STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555838	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camden Postacute Care, Inc	1331 Camden Avenue Campbell, CA 95008

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 3. Review of Resident 23's admission record indicated she was admitted to the facility on [DATE] with primary diagnosis of Parkinson's disease (is a progressive movement disorder of the nervous system). During a review of Resident 23's MDS, dated [DATE], the MDS indicated her eating (the ability to use utensils to bring food and /or liquid to the mouth and swallow food and /or liquid once the meal is placed before the resident) was dependent. Review of Resident 23's nutrition assessment, dated 1/9/25, indicated, Resident 23 was on no added salt, puree texture, regular liquid consistency; one on one feeding assistance. During a dining observation on 5/12/25, at 12:11 p.m., in the dining room, Resident 23 was observed sitting alone by a table facing her lunch tray. There was no staff observed providing assistance to Resident 23 while other residents had started eating their meals and were being provided assistance. During a concurrent observation and interview on 5/12/25, at 12:15 p.m., with CNA H, in the dining room, CNA H stated Resident 23 was waiting for her daughter to come and feed her. While CNA H was explaining why Resident 23 was left behind waiting for feeding assistance, LVN I suddenly walked into the dining room and placed a spoon onto Resident 23's hand and asked to scoop food from the plate. During another meal observation on 05/14/25, at 12:01 p.m., Resident 23 was observed sitting by the dining table next to a resident that was being fed by LVN E. Resident 23 was observed with no feeding assistance provided while the other residents were assisted. Resident 23 waited about two minutes before Activity Assistant (AA) J provided assistance to the resident. During a concurrent interview with AA J, AA J stated Resident 23 would need assistance with feeding during mealtime. During an interview on 5/15/25, at 9:20 a.m., with the Social Service Director (SSD), the SSD stated all the residents should be fed at the same time during mealtime in the social dining room. During an interview on 5/16/25, at 11 a.m., with the DON, the DON confirmed that residents should be served meal at the same time in the dining room, and staff should not delay providing feeding assistance to Resident 23. (continued on next page)

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 - Few	During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated 4/2018, the P&P indicated, The facility shall provide assistance for all patients with meals in a manner that meets the individual needs of each patient. Nursing staff and /or feeding assistants will feed those patients needing full assistance upon delivery of food trays. Based on observation, interview, and record review, the facility failed to treat four of 15 sampled residents (Resident 1, Resident 18, Resident 23 and Resident 28) with dignity and respect when: 1. Housekeeping (HK) N and the dietary staff were speaking in their own language other than English in the presence of Resident 1; 2. Resident 18 and 28 urinary catheter drainage bags (a urinary catheter is a thin, flexible tube used to drain urine from the bladder) were left uncovered; and 3. Staff did not assist Resident 23 during lunch while other residents in the same dining room were already eating with staff assistance. These failures had the potential to negatively affect resident's emotional and psychosocial well-being. Findings: 1. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 3/25/25, indicated Resident 1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). During a concurrent observation and interview on 5/12/25 at 11:07 a.m., with Resident 1, she stated staff spoke in foreign language while providing care and working in the facility. Resident 1 further stated that Certified Nursing Assistants (CNA's) and HK staff were speaking with their own language other than English while providing care or when HK staff was working inside the room and in the hallway. During an initial tour of the facility on 5/12/25 at 11:07 a.m., HK N was talking to the dietary staff in the hallway in a foreign language other than English. During an interview on 5/16/25 at 9:47 a.m., with HK N, she confirmed that she was working in the facility on 5/12/25 as a janitor and she was communicating with the dietary staff in the hallway infront of Resident 1's room. HK N further stated that she should speak English while working in the facility especially when residents were present. During concurrent interview and record review on 5/15/25 at 11:38 a.m., with Registered Nurse (RN) A, she reviewed Resident 1's clinical records and stated Resident 1 was admitted to the facility on [DATE] with diagnosis including right eye blindness, left eye low vision, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (feeling of worry and fear). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. During the facility tour observation on 5/12/25 at 8:27 a.m., Resident 28 was observed with an uncovered urinary catheter drainage bag hanging from his bed. During a concurrent observation and interview on 5/12/25 at 8:28 a.m., with Resident 28, he stated that facility staff did not put cover on his urinary catheter draining bag that was hanging from his bed. During a concurrent observation and interview on 5/12/25 at 8:59 a.m., with Licensed Vocational Nurse (LVN) O, she acknowledged the above observation and stated it should have been covered with privacy blue bag. During a concurrent interview and record review on 5/16/25 at 9:20 a.m., with RN A, she reviewed Resident 28's clinical records and stated that Resident 28 was admitted to the facility on [DATE] with the diagnosis including neuro muscular dysfunction of bladder (urinary bladder problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination) and has supra pubic (a type of urinary catheter inserted into the bladder through a small incision in the lower abdomen, above the pubic bone) that attached to the urinary catheter drainage bag. She further stated that one of the care plan interventions for supra pubic catheter was to provide privacy bag for the catheter urinary bag. During an interview on 5/16/25 at 10 a.m., with the Director of Nursing (DON), the DON stated all residents with urinary catheters should have privacy bags covering the urinary catheter drainage bag. 2b. During an initial room observation on 5/12/25 at 7:54 a.m., Resident 18's indwelling catheter (a thin, flexible tube inserted into bladder [a body organ that stores urine] to drain urine out) urine collection drainage bag was anchored to his bed frame not covered with privacy bag. Review of Resident 18's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 18 was admitted to facility on 1/27/16 with diagnoses including neuromuscular dysfunction of bladder (problem with muscles controlling bladder function can lead to variety of problems including difficulty emptying the bladder). Review of Resident 18's physician order dated 10/15/24 indicated, Suprapubic Catheter Review of Resident 18's care plan for bladder elimination (voiding urine) indicated, Provide privacy bag for the catheter urinary bag. During an interview with CNA L on 5/12/25 at 8:03 a.m., CNA L confirmed Resident 18's urine collection drainage bag was not covered with privacy bag. During an interview with LVN I on 5/15/25 at 3:10 p.m., LVN I stated nursing staff should have covered Resident 18's urine collection drainage bag with privacy bag for privacy, dignity and infection control. During an interview with the facility's Director of Staff Development (DSD) on 5/15/25 at 3:18 p.m., the DSD stated nursing staff should have covered Resident 18's urine collection drainage bag with a privacy bag for privacy, dignity and infection control. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's, policy and procedure (P&P) dated 1/28, titled Quality of life - Dignity the P&P indicated, each resident shall be cared for a manner that promotes and enhances quality of life, dignity, respect and individuality Residents shall be always treated with dignity and respect . Staff shall promote dignity and assist residents as needed by : Helping the resident to keep urinary catheter bags covered.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform interdisciplinary team (IDT, staff from different departments who coordinate the residents care) assessment and obtain a physician order for self-administration of medication for two of eight sampled residents (Resident 27 and 37) when: 1. Resident 27 had over the counter (OTC, can be purchased without a prescription from medical doctor) bottle of isopropyl alcohol (used for cleaning wounds and as disinfectant) on the bedside tray table unattended; and 2. Resident 37 had a bottle of OTC hydrogen peroxide (used for cleaning wounds and as disinfectant), and a bottle folic acid (vitamin supplement) medication on the bedside table unattended. This failure had the potential for unsafe and improper administration of OTC and medication supplement for Residents 27 and 37. Findings: 1. During an observation and interview with Resident 27 on 5/12/25 at 8:20 a.m., there was a bottle of isopropyl alcohol on Resident 27's tray table that was unattended and was next to the resident. Resident 27 stated he had used the isopropyl alcohol to clean his skin everyday. Resident 27 also stated the facility did not provide the isopropyl alcohol and he had bought it himself from the store when he went outside the facility. Resident 27 further stated the facility nursing staff were aware of that he was using the isopropyl alcohol to clean his skin everyday. Review of Resident 27's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 27 was admitted to facility on 9/5/2024. Resident 27's FS also indicated diagnosis included non-pressure chronic ulcer of left foot (persistent open sore that's not caused by prolonged pressure or friction). Review of Resident 27's Minimum Data Set (MDS, clinical, and functional assessment tool) dated 3/11/25 indicated Resident 27's Brief Interview for Mental Status (BIMS) score was 15 of 15 (score of 0 to 7: severe cognitive impairment, 8 to 12: moderate cognitive impairment, and 13 to 15: intact cognition). Review of Resident 27's clinical documentation indicated there was no documented evidence of the IDT's assessment for self-administration of medication. Review of Resident 27's physician orders indicated there was no order for OTC isopropyl alcohol for self-administration. During an interview with Licensed Vocational Nurse (LVN) I on 5/12/25 at 8:26 a.m., LVN I confirmed a bottle of isopropyl alcohol OTC medication was left on Resident 27's tray table unattended. LVN I stated the medication should not be left in the room unattended for Resident 27 to self-use. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation and interview with Resident 37 on 5/12/25 at 12:35 p.m., a bottle of 1/4 full liquid of hydrogen peroxide, and a bottle of folic acid 1 milligram (mg, a unit of mass equal to a thousandth of a gram) tablets were on the tray table next to Resident 37's bed unattended. During a concurrent interview with Resident 37, he stated he was using stated the hydrogen peroxide to clean his teeth once a week and taking folic acid one tablet every day from the medication bottle. Resident 37 also stated his son brought the hydrogen peroxide and the folic acid to the facility months ago. Resident 37 further stated the facility nursing staff were aware of self-administration of both medications. Review of Resident 37's FS indicated Resident 37 was admitted to facility on 1/3/25 with the diagnoses including anemia (a condition with blood doesn't have enough healthy red blood cells). Review of Resident 37's MDS dated [DATE] indicated Resident 37's BIMS score was 15 of 15. Review of Resident 37's clinical documentation indicated IDT's assessment for self-medication administration dated 4/7/25 indicated resident request for self-medication administration of medication was documented No. Review of Resident 37's physician orders indicated there were no orders for hydrogen peroxide and folic acid for self-administration. During an interview with LVN I on 5/12/25 at 12:46 p.m., LVN I confirmed a bottle of OTC hydrogen peroxide and folic acid medications were left on Resident 37's tray table unattended. LVN I stated both medications should not be left in the room unattended for self-administration for Resident 37. During an interview with Registered Nurse (RN) A on 5/15/25 at 1:59 p.m., RN A confirmed there were no IDT assessment and physician orders for self-medication administration for Resident 27 and 37. RN A stated medications should not be at bedside unattended for both residents. Review of the facility's policy and procedure (P&P) titled, Medications storage in the facility, effective date: April 2008, the P&P indicated, For residents who self-administer medications, the following conditions are met for bedside storage to occur: 1. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required if unlocked storage is deemed inappropriate . Review of facility's P&P titled, Preparation and General Guidelines, effective date: April 2008, the P&P indicated, Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facility's interdisciplinary team. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a routine basis

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure their policy and procedure (P&P) for an advance directive (AD, a written instruction, such as a living will or durable power of attorney [a document that authorizes to act on behalf of resident] for healthcare when the individual is incapacitated) for six of 8 sampled residents (Resident 10, 13,18,19,27, and 37). This failure could lead to the delivery of unnecessary or inappropriate medical services against sampled residents' goals and wishes. Findings: Review of Resident 10's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 10 was admitted to facility on 10/24/24. Review of Resident 10's form for physician orders for life-sustaining treatment (POLST, a document that specifies the medical treatments the resident wants to receive during serious illness) form prepared on 10/29/24 indicated section D for AD documented No Advance Directive. Further review of Resident 10's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 10 to execute an AD. Review of Resident 13's FS indicated Resident 13 was admitted to facility on 7/8/24. Review of Resident 13's POLST form prepared on 7/8/24 indicated section D for AD documented No Advance Directive. Further review of Resident 13's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 13 to execute an AD. Review of Resident 18's FS indicated Resident 18 was admitted to facility on 1/27/16. Review of Resident 18's POLST form prepared on 11/21/2019 indicated section D for AD documented No Advance Directive. Further review of Resident 18's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 18 to execute an AD. Review of Resident 19's FS indicated Resident 19 was admitted to facility on 11/2/20. Review of Resident 19's POLST form prepared on 10/21/20 indicated section D for AD documented Advance Directive not available. Further review of Resident 19's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 19 to execute an AD. Review of Resident 27's FS indicated Resident 27 was admitted to facility on 9/5/24. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 27's POLST form prepared on 9/6/24 indicated section D for AD documented No Advance Directive. Further review of Resident 27's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 27 to execute an AD. Review of Resident 37's FS indicated Resident 37 was admitted to facility on 1/3/25. Review of Resident 37's POLST form prepared on 1/6/25 indicated section D for AD documented Advance Directive not available. Further review of Resident 37's clinical record indicated there was no documented evidence that the facility discussed, offered or assisted Resident 37 to execute an AD. During a concurrent record review and interview with the facility's social service director (SSD) on 5/14/25 at 1:45 p.m., the SSD reviewed POLST form for the above residents. The SSD confirmed there was no AD for the above residents. The SSD stated she did not discuss, offer or assist the residents to execute an AD. The SSD also stated she should have offered and assisted the residents to execute an AD. During a concurrent record review and interview with Registered Nurse (RN) A on 5/15/25 at 8:29 a.m., RN A reviewed POLST form for the above residents. RN A confirmed there was no AD for the above residents. RN A stated the SSD was responsible to follow up the AD for residents. RN A also stated SSD should have offered and provided assistance to execute an AD for residents. Review of facility's policy and procedure (P&P) titled, Advance Directive, release date January 2018, the P&P indicated, If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a clean and homelike environment was provided for two of 14 sampled residents (Resident 1 and Resident 25) when: 1. The privacy curtain in Resident 25's room was left sticky, had brownish dry food particles, and dirty; and 2. In Resident 1's room, the floor was sticky when walked on and Resident 1 complained that her room was not cleaned by the housekeeper daily. These failures increased the potential for Resident 1 and Resident 25 not attaining their highest practicable well-being. Findings: 1. During an initial tour of the facility on 5/12/25 at 9:01 a.m., Resident 25's privacy curtain in his room was left sticky, and had brownish dry substances. During a concurrent observation and interview on 5/12/25 at 9:02 a.m., with Licensed Vocational Nurse (LVN) O, she confirmed the above observation and stated that those brownish dry substance was food particles, sticky and dirty. She further stated that it should have been changed by the housekeeper or janitor. 2. During concurrent interview and record review on 5/15/25 at 11:38 a.m., with Registered Nurse (RN) A, she reviewed Resident 1's clinical records and stated Resident 1 was admitted to the facility on [DATE] with diagnoses including right eye blindness, left eye low vision, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (feeling of worry and fear). Resident 1's Minimum Data Set (MDS, an assessment tool) dated 3/25/25, indicated she had a BIMS (Brief Interview for Mental Status) of 15 meaning her cognition was intact and Resident 1 could walk independently using her roller walker with set up help only. During a concurrent observation and interview on 5/12/25 at 11:07 a.m. with Resident 1 in her room, the floor was sticky when walked on. Resident 1 stated housekeeping just came today to clean her room because the state surveyor was in the facility and did not mop the floor with a wet mop. Resident 1 further stated Housekeeper did not do a good job and she was not okay if the floor was still dirty and sticky. During an interview on 5/14/25 at 1:05 p.m., with the Housekeeping Supervisor (HKS), he stated that housekeeping and janitor were responsible for daily cleaning and deep cleaning of the resident's room once a month. The HKS further stated that changing of residents' privacy curtain was scheduled once a month during deep cleaning and as needed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/25 at 1:07 p.m., with the HKS, he stated that he could not provide any documentation that the residents' room were cleaned daily, and deep cleaning was done once a month because he was just doing the visual checking of each room. He further stated that he will create a Daily Room Clean sign off sheet, deep Clean Room Check list and daily clean room check list starting today 5/14/25. A policy and procedure was requested but was not provided by the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR, screening for residents with mental disorder and residents with intellectual disability) Level 1 and Level II screening was completed for two of 15 sampled residents (Resident 9 and 13). This failure had the potential for mentally ill sampled residents not to receive benefit from specialized health care and services. Findings: Review of Resident 9's admission record indicated he was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (is a mental health problem where you experience psychosis as well as mood symptoms) and major depressive disorder (is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time). Review of Resident 9's notice of PASRR Level I screening results dated 9/3/24, indicated, A serious mental illness (SMI, is characterized as any mental health condition that impairs seriously or severely from one to several significant life activities) level II mental health evaluation was required. During a further review of Resident 9's notice of attempted evaluation dated 9/3/24, indicated, Unable to complete level II evaluation for serious mental illness (SMI). Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the level I screening. The case is now closed. To open, the facility must resubmit a new level I screening. During an interview on 5/13/25, at 10:40 a.m., with Registered Nurse (RN) A who was the minimum data set (MDS, an assessment tool) nurse, RN A verified and confirmed there was no PASRR level II referral and evaluation done for Resident 9 because they forgot to follow up the notice of attempted evaluation letter to resubmit a new level I screening for Resident 9. Review of Resident 13's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 13 was admitted to facility on 7/8/24 and readmitted on [DATE]. Review of Resident 13's FS indicated Resident 13's diagnoses included delusional disorders (a serious mental illness that involves persistent false beliefs, that are not based in reality) dated 7/12/24 and schizophrenia (a serious mental illness [SMI] that interferes with affects resident's ability to think clearly, manage emotions, make decisions and relate to others) dated 8/26/24. Review of Resident 13's discharge summary notes from an acute hospital (AH, a short-term acute care provides intense medical treatment with severe illnesses, injuries, or conditions that require rapid interventions) dated 7/8/24 indicated no SMI. Review of Resident 13's discharge summary notes from the AH dated 8/26/24 indicated diagnosis of schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's Minimum Data Set (MDS, resident's clinical and functional assessment tool) assessment, dated 7/12/24, under section I for active diagnoses indicated, psychotic disorder. Review of Resident 13's MDS dated [DATE], under section I for active diagnoses indicated, schizophrenia and psychotic disorder. Review of Resident 13's PASRR Level 1 screening assessment dated [DATE] indicated no SMI. Further review of Resident 13's clinical record indicated there was no documented evidence of Level 1 PASRR screening after 7/12/24 or 8/26/24 when there was a diagnoses of SMI. During an interview with the facility's admission and Marketing Manager (AMM) on 5/14/25 at 8:32 a.m., the AMM confirmed there was no Level 1 screening completed after 7/5/24 for Resident 1. The AMM stated the admission staff was responsible for PASRR Level 1 screening. The AMM also stated the facility should have a Level 1 screening when Resident 13 was diagnosed with SMI. During an interview with RN A on 5/14/25 at 1:06 p.m., RN A confirmed Resident 13's SMI diagnoses dated 7/12/2024 and 8/26/2024 and confirmed there was no documented evidence of Level 1 screening being done. RN A stated the facility should have completed a new Level 1 PASRR for Resident 13. RN A also stated there was a potential for Resident 13 to miss receiving specialized mental health services by not completing the Level 1 PASRR screening. During telephone interview with the Medical Doctor (MD) on 5/15/25 at 1:45 p.m., the MD stated that the AH potentially did not capture Resident 13's diagnoses of schizophrenia during July 2024 stay. The MD also stated the diagnosis typically do not develop at late stages of life. The MD further stated that the resident had the diagnosis for long time. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review, dated 1/2018, the P&P indicated, It is the policy of this facility to comply with federal and state regulations regarding the Preadmission Screening and Resident Review (PASRR) process. PASRR ensures that individuals with serious mental illness (SMI), intellectual disabilities (ID: resident has difficulties with cognitive abilities of learning, reasoning, problem solving, practical and social skills), or related conditions are appropriately placed in a skilled nursing facility (SNF) and receive necessary services. If the Level I screening indicates a potential SMI . the resident must be referred for a Level II PASRR evaluation conducted by the designated state agency or contracted entity. The Admissions Coordinator must submit all required documentation to the state PASRR agency and follow up to ensure timely completion of the Level II evaluation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan with measurable objectives, goal and person-centered interventions, for one out of 15 sampled residents (Resident 5). This deficient practice had the potential to result in not meeting the residents' needs. Findings: During a concurrent interview and record review on 5/15/25 at 11:10 a.m., with Registered Nurse (RN) A, RN A reviewed Resident 5's clinical records and stated that Resident 5 was admitted to the facility on [DATE] with diagnosis including paraplegia (paralysis of the legs and lower body.), Chronic kidney disease (CKD, the gradual loss of kidney function), contracture (hardening of muscles and other tissues causing rigidity to the joints of muscle) left lower leg, contracture of muscles multiple sites, pressure ulcer left and right buttock stage 4 (most severe form of bedsore, also called a pressure sore, pressure ulcer, or decubitus ulcer and is a deep wound reaching the muscles, ligaments, or bones. They often cause extreme pain, infection, invasive surgeries, or even death.), pressure ulcer of sacral region and abnormal posture. During a concurrent interview and record review on 5/11/18 at 11:18 with RN A, RN A reviewed Resident 5's pressure ulcer care plan initiated date was 6/24/ 24 with focus problem, pressure ulcer left and right buttock stage 4, pressure ulcer of sacral region stage four, right lateral lower leg, vascular and left posterior thigh MASD (Moisture-Associated Skin Damage) were combined with the same goals and interventions. RN A stated that each pressure ulcers site should have been care planned individually with own goals and interventions to provide Resident 5 a person-centered care. RN A further stated that interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) skin meeting dated 5/1/25 indicated different measurements for each individual pressure ulcers site, change of treatments and status of the pressure ulcers site and confirmed that the pressure ulcer care plan was not individualized and person-centered care specifically for Resident 5. Facility did not provide the policy and procedure.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise the individualized and comprehensive care plans for two of 15 sampled residents (Resident 12 and Resident 40) when: 1. A care plan to address Resident 12's dementia (memory loss) was not updated and revised; and 2. A care plan to address Resident 40's end stage of renal disease (ESRD, a severe and irreversible condition where the kidneys have lost most of their function and are no longer able to adequately filter waste products from the blood) on hemodialysis (HD, is a life-saving treatment for kidney failure that removes waste and extra fluids from the blood and regulates blood pressure) was not updated and revised after increasing HD from three times per week to four times per week. These failures had the potential to result in not meeting the residents' needs. Findings: Review of Resident 12's admission record indicated he was initially admitted to the facility on [DATE] and had diagnoses including dementia with other behavioral and disturbance (loss of memory, language, problem-solving and changes in behavior and mood). Review of Resident 12's Minimum Data Set (MDS, an assessment tool), dated 4/20/25, indicated that his Brief Interview for Mental Status (BIMS) score was of 7 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition), severely impaired cognition. Review of Resident 12's care plan addressing his impaired cognitive function and dementia with initial date of 11/13/24 indicated, Ask yes/no questions in order to determine the resident's needs. Cue, resident and supervise as needed. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. During observations on 5/13/25, at 8:38 a.m. and 5/15/25, at 10:30 a.m., Resident 12 was lying in bed most of the time. He was confused and verbally responsive to express his needs. During an interview on 5/14/25, at 11:13 a.m. and 5/16/25, at 8:45 a.m., with the Social Service Director (SSD), the SSD stated Resident 12 spoke different language other than English and used to self-propel in his wheelchair in the facility with more vocal, after hospitalization Resident 12 became spending more time in bed than before. The SSD further stated Resident 12 had a personal cellphone at bedside and it was very important for him to speak with his family members over the phone to support his psychosocial well-being and the cellphone need to be fully charge on daily basis in order for resident to receive calls from his family members. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 5/16/25, at 12:05 p.m., with the Director of Nursing (DON), Resident 12's dementia care plan, dated 11/13/24 was reviewed. The dementia care plan did not include keeping Resident 12's personal cellphone fully charge at bedside and to assist him to receive calls from his family members. The DON confirmed Resident 12's dementia care plan should have been updated and revised in accordance with Resident 12's culture background and to have an individualized person-centered care plan. 2. Review of Resident 40's admission record indicated she was admitted to the facility on [DATE] and had diagnoses including ESRD and dependence on renal dialysis. During an interview on 5/12/25, at 8:40 a.m., with Resident 40, Resident 40 stated she was receiving HD four times per week through a catheter on her right upper chest, which was covered with clean, dry dressing. Review of Resident 40's ESRD HD care plan dated 5/16/23, indicated Resident 40 had HD three times per week through her right upper chest with a Perma catheter (is a type of central venous catheter used for long-term hemodialysis access). During an interview and concurrent record review on 5/16/25, at 1:45 p.m., the DON reviewed Resident 40's ESRD HD care plan, dated 5/16/23. The DON confirmed the care plan needs to be updated and revise for the HD schedule, from three times per week increasing to four times per week. The DON stated each resident's care plan needs to be reviewed and updated every three months. During a review of the facility's policy and procedure (P&P) titled, Care Plan Conference, dated 12/2016, the P&P indicated, Fundamental information at interval of every 90 days thereafter; with any subsequent completed assessments; and, when there is a change in resident status or condition. Care plans are reviewed to meet the needs and requests of the resident/ resident's family .

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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** Based on observation, interview and record review, the facility failed to ensure the safety of one of four residents (Residents 29) who smoke without oversight staff supervision. This failure had the potential to put Resident 29 at risk of harm. Findings: During a concurrent observation and interview on 5/16/25 at 10:413 a.m., Residents 29 was in the patio smoking and was not wearing a smoking apron. There was no facility staff in the patio providing supervision for Resident 29. without facility staff's supervision. Resident 29 stated facility staff was not supervising him when he was smoking except when staff provides his cigarette and light his cigarette. During a concurrent observation and interview on 5/16/25 at 10:14 a.m., with Activity Assistant (AA) J, she confirmed the above observation and stated that Resident 29 needs supervision from the facility staff while smoking for safety. During a concurrent interview and record review with Registered Nurse (RN) A, she reviewed Resident 29's clinical records and stated Resident 29 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including of muscle weakness, hemiplegia (paralysis that affects just one side) hemiparesis (weakness on half of the body) and hemiparesis (weakness on half of the body) following cerebral infarction (stroke, lack of blood flow to the brain, causes brain tissue to die) and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar (glucose). Resident 29's Smoking-Safety Screen initially dated 5/11/24 and smoking assessment dated [DATE], indicated interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) decision indicated Resident 29 can smoke with oversight supervision, safe to smoke with oversight supervision due to Resident 29's current physical function and diagnoses of gout, hemiplegia and hemiparesis following stroke. During an interview on 5/16/25 at 10:16 a.m., with the Director of Nursing (DON), the DON stated that facility staff should supervise residents who smokes during smoking schedules. The facility did not provide a policy and procedure.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During a concurrent observation and interview on 05/12/25 8:40 a.m., with Resident 5, he was lying in bed with 1/2 both siderails up and stated he was using the 1/2 both rails for his turning and repositioning. During a concurrent interview and record review on 05/14/25 at 10:57a.m., with RN A, she reviewed Resident 5's clinical records documentation and stated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 5's bed. Review of Resident 5's MDS assessment dated [DATE], indicated Resident 5's BIMS score was 15, intact cognition. Review of facility's policy and procedure (P&P) titled, Bed Rails, release date July 2017, the P&P indicated, The Interdisciplinary Team (IDT: interdisciplinary team, a group of healthcare professionals from different disciplines work together to provide and coordinate care for residents) will determine whether a resident should be provided with bed rails on his/her bed, based on individual assessment which includes the risk of entrapment. The facility must attempt to use appropriate alternatives prior to installing a side/bed rail. Assess resident for risk of entrapment from bed rail prior to installation. Review the risks and benefits of bed rails with the resident or resident representative. Prior to placing a side rail on the bed, informed consent will be obtained Based on observation, interview, and record review, the facility failed to follow their bed rails (side rails, bed rails, safety rails, grab/assist bars: adjustable metal or rigid plastic bars that attached to the bed) policy for six of 15 sampled residents (Resident 39,19,27,33,17, and 5) when: 1. There was no documentation that alternatives for side rails were attempted prior to installing bed rails; 2. There was no informed consent (IC, the process of communication between health care provider and resident that often leads to agreement or permission for care, treatment or services or interventions) from resident or responsible parties (RP, individual designated to make decisions on behalf of the residents) including risks and benefits explained prior to installing bed rails; and 3. There was no documentation that an assessment for the use of bed rails and risk for entrapment prior to installing bed rails was done. These failures resulted in the residents and RP's not being fully informed of the risks of the use of bed rails and had the potential to place the residents at risk of serious injury. Findings: During an observation on 5/12/25 at 8:10 a.m., noted Resident 39's bed had partial bed rails up on both sides. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 39's face sheet (FS, a document that gives resident's information at a quick glance) indicated Resident 39 was admitted to facility on 12/12/22. Review of Resident 39's minimum data set (MDS, resident's clinical and functional assessment tool) assessment dated [DATE] indicated Resident 39's brief interview for mental status (BIMS) score was 15 of 15 (score of 13-15: intact cognition). Review of Resident 39's clinical documentation indicated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for the use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 39's bed. During an observation on 5/12/25 at 8:11 a.m., Resident 19's bed was noted with one partial bed rail up at the foot of the bed on left side. Review of Resident 19's FS indicated Resident 19 was admitted to facility on 11/2/20. Review of Resident 19's MDS assessment dated [DATE] indicated Resident 19's BIMS score was 15 of 15, intact cognition. Review of Resident 19's clinical documentation indicated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 19's bed. During an observation on 5/12/25 at 8:20 a.m., Resident 27's bed was noted with partial bed rails up on both sides. Review of Resident 27's FS indicated Resident 27 was admitted to facility on 9/5/24. Review of Resident 27's MDS assessment dated [DATE] indicated Resident 27's BIMS score was 15 of 15, intact cognition. Review of Resident 27's clinical documentation indicated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 27's bed. During an observation on 5/12/25 at 9:08 a.m., Resident 33's bed was noted with one partial bed rail up at the head of the bed on left side. Review of Resident 33's FS indicated Resident 33 was admitted to facility on 8/14/20. Review of Resident 33's MDS assessment dated [DATE] indicated Resident 33's BIMS score was 4 of 15 (score of 0-7: severe impaired cognition). Review of Resident 33's clinical documentation indicated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 33's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/12/25 at 9:23 a.m., Resident 17's bed was noted with one partial bed rail up at the head of the bed on left side. Review of Resident 17's FS indicated Resident 17 was admitted to facility on 3/28/17. Review of Resident 17's MDS assessment dated [DATE] indicated Resident 17's BIMS score was 5 of 15, severe impaired cognition. Review of Resident 17's clinical documentation indicated there was no documented evidence for bed rail assessment, alternatives attempted, risk versus benefits explained for use of bed rails, IC taken, and risk of entrapment assessment prior to installing bed rails for Resident 17's bed. During an interview with Registered Nurse (RN) A on 5/15/25 at 8:39 a.m., RN A confirmed the above residents had bed rail/s. RN A also confirmed there was no documented evidence for bed rails assessment, attempted alternatives, risk and benefits education, informed consent taken and risk for entrapment assessment completed before using bed rails for the above residents. RN A stated facility should have documented and followed their policy for bed rails for these residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure there was sufficient direct care nursing staff to provide nursing and related care and services to meet resident's needs safely for 24 hours a day during the weekend. This failure had the potential to compromise care, health, and well-being of the 55 residents residing in the facility. Findings: Review of facility's census and direct care service hours per patient day (DHPPD) form dated 5/10/25 (Saturday) indicated actual CNA (certified nursing assistant) DHPPD was 2.13, and actual total DHPPD (including CNA and license nurses) was 3.15. Review of DHPPD form dated 5/11/25 (Sunday) indicated an actual CNA DHPPD of 1.99, and actual total DHPPD of 2.99. During concurrent record review of DHPPD forms and interview with the facility's Director of Staff Development (DSD) on 5/15/25 at 10:52 a.m., the DSD reviewed the DHPPD forms above on both days. The DSD confirmed the above DHPPD for CNA and the total for both days. The DSD stated the facility did not meet sufficient DHPPD on both days on the weekend. The DSD also stated the facility should have 2.4 CNA DHPPD, and 3.5 total DHPPD for both days to provide sufficient nursing staffing to meet all resident's care needs. During an interview with Registered Nurse (RN) A on 5/15/25, at 2:20 p.m., RN A stated facility should have provided sufficient direct care nursing staff during the weekend and provided 2.4 CNA DHPPD and 3.5 total DHPPD. Review of facility's policy and procedure (P&P) titled, Direct Healthcare Service Hours Per Patient Day, release date [DATE], the P&P indicated, the facility will employ and schedule sufficient licensed nurses and CNAs to meet or exceed the minimum required 3.5 DHPPD and 2.4 CNA DHPPD on every calendar day.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of Resident 156's admission record indicated he was admitted to the facility on [DATE] and had diagnoses including gastro esophageal reflux disease (GERD, which is a common condition in where stomach acid flows back up into the esophagus, causing a burning sensation in the chest , often called heart burn) and other chronic pain. Review of Resident 156's MRR dated 4/30/25, indicated the CP identified a medication form concern for gabapentin (medication used to control seizures [is abnormal electrical activity in your brain], to treat nerve pain)100 milligrams (mg, unit of measurement) with recommendations as pharmacy is sending capsules form, update your MAR (Medication administration record) and frequency issue for pantoprazole (medication used to treat damage from GERD) 20 mg, with recommendations as clarify frequency and update your order. However, the MRR did not have an evidence that it was reviewed by the nurse nor a signature that indicated it was reviewed. Review of Resident 156 physician's orders dated 5/13/25, indicated, Pantoprazole sodium oral tablet delayed release 20 mg (pantoprazole sodium) give 1 tablet by mouth before meals for GERD. Gabapentin Capsule 10 mg, give 1 capsule by mouth every 24 hours as needed for neuropathic pain. During an interview on 5/13/25, at 2:20 p.m., with Registered Nurse (RN) A, RN A stated Resident 156's drug regimen review with recommendations was missed and was not followed-up. During an interview on 5/16/25, at 11:05 a.m., with the DON, the DON confirmed that Resident 156's MRR with recommendations should have acted upon when the facility received the CP's recommendations for potential clinically significant medication issues identified on 4/30/25. Review of the facility's policy and procedure (P&P) titled, Consultant Pharmacist Reports, dated 6/202, the P&P indicated, The findings are phoned, faxed, or e-mailed to the director of nursing or designee and documented and stored with the other consultant pharmacist recommendations within 72 hours. Recommendations are acted upon and documented by the facility staff and or the prescriber. Based on interview and record review, the facility failed to ensure the consultant pharmacist (CP, a licensed pharmacist provides expert clinical advice and guidance on medication use) identified and reported the lack of blood work related to use of anticoagulant (AC, used to treat prevent or delays blood clots forming in blood vessels) medication to the facility during the monthly medication regimen review (MRR, a thorough evaluation of resident's medications) for one of three sampled resident (Resident 10); and the facility failed to follow up MRR recommendations for one of two sampled resident (Resident 156). These failures resulted in Resident 10 not receiving a baseline and periodical blood work, and Resident 156's medication orders not clarified. Findings: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 10 was admitted to facility on 10/24/24 with diagnoses including atrial fibrillation (A Fib, an irregular, often rapid heart rate that commonly causes poor blood flow), pulmonary embolism (blood clot in lung vessels). Review of Resident 10's physician order dated 10/24/24 indicated rivaroxaban (used to treat reduce and prevent blood clots) 20 milligrams (mg: a unit of mass equal to a thousandth of a gram) in the evening for A Fib. Further review of Resident 10's physician orders indicated there was no laboratory (lab) work ordered to monitor kidney function and blood levels since Resident 10 was admitted to facility. Review of the facility provided MRR reports for Resident 10 indicated there was no MRR related to the use of an AC medication and lack of lab work orders. Review of Resident 10's care plan for AC drug therapy dated 11/11/24 indicated intervention, Monitor lab reports, and notify physician promptly of results. During an interview with Licensed Vocational Nurse I (LVN I) on 5/16/25 at 8:56 a.m., LVN I confirmed Resident 10 receives AC medication every evening. LVN I also confirmed there were no lab work ordered for Resident 10 since admission to the facility. LVN I stated there should be a lab work order for Resident 10 due to an AC medication use. LVN I stated she will request to the MD (medical doctor) a lab work order for Resident 10. During an interview with the Director of Nursing (DON) on 5/16/25 at 9:56 a.m., the DON confirmed there was no MRR recommendation for Resident 10 to have lab work with the use of AC medication. The DON also confirmed there were no blood work orders since Resident 10 was admitted to facility. The DON stated Resident 10 should have a baseline and periodical lab orders to monitor kidney and blood levels when receiving an AC medication. During a telephone interview with the facility's CP on 5/16/25 at 9:56 a.m., the CP confirmed there was no MRR recommendation for Resident 10 to have lab work with the use of AC medication. The CP stated routine blood work was not recommended for the use of rivaroxaban. The CP also stated baseline and periodical blood work was needed to monitor kidney and blood levels when resident receives this medication. The CP further stated she should have identified the lack of blood work orders and recommended blood work orders during monthly MRR review for Resident 10. Review of facility's policy and procedure (P&P) tilted, Anticoagulation-Clinical Protocol, release date: January 2018, the P&P indicated, The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking . Review of facility's P&P titled, Consultant Pharmacist Reports, effective date: June 2021, the P&P indicated, Resident-specific irregularities and /or clinically significant risks resulting from or associated with medications are documented and reported to the Director of Nursing and/or prescriber as appropriate. Recommendations are acted upon and documented by the facility staff and or the prescriber.

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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. Based on observation, interview, and record review, the facility had a 5.56% medication error rate when two medication errors out of 36 opportunities were identified during medication pass for two residents (Resident 16 and 41). These failures had the potential to result in ineffective drug therapy and possible adverse effects for the resident. Findings: 1. During a review of Resident 16 physician's orders dated 2/21/25, it indicated, Glipizide (is used to treat high blood sugar levels) tablet 5 milligrams (mg, unit of measurement), give 0.5 tablet by mouth in the afternoon related to type two diabetes mellitus (a chronic condition that happens with persistent high blood sugar levels), 0.5 tablet =2.5 mg. give 30 minutes prior to meals. During a medication administration observation on 5/12/25, at 4:04 p.m., Registered Nurse (RN) B prepared half tablet of glipizide in a medicine cup after verifying the medication orders then administered to Resident 16 with a cup of water. 2. During a review of Resident 41's minimum data set (MDS, an assessment tool) dated 3/14/25, it indicated his Brief interview for Mental Status (BIMS, is a quick assessment used to gauge a person's cognitive functioning) score of 13 (score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). During a review of Resident 41 physician's orders dated 4/26/25, it indicated, Hydrocortisone (is used to treat a variety of inflammatory, autoimmune, and hormonal conditions) oral tablet 10 mg, give 1 tablet by mouth in the morning for low cortisol, give with food. During a medication administration observation on 5/12/25, at 4:35 p.m., Licensed Vocational Nurse (LVN) C checked Resident 41's vital signs first and then prepared two scheduled medications including one tablet of hydrocortisone 5 mg, and administered the medications to Resident 41 without food. During an interview on 5/12/25, at 4:43 p.m., with LVN C, she stated she thought Resident 41 already had snacks around 3 p.m. in the afternoon, so Resident 41 does not need to take food with hydrocortisone because Resident 41's stomach was not empty. During a concurrent interview with Resident 41 in his room, Resident 41 stated that he did not take any snacks in the afternoon between 2 p.m. to 3 p.m. During a telephone interview on 5/14/25, at 10:05 a.m., with the Consultant Pharmacist (CP), the CP confirmed glipizide would need to be given 30 minutes before meals and hydrocortisone would need to take with food to prevent gastrointestinal irritation. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines, dated 10/2017, the P&P indicated, Medications are administered in accordance with written orders of the attending physician. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label . if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.

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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. Based on observation, interview, and record review, the facility failed to ensure medications were labeled and stored accordance with currently accepted professional standards for two of 15 sampled Residents(5 and 25) when: 1. A bottle of oral liquid lorazepam (a controlled medication used to relieve anxiety [persistent worry and fear about everyday situations]) without legible expiration date was stored in the medication room for Resident 25 to be used; and 2. An unlabeled normal saline solution (NSS, 0.9% sodium chloride in water) in a bottle was found at Resident 5's bedside table unattended. These deficient practices could lead to unsafe and ineffective medication use for the residents. Findings: 1. During an observation on 5/12/25, at 7:30 a.m. to 7:50 a.m., in the medication storage room with Licensed Vocational Nurse (LVN) I, Resident 25's lorazepam medication did not have a legible expiration date. Review of Resident 25's controlled drug record indicated the last time the lorazepam medication was administered to Resident 25 was on 9/30/24. A further review of Resident 25's initial telephone order dated 9/19/24 indicated, Lorazepam oral concentrate 2 mg/ml (Lorazepam). Give 0.5 ml by mouth every 4 hours as needed for anxiety for 14 days. During an interview on 5/12/25, at 10:10 a.m. and 10:20 a.m., with Registered Nurse (RN) A, RN A stated the expiration date on lorazepam bottle was not clear and readable. RN A further stated that expiration date should be clear, able to be read, and it should have clarified with the pharmacy upon opening to be used on 9/30/24 for Resident 25. During a follow-up interview on 5/16/25, at 10:50 a.m., with the Director of Nursing (DON), the DON stated license staff should have clarified and requested a new bottle of oral liquid lorazepam with clear expiration date for Resident 25. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering And Receiving From Pharmacy -Medication Labels, dated 4/2008, the P&P indicated, Each prescription medication label includes . expiration date of medication. 2. During an initial tour of the facility on 5/12/25 at 8:54 a.m., on top of Resident 5's bedside table there was one bottle of NSS unlabelled and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent observation and interview on 5/12/25 at 8:55 a.m., with Resident 5, he stated that facility staff left the bottle of NSS for them to use for his foley catheter (F/C, a thin, flexible tube inserted into bladder [body organ, that stores urine] to drain urine) flushing (a process of cleaning of obstructions) and wound (open area) treatment. During concurrent observation and interview on 5/12/25 at 8:56 a.m., with Licensed Vocational Nurse (LVN) O, she confirmed the above observation and stated that the bottle of NSS should have been labeled and stored in the treatment cart. LVN O further stated that it should not be kept at the bedside table unattended. During a concurrent interview and record review on 5/14/25 at 10:57 a.m., with RN A, she reviewed Resident 5's clinical records and stated that the Minimum Data Set (MDS, an assessment tool) dated 3/21/25 indicated he was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). Review of facility's P&P titled, Medication storage in the facility, effective date: April 2008, the P&P indicated, All nurses and aids are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and give to unauthorized medications to the charge nurse .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen when: 1 One can of grape juice in the dry storage room was dented and was not removed to prevent use; and 2. One pack of open cereal with no date when it was opened and no expiration date; 3. Refrigerator #2 had the following: 12 pieces of tomatoes inside a plastic bag container, three pieces of carrots inside a plastic bag, four pieces of white onions inside a plastic bag, 2 bunches of lettuce inside a plastic bag and one bunch of celery inside a plastic bag were not labeled and no date when it was delivered to the facility; and 4. Freezer #2 in front of the kitchen, there was one pack of cauliflower, and one pack of chopped spinach with no opened date or expiration date. These failures had the potential to result in a foodborne illness outbreak amongst a population of 55 vulnerable residents with complex medical conditions. Findings: 1. During an initial kitchen tour on 5/12/25 at 7:48 a.m., with the Dietary Manager (DM), she confirmed one can of grape juice in the dry storage room in the other building was dented and was not removed to prevent use. According to the United States Food and Drug Administration (FDA, a federal agency) indicated, A sharp dent on either the top or side seam can damage the seam and allow bacteria to enter the can. Discard any can with a deep dent on any seam. Review of the facility undated policy and procedure (P&P), titled, Food Storage - Dented Cans, indicated, food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility .All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. 2. During an initial kitchen tour observation and interview on 5/12/25 at 7:44 a.m., with the DM, she confirmed one pack of open cereal had no date when it was opened and no expiration date and the DM stated that it should have been dated when it was opened and with expiration date. 3. During an initial kitchen tour on 5/12/25, at 7:53 a.m., with the DM, refrigerator #2 had 12 pieces of tomatoes inside a plastic bag container, three pieces of carrots inside a plastic bag, four pieces of white onions inside a plastic bag, 2 bunches of lettuce inside the plastic bag and one bunch of celery inside a plastic bag were not labeled and no date when it was delivered to the facility. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an initial kitchen tour on 5/12/25, at 7:55 a.m., with the DM, freezer #2 in front of the kitchen, there was one pack of cauliflower, and one pack of chopped spinach with no date or expiration date. Review of the facility undated P&P, titled, Labeling and Dating of Foods indicated, all food items in the storeroom, refrigerator, and freezer need to be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adhere with their infection prevention and control program to ensure proper hand hygiene and personal protective equipment (PPE, is equipment used to prevent or minimize exposure to hazards such as gown and gloves) were implemented during delivery of care to residents in the facility when: 1. Facility staff did not follow the Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, is a germ that is resistant to many antibiotics] in nursing homes) wearing personal protective equipment (PPE, is equipment used to prevent or minimize exposure to hazards such as gown and gloves) during wound dressing change to Resident 12 and during Foley catheter (F/C: a thin felxible tube inserted in to bladder [a body organ that stores urine] to drain urine) care to Resident 109; 2. Licensed Vocational Nurse (LVN) E did not perform hand hygiene in every glove changed during wound treatment observation; 3. Resident 25's unlabeled nebulizer (a medical device that delivers medication in the form of fine mist) container mouthpiece with tubing mask (plastic mask and tubing used as a connected to nebulizer) that was attached to the machine was exposed and touching the bedside table, the unlabeled yankauer suction tube (oral suctioning tool) tip catheter with tubing attached to the suction canister was stored inside the bedside drawer in an open plastic package; and 4. Facility staff did not perform hand hygiene prior to providing feeding assistance to Resident 23 during lunch time on 5/12/25. These failures had the potential to result in cross-contamination and the spread of infection between 55 residents in the facility. Findings: 1. During an initial tour observation on 5/12/25, at 7:57 and 7:59 a.m., a sign for EBP was posted on Resident 12's and 109's room door. Resident 109 was confined in bed and Resident 12 had a F/C anchored below the bladder level to the bed frame. During a review of Resident 12's admission record indicated his initial admission date was 11/4/24 and readmission date was 12/20/25. Resident 12 had diagnoses including sepsis with unspecified organism (a life-threatening condition where the body's response to infection causes damage to its own tissues and organs, and the specific causative organism is not identified), and infection and inflammatory reaction (body's response to an illness) due to indwelling urethral catheter and Methicillin-resistant Staphylococcus aureus (MRSA, is a type of staph infection that is resistant to certain antibiotics, making it harder to treat). During a review of Resident 109's admission record indicated he was admitted to the facility on [DATE] and Resident 109 had diagnoses including multiple sclerosis (a chronic neurological disorder) and with multiple pressure ulcer (bed sore, caused by prolonged pressure combined with shear) wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/15/25, at 10:50 a.m., in Resident 109's room, Certified Nursing Assistant (CNA) F assisted Licensed Vocational Nurse (LVN) E to perform wound dressing change to Resident 109's multiple wounds. Both CNA F and LVN E were observed only wearing surgical disposable facemask and gloves, both CNA F and LVN E did not wear disposable gown. During an interview on 5/15/25, at 2:10 p.m., with the Director of Staff Development (DSD), the DSD stated when providing wound care, foley care and activities of daily living (ADL, the tasks of everyday life include eating, dressing, getting into or out of a bed or chair, taking a bath or shower) care to the residents with EBP, staff must wear PPE including gown and gloves, a facemask (optional) to perform care. During an interview on 5/16/25, at 9:55 a.m., with CNA F, CNA F stated she did not wear gown during Resident 109's wound dressing change and ADL care. CNA F further stated she did not wear gown when emptying Resident 12's urine bag or ADL care. During an interview on 5/16/25, at 10:02 a.m., with LVN E, LVN E stated she did not wear gown during wound dressing change to Resident 109. LVN E further stated she also forgot wearing gown during foley care to Resident 12. LVN E confirmed she should have worn PPE during wound care and foley care to both Resident 12 and 109, because they were on EBP, and a PPE cart was placed nearby their room in the hallway. During a follow-up interview on 5/16/25, at 10 a.m., with CNA G, CNA G stated she did not wear PPE during ADL care to a resident who was on EBP because it was not required except during handling a foley catheter with urine bag. During a follow-up interview on 5/16/25, at 11:05 a.m., with the Director of Nursing (DON), the DON confirmed staff should wear PPE during wound care, foley care and ADL care to the residents who were on EBP. The DON further stated staff had received in-services regarding PPE in the past and facility staff should follow instructions to implement appropriate PPE. During a review of the centers for disease control and prevention (CDC) titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, it indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html 2. During a wound treatment observation on 5/16/25 at 11:07 with LVN E, after washing her hands and putting pair of gloves she started to prepare the treatment supplies infront of the treatment cart outside Resident 5's room then locked the treatment cart using the same pair of gloves, she picked up and threw a medication cup with wound barrier into the garbage can that was attached to the treatment cart. LVN E dropped it on the floor then she opened the treatment cart using the same pair of gloves, put wound cream inside the medication cup, locked the treatment cart, touched the key, touched Resident 5's privacy curtain, bedside table with treatment supplies on top without changing gloves or performing hand hygiene. LVN E took out the used pair of gloves from the start of the treatment preparation and changed it to a new pair of gloves without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a wound observation on 5/16/25 at 11:12 a.m., LVN E started to do the wound dressing treatment to Resident 5's different wound sites without performing hand hygiene in every change of gloves. During an interview on 5/16/25 at 11:50 a.m., with LVN E, she acknowledged the above observation and stated that she should perform hand hygiene in every change of gloves for each wound site to prevent contamination that could cause the spread of infections. Review of facility's P&P dated 2018, titled, Handwashing Hand Hygiene, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. During an initial observation tour of the facility on 5/12/25 at 8:46 a.m., Resident 25's unlabeled nebulizer container mouthpiece with tubing mask that was attached to the machine was exposed and touching the bedside table and the unlabeled yankauer suction tube tip catheter with tubing was attached to the suction canister was stored inside the bedside drawer in an open plastic package together with open wet wipes, lotion, mouth wash, paper, cardboard and an open tissue box . During a concurrent observation and interview with LVN O on 5/12/25 at 8:48 a.m., she confirmed the above observation and stated the nebulizer container mouthpiece should be stored inside the plastic bag after cleaning, label it with a date, resident's name and discard every seven days. She stated that the suction tip catheter with tubing should be stored inside the plastic bag, labeled with resident's name and store it on top of the bedside table to prevent contamination from personal items. She further stated that these are infection control issues. Review of the facility's policy and procedure (P&P) dated 1/2018, titled Departmental (Respiratory Therapy)-Prevention of Infection indicated, infection control considerations related to Medication nebulizers after completion of therapy: remove the nebulizer container, rinse the container, with fresh tap water, dry on a clean paper towel or gauze sponge, reconnect to the administration set - up when air dried, take care not to contaminate internal nebulizer tubes , wipe the mouth piece with damp paper towel or gauze sponge , store the circuit in plastic bag, marked with date and resident's name, between uses and discard the administration set-up every seven days infection control considerations related to suction machines indicated after completion of suctioning : discard single-use suction catheters immediately in appropriate waste receptacle if using reusable tubing: rinse tubing with sterile water, hang tubing to air dry in a clean, designated area or store in a clean plastic bag labeled with resident's name, ensure tubing is not in contact with the contaminated surfaces , suction tubing must be replaced at least seven days or sooner if visibly soiled and thoroughly clean and disinfect the . 4. During lunch meal observation in the dining room on 5/12/25 at 12:18 p.m., noted Certified Nursing Assistant / Activity Assistant M (CNA / AA M) was feeding Resident 30. CNA / AA M got up from the chair, went to another table to Resident 23, opened lunch plate cover, and started feeding Resident 23. CNA/AA M did not perform hand hygiene between task. During an interview with CNA / AA M on 5/12/25 at 12:24 p.m., CNA / AA M confirmed that she did not perform hand hygiene before feeding Resident 23 and after feeding Resident 30. CNA / AA M stated she should wash her hands before feeding Resident 23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 5/16/25 at 10:28 a.m., the DON stated nursing staff should perform hand hygiene in between when feeding two residents. Review of facility's P&P titled, Handwashing Hand Hygiene, release date: 2018, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. a. Before and after assisting a resident with meals

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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** Based on observation and interview, the facility failed to ensure a resident's room accommodated no more than four residents when room [ROOM NUMBER] had six beds, and six residents and room [ROOM NUMBER] had five beds and five residents. Having more than four residents per room had the potential of compromising the quality of life and quality of care the residents received. Findings: During an observation on 5/13/25 at 11:50 a.m., there were six beds and six residents in room [ROOM NUMBER] and five beds and five residents were in room [ROOM NUMBER]. Both these rooms had an adequate space for residents to move around and for the care to be given. Each resident had a bed, a privacy curtain, a nightstand, and a closet. The beds did not block any closets, bathrooms, or exits. There was no safety hazard or privacy concerns noted. During interviews with randomly selected residents, there were no quality of care issues identified concerning the size of the room and number of occupants in room [ROOM NUMBER] and 2. During an interview with Certified Nursing Assistant (CNA) K on 5/15/25 at 11:06 a.m., CNA K confirmed room [ROOM NUMBER] and room [ROOM NUMBER] had more than four residents. CNA K stated there were no concerns when providing care for residents in room [ROOM NUMBER] and room [ROOM NUMBER] with more than four residents in both rooms. During an interview with Licensed Vocational Nurse (LVN) I on 5/15/25 at 12:08 p.m., LVN I confirmed there were more than four residents in room [ROOM NUMBER] and 2. LVN I stated there were no care, privacy and safety concerns of residents in room [ROOM NUMBER] and 2. Recommend continuance of the room waiver.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555838	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camden Postacute Care, Inc	1331 Camden Avenue Campbell, CA 95008

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview and record review, the following multi-resident rooms were less than 80 square feet per resident. Findings: Room Beds Square Feet/Room Square Feet/Resident 2 2 146 73 3 2 148 74 4, 5, 6 3 225 75 7 3 222 74 8 2 156 78 9 2 144 72 10, 11, 12, 13 2 146 73 14 2 148 74 15, 16, 17, 18 2 140 70 19 3 228 76 20 3 225 75 21 3 228 76 room [ROOM NUMBER] 6 432 72 room [ROOM NUMBER] 5 323.4 64.68 During an observation, interview with staff and resident on 5/13/25 at 11:50 a.m., on 5/14/2025 at 2:10 p.m., on 5/15/2025 at 11:06 a.m., and 12:08 p.m., there were no care or privacy issues identified with the lack of space regarding the size of resident rooms. During an interview with the facility's administrator (ADMN) on 5/15/25 at 12:15 p.m., the ADMN confirmed the rooms indicated above had less than 80 square feet space per resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555838	A. Building B. Wing	05/16/2025

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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	The residents were observed in their rooms throughout the survey. The nursing care and services were not impacted by the shortage of space for residents' rooms. The closet and storage spaces were sufficient to accommodate the needs of the residents. Review of the facility's room variance reports recommend the waiver remain in place.