/2025 at 3:02 p.m. with the IPN, the IPN stated that Eliminate is a typical medication used to treat scabies and there was an order of Eliminate treatment on 4/21/2025 for Resident 31. The IPN stated that the facility implemented contact isolation for Resident 31 on 5/2/2025, rather than placing entire room under isolation when the dermatologist ordered both contact isolation and Ivermectin for Resident 31. The IPN stated that she assumed each cubicle within the shared room was effectively separated. The IPN stated that she should have conducted a skin assessment for Resident 31's roommates first, followed by assessments for any residents and staff who had contact with Resident 31. An situation, background, assessment, and recommendation (SBAR-simple communication tool, often used in healthcare) should have been initiated, a care plan developed, and an Interdisciplinary team (IDT-a collaborative gathering where different healthcare professionals come together to discuss a patient's care plan and coordinate services) meeting held to address Resident 31's condition and prevent the spread of scabies, however, these steps were not taken, as a result, there is a potential risk of scabies spreading to others During an interview on /8/2025 at 12:08 p.m. with the DON, the DON stated that she was not familiar with scabies guidelines but referred to IPN. During a review of Los Angeles county guidelines, titled Scabies prevention and Control Guidelines for Healthcare Settings, revised July 2019, provided by IPN on 5/8/2025 at 3:50 p.m. as their referral, the guidelines indicated that a. Identify and prepare a line listing of all patients/residents who were contacts to a patient/resident with scabies or healthcare worker (HCW) with scabies during the exposure period (Appendix J). This includes patients/residents who resided on the same ward as an atypical scabies case during the exposure period, defined as six weeks prior to symptom onset, and those who were already discharged . b. Examine in-house patient/resident contacts to determine presence of signs and symptoms of scabies. c. Provide prophylactic scabicide along with written instructions for application (Appendix D), to all HCW with direct contact to a scabies case. HCW who refuse prophylactic treatment must be required to wear gowns and gloves for contact with patients/residents or fell ow HCW for 6 weeks from the date of the last potential exposure (usually 6 weeks from implementation of control measures). The guidelines also indicated, If the patient/resident was housed on more than one unit before control measures were initiated, each unit must be considered affected. The guideline's appendix I, titled Contact precautions and environmental control for patients/residents with scabies' indicated that to place patients/residents with typical scabies on contact precautions during the treatment period; 24 hours after application of 5% permethrin cream or 24 hours after last application of scabicides requiring more than one application. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	45777 46537 50387 51310

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44055 Based on interview and record review, the facility failed to provide documented evidence of all employees screening, education, offering, and current Corona virus disease, COVID-19 (contagious infectious disease), vaccination (medications used to prevent diseases usually given by injection or by mouth) status. This failure had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to COVID-19. Findings: During a concurrent interview on 5/7/2025 at 10:07 a.m. with the Infection Prevention Nurse (IPN), and record review of the facility's employee records of COVID-19 status 2024 to 2025 for physicians, consultants, and Rehabilitation Staffs' COVID-19 immunization status were unknown. There was no documented evidence that the physicians, consultants, and rehabilitation staff were screened, educated, and offered current Covid-19 vaccination. The IPN stated she did not get the physicians and consultants and Rehabilitation Staffs' Covid-19 immunization status. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Vaccination Policy, created 7/2/2022, the P&P indicated the Covid Vaccination policy applies to all employees.

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51684 Based on observation, interview and record review, the facility failed to meet the requirement of no more than four residents per room, when three of the 63 resident Rooms, which included room [ROOM NUMBER], 50, and 61, accommodated more than four residents. This failure had the potential to decrease the residents' privacy, quality of care, quality of life, and negatively affect the delivery of each of the residents' care needs and treatment. Findings: During observations of the facility from 5/5/25 through 5/8/25 there were five residents residing in room [ROOM NUMBER], six residents residing in room [ROOM NUMBER] and six residents residing in room [ROOM NUMBER]. During an interview on 5/7/2025 at 2:58 p.m. with the Administrator (ADM), the ADM stated there were no complaints from the staff or residents regarding the number of residents residing in rooms [ROOM NUMBER]. The facility will provide a waiver request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Intercommunity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 Grand Avenue Long Beach, CA 90815	

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review the facility failed to meet the requirement to provide 80 square feet (sq. ft- a unit of area measurement) per resident bedrooms. This deficient practice had the potential to result in inadequate space to provide privacy, space during daily care and access during an emergency. Findings: During a review of the facility's Client Accommodation Analysis form dated 5/5/2025, the form indicated the following rooms did not meet the requirement of 80 sq. ft per resident. The residents' rooms were as follows: room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. room [ROOM NUMBER] (3 beds) 210 sq. ft. During an interview on 5/7/2025 at 2:58 p.m. with the ADM, the ADM requested for a continuance of the previously granted waiver/variance. The facility requested to continue the room waiver for 2025. During several room observations from 5/7/2025 through 5/8/202, there were no adverse effects noted to the residents' privacy, health and safety, which could have been compromised by the size of the rooms.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 44055 Based on observation, interview and record review the facility failed to ensure 160 of 160 facility staff were educated on Enhanced barrier Precautions (EBP - involve gown and glove use during high-contact resident care activities). This deficient practice had the potential to result in increased risk of cross contamination (the physical movement or transfer of harmful germs from one person, object or place to another). Findings: During a review of Resident 119's Face Sheet, the face sheet indicated the facility originally admitted Resident 119 on 11/22/2021 with a diagnosis including gastrostomy (G-Tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status. During a review of Resident 119's Minimum Data set (MDS), a resident assessment tool, dated 3/31/2025, the MDS indicated the resident's cognition was severely impaired. The MDS indicated Resident 119 was dependent on staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an observation on 5/5/2025 at 9:55 a.m., Resident 119 was observed with a G-tube and there was no isolation signs on resident 119's door entrance and there was no PPE cart. During an interview on 5/5/2025 at 3:14 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was unaware of what EBP was and that the facility does not place residents on EBP. During an interview on 5/8/2025 at 11:30 a.m. with the Infection Prevention Nurse (IPN), the IPN stated 160 facility staff needs to be educated on EBP. During an interview with the Director of Nursing (DON) on 5/8/2025 at 2:17 p.m., the DON stated the facility needs to follow Centers for Disease Control guidance. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions the P&P indicated all staff will be trained on when and how to use EBP, with annual refreshers and ongoing audits. 45777