STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555850	A. Building B. Wing	06/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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 - 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** 45456 Based on observation, interview, and record review, the facility failed to provide a dignity bag (a bag used to cover and hold the catheter drainage/collection bag) for two (2) of three (3) sampled residents (Resident 14 and 126) who has a urinary indwelling catheter (tube inserted into the bladder to drain urine to a collection bag). This deficient practice had failed to safeguard the residents' dignity and had a potential to affect the residents' emotional and mental well-being. Findings: 1. A review of Resident 14's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 14's History and Physical (H&P), dated 6/11/2024, indicated Resident 14's diagnoses included focal seizures (also known as auras, occur in one area on one side of the brain, includes involuntary movements called automatism [like rubbing of the hands, lip-smacking, and chewing]), chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and bullous pemphigoid (a rare autoimmune disease that causes blisters or sores on your skin) A review of Resident 14's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 6/5/2024, indicated Resident 14 was comatose (in a state of deep and usually prolonged unconsciousness [unable to wake up because of illness or injury]; unable to respond to external stimuli). The MDS also indicated Resident 14 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) in oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. During an observation inside Resident 14's room on 6/29/2024 at 9:16 AM, Resident 14 was sleeping. Resident 14's Foley catheter (urinary indwelling catheter) drainage collection bag was not placed inside a dignity bag exposing resident's urine in the drainage collection bag. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 6/30/2024 at 5:43 PM, the DON stated, We do use dignity bag if the resident was sharing a room. We usually do not use it for residents in the private room, but we should use one. It should be in our policy to use it to make it clear to when to use it and not to use it. The DON stated, We should have a dignity bag if the Foley catheter bag was visible to other visitors, to respect the resident's privacy and dignity. 2. A review of Resident 126's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 126's MDS, dated [DATE], indicated Resident 126's active diagnoses included cerebral vascular accident (CVA or stroke, an interruption in the flow of blood to cells in the brain), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), and hypertension (high blood pressure). The MDS also indicated Resident 126 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 126 was dependent oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right. During an observation inside Resident 126's room on 6/28/2024, at 12:54 PM, Resident 126 had 2 visitors inside the room. Resident 126 was sleeping. Resident 126's Foley catheter bag was observed with no dignity bag. During a concurrent observation in Resident 126's room and interview with Registered Nurse 3 (RN 3) on 6/28/2024, at 1 PM, RN3 stated, The Foley catheter bag does not have a dignity bag because Resident 126 was in the private room and so that we can see her urine easily. During an observation outside Resident 126's room on 6/29/2024 at 9:20 AM, Resident 126's Foley catheter bag was observed with no dignity bag and was placed on the side of bed where it can be easily seen outside the residents room from the hallway. During an interview with the DON, on 6/29/2024 at 4:43 PM, the DON stated, Foley catheter should not be placed on the area where visitors could easily see it. The DON also stated the facility staff should have placed a dignity bag if Resident 126's Foley catheter bag was visible to other visitors, and this is important to respect the resident's privacy and dignity. A review of the facility's Policy and Procedure titled, Patient Rights and Responsibilities, dated 7/2023, indicated in order to protect the personal welfare and safeguard the dignity of a patient as a human being, the hospital and the medical staff have adopted the following patient rights and responsibilities: considerate and respectful care, and to be made comfortable. The policy also indicated have personal privacy respected and confidentiality treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview and record review, the facility failed to ensure call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one (1) of 12 sampled residents (Resident 19) as indicated in the facility's policy and procedure. This deficient practice had the potential not to meet the Resident 19's needs and preference. Findings: A review of Resident 19's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 19's History and Physical, dated 11/10/2022, indicated Resident 19's diagnoses which included anoxic encephalopathy (or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning [for example, carbon monoxide or drug overdose], vascular injury or insult, or cardiac arrest), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide) ventilator dependent (if a resident is unable to wean off a ventilator and breathe independently) and left middle cerebral artery (MCA, stroke occurs when blood flow from the MCA, one of the largest arteries of the brain, is suddenly interrupted [ischemia] or altogether stopped [infarction]) ischemic stroke. A review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 5/15/2024, indicated Resident 19 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 19 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. The MDS functional limitation in range of motion (ROM, extent of movement of a joint) for Resident 19 indicated impairment on both sides for upper and lower extremity. During a concurrent observation and interview with Resident 19 on 6/28/2024, at 12:28 PM, Resident 19's call light was observed placed next to his left arm. Resident 19 shook his head to confirm that he was not able to move his left hand. During a concurrent observation and interview with Registered Nurse 1 (RN 1) on 6/28/2024, at 12:31 PM, Resident 19 shook his head and frowned when asked by RN 1 if he can move his left hand. Resident 19 kept on moving his fingers on his right hand. RN 1 stated, Resident 19 can only use his right hand and is unable to use his left hand. RN 1 stated the call light should be placed near Resident 19's right hand. RN 1 also stated the call light is important to be within the resident's reach so the resident can call for assistance if they need help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 6/30/2024, at 5:35 PM, the DON stated, Call light should be on the resident's strong side. The purpose of the call light was to call the staff for assistance and to get to the residents right away. A review of facility's Policy and Procedure (P&P) titled, Patient Call Light System, revised 7/2022 indicated, all patient call light must be answered promptly to address patient needs, provide reassurance, and ensure a high standard of patient care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and/or resident representatives for six (6) of eight (8) sampled residents (Residents 3, 16, 21, 22, 23, and 19). This deficient practice violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to unwanted treatment with the residents' wishes regarding health care. Findings: 1. A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 2/27/2024, indicated Resident 3 had diagnoses of chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), chronic vegetative state (condition where resident has woken from a coma but still lacks awareness), and anoxic encephalopathy (a brain injury that results from a lack of oxygen to the brain tissue). A review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/27/2024, indicated Resident 3 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 3 had impairment to both upper extremity (shoulder, elbow, wrist hand) and lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 3 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands), roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 3 and the activities were not performed prior to the current illness, exacerbation, or injury. A review of Resident 3's medical record from 3/31/2023 to 6/29/2024 there was no Advance Directive in Resident 3's chart or electronic medical record. 2. A review of Resident 16's Admission Record indicated Resident 16 was admitted to the facility on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's H&P, dated 9/13/2023, indicated Resident 16 had diagnoses of respiratory failure, tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), and ventilator (a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs). A review of Resident 16's MDS, dated [DATE], indicated Resident 16 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 16 had impairment to both upper and lower extremities. The MDS indicated Resident 16 was dependent for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 16 and the activities were not performed prior to the current illness, exacerbation, or injury. A review of Resident 16's medical record from 9/11/2023 to 6/29/2024 there was no documented evidence of Advance Directive information for Resident 16. 3. A review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE]. A review of Resident 21's H&P, dated 4/23/2024, indicated Resident 21 had diagnoses of chronic respiratory failure ventilator dependent (when resident is unable to wean off a ventilator and breathe independently), s/p tracheostomy, s/p gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or medication administration), and quadriplegia (paralysis of all four limbs). A review of Resident 21's MDS, dated [DATE], indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 21 had impairment to both upper and lower extremities. The MDS indicated Resident 21 was dependent for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 21 and the activities were not performed prior to the current illness, exacerbation, or injury. A review of Resident 21's medical record from 4/26/2023 to 6/29/2024, there was no Advance Directive in Resident 21's chart. A review of Resident 21's electronic medical record indicated on 4/19/2023 there was no Advanced Directive on file and there was no documented evidence Advanced Directive information was provided to the resident or resident's representative. 4. A review of Resident 22's Admission Record indicated Resident 22 was admitted to the facility on [DATE]. A review of Resident 22's H&P, dated 5/16/2024, indicated Resident 22 had diagnoses of respiratory failure with ventilator dependence, Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), seizure disorder (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably), and cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 22's MDS, dated [DATE], indicated Resident 22 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 22 had impairment to both upper and lower extremities. The MDS indicated Resident 22 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 22 due to medical condition or safety concerns. A review of Resident 22's medical record from 5/15/2023 to 6/29/2024 there was no Advance Directive in Resident 22's chart. A review of Resident 22's electronic medical record indicated on 4/27/2024 at 12:30 PM there was no Advance Directive, there was no documented evidence that the Advance Directive information was provided to the resident's representative, no Advance Directive form signed, and no Advance Directive executed. 5. A review of Resident 23's Admission Record indicated Resident 23 was admitted to the facility on [DATE]. A review of Resident 23's H&P, dated 3/19/2024, indicated Resident 23 had diagnoses of respiratory failure with ventilator support, CVA, and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A review of Resident 23's MDS, dated [DATE], indicated Resident 23 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 23 had impairment to both upper and lower extremities. The MDS indicated Resident 23 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 23 due to medical condition or safety concerns. A review of Resident 23's medical record from 3/18/2023 to 6/29/2024 there was no Advance Directive in Resident 23's chart. A review of Resident 23's electronic medical record indicated on 3/18/2024 at 3:21 PM there was no Advanced Directive information on file. 45456 6. A review of Resident 19's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 19's H&P, dated 11/10/2022, indicated Resident 19 had diagnoses which included anoxic encephalopathy, chronic respiratory failure ventilator dependent and sepsis (a life-threatening emergency that happens when your body response to an infection damages vital organs and, often, causes death). A review of Resident 19's MDS, dated [DATE], indicated Resident 19 has intact cognitive (skills for daily decision making. The MDS also indicated Resident 19 was dependent oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the DON and record review of Resident 19's chart from 11/10/2022 until 6/29/2024, at 10:52 AM, there was no Advance Directive form for Resident 19. A record review of Resident 19's electronic health record with the DON, the DON stated that she documented on 6/28/2024 at 4:50 PM, on Resident 19's electronic health record that he had no Advance Directive form on file. During an interview on 6/29/2024 at 7:51 PM with the Director of Nursing (DON), the DON stated a family member was usually with the resident upon admission. The DON stated the resident or responsible party were responsible for signing the admission paperwork which included the Advanced Directive forms. During a concurrent interview and record review of the residents' electronic medical record on 6/29/2024 at 8:10 PM with the DON, the DON stated Resident 21's electronic records indicated there was no Advanced Directive, no Advanced Directive provided, and no Advanced Directive on file. The DON stated the clerk should had waited for Resident 21's family member to sign the Advance Directive forms since Resident 21's family member visited Resident 21 every day. The DON also verified there was no Advanced Directives forms in the electronic records and chart for Residents 3, 16, 19, 22, and 23. During a concurrent interview and record review of the facility's Advance Health Care Directives policy dated 2/2022, on 6/29/2024 at 8:18 PM with the DON, the DON stated each resident should be offered an Advanced Directive. The DON stated the resident's Advanced Directive should be placed in the chart for the staff's reference. The DON stated if the resident was not alert and oriented and did not have a responsible party, then the social service worker should be referred to. The DON stated the residents, and their responsible parties should be made aware of Advanced Directives to provide them an opportunity to make their choices in terms of medical treatment and for the facility to follow the resident's healthcare preferences. The DON stated when the residents and their responsible parties were not provided with the information, the facility may bypass the resident's and/ or resident representative's healthcare preferences. During an interview on 6/30/2024 at 5:49 PM with the DON, the DON stated the residents should have a paper copy of the Advanced Directive Form in their chart or scanned in the electronic medical records. The DON stated Advanced Directives guide the facility staff to meet the plan, wishes, and healthcare decisions for the residents. A review of the facility's Policy and Procedure titled, Advance Health Care Directives (AHCD), reviewed 2/2022, indicated for each adult inpatient admitted , the Admitting Department will complete the Advance Directive Acknowledgement Flow Chart (ADAFC) and obtain the patient's signature. For long-term care patient (Sub-Acute), Admitting will notify Social Services. Social Services will contact family/surrogate decision maker to obtain the information and facilitate it to Nursing.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview and record review, the facility failed to protect the confidentiality of the information of two (2) of 12 sampled residents (Resident 1 and Resident 14) in accordance with the facility's policy and procedure. This deficient practice violated the rights of Resident 1 and 14 for privacy and confidentiality of personal and medical records which can lead into exposure and misuse of Resident 1 and 14's Protected Health Information (PHI). Findings: 1. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 1's History and Physical dated 2/27/2024, indicated Resident 1's active diagnoses included chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and asthma (is a condition in which your airways narrow and swell and may produce extra mucus) A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 4/17/2024, indicated Resident 19 was comatose (persistent vegetative state/ no discernible consciousness). The MDS also indicated Resident 19 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and chair/bed-to-chair transfer. During an observation in Resident 1's room with Licensed Vocational Nurse 2 (LVN 2) on 6/29/2024, at 4:47 PM, observed LVN 2 left his monitor screen turned on in the hallway in front of Resident 1's door with Resident 1's medication list displayed on the screen, then LVN 2 went inside Resident 1's room. The monitor screen was left turned on from 4:47 PM to 5:51 PM. During an interview with LVN 2 on 6/29/2024, at 5:08 PM, LVN 2 stated, I forgot to turn it off. The computer monitor should be turned off when you step away from the computer to comply with Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules, and to protect the resident's information. During an interview with the Director of Nursing (DON) on 6/30/2024 at 5:33PM, the DON stated, Computer screens should be locked all the time to protect the privacy of the residents, and resident's information on the screen to comply with HIPAA. 2. A review of Resident 14's Admission Record indicated the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 14's History and Physical dated 6/11/2024, indicated Resident 14's diagnoses included focal seizures (also known as auras, occur in one area on one side of the brain, includes involuntary movements called automatism [like rubbing of the hands, lip-smacking, and chewing]), COPD and bullous pemphigoid (a rare autoimmune disease that causes blisters or sores on your skin) A review of Resident 14's MDS dated [DATE], indicated Resident 14 was comatose. The MDS also indicated Resident 14 was dependent in oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. During an observation inside room [ROOM NUMBER] with LVN 1 on 6/29/2024 at 5:25 PM, LVN 1 left his computer monitor turned on by the Resident 14's door from 5:25 PM to 5:29 PM when LVN 1 proceeded to check Resident 14's gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) placement. Resident 14's medication list was displayed on the computer screen, which was visible to any passerby. During an observation inside room [ROOM NUMBER] with LVN 1 on 6/29/2024, at 5:29 PM, LVN 1 left his computer monitor turned on for 4 minutes by the Resident 14's door then proceeded to administer Resident 14's medication via G-tube. During an interview with LVN 1 on 6/29/2024, at 5:31 PM, LVN 1 stated, I did not turn off the computer monitor. LVN 1 also stated it is important to turn off the computer monitor for resident's privacy. A review of the facility's Policy and Procedure titled, Privacy and Confidentiality of Patients - General Guidelines, approval dated, 11/2023, indicated facility must maintain the confidentiality and security of PHI in any form- electronic, on paper or oral. All personnel cannot use or disclose PHI unless the patient authorizes it, except for purposes of treatment, payment, and healthcare operations.

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Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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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** 45456 Based on interview and record review the facility failed to revise the comprehensive care plan for the prevention of pressure ulcer (painful wound caused as a result of pressure or friction) for one (1) of 12 sampled residents (Resident 126) as indicated on the facility's policy. This deficient practice had the potential for Resident 126 not to be monitored for the specific interventions and to be at risk for progression of pressure ulcer. Findings: A review of Resident 126's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 126's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 6/26/2024, indicated Resident 126's active diagnoses included cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), and hypertension (high blood pressure). The MDS also indicated Resident 179 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 126 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right. A review of Resident 126's care plan dated 6/17/2024, titled Pressure Injury Deep Tissue Pressure Injury (DTPI, persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) sacro-coccyx (sacral spine-the sacrum and the coccyx [tailbone]) healing. The care plan did not indicated interventions for the use of LAL. A review of Resident 126's Physician's Order dated 6/25/2024, indicated low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure sores designed to circulate a constant flow of air for the management of pressure sores) for pressure injury management. During a concurrent interview with the Director of Nursing (DON) and record review of Resident 126's care plan titled Pressure Injury dated 6/17/2024, on 6/30/2024 at 5:41 PM. The The DON stated, The LAL should be included in the care plan if it is part of the pressure injury intervention. We review the care plan every shift. If there were any changes, we revise the care plan right away and it was done by the charge nurses. The DON also stated, the intervention for the LAL use should have been added in the care plan for Pressure Injury DTPI during Resident 126's admission and/ or when it was ordered by the physician on 6/25/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Pressure Injury prevention and management protocol, revised 6/2019, indicated plan and implement appropriate care according to pressure Injury Prevention & Management Protocol for Patient, and document in patient's care plan.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to implement proper gastrostomy tube (GT, a tube inserted through the belly that brings nutrition directly to the stomach) feeding practices and procedures for two (2) of two sampled residents (Resident 21 and 19) by failing to: 1. Properly label Resident 21's opened gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage) feeding solution bottle at the bedside. This deficient practice had the potential to result in Resident 21's delayed feedings and incorrect total feeding amount received in a day. 2. Ensure Resident 19's GT water bag flush was labeled completely to include the total number of hours in accordance with the physician's order. This deficient practice had the potential for Resident 19's water flush bag not being replaced on time that might put the resident at risk of suffering common complications of tube feeding. Findings: 1. A review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE]. A review of Resident 21's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 4/23/2024, indicated Resident 21 had diagnoses of chronic respiratory failure ventilator (a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs) dependent (when resident is unable to wean off a ventilator and breathe independently), status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), s/p gastrostomy (GT, a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding and medication administration), and quadriplegia (paralysis of all four limbs). A review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/2/2024, indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 21 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 21 and the activities were not performed prior to the current illness, exacerbation, or injury. The MDS indicated Resident 21 had a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's Physician's Monthly Orders, dated 5/2/2023, indicated GT feeding of Jevity (a calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term feeding) 1.2 at 60 milliliters (ml, unit of volume)/hour for 20 hours daily from 2 PM to 10 AM via enteral pump (a medical device used to deliver nutrients directly into the gastrointestinal [GI] tract of a resident who is unable to take food or liquids orally). A review of Resident 21's Tube Feeding Care Plan, dated 5/2/2024, indicated Resident 21 was at risk for complication related to tube feeding. Staff interventions were to administer tube feeding of formula and flush water or fluids as indicated on the physician's order, monitor intake and output every shift, and to monitor feeding tolerance. During an observation in Resident 21's room on 6/28/2024 at 11:49 AM, Resident 21's feeding tube was disconnected from resident. The Jevity formula was prepped and primed (fill the tubing with formula) and hung on the enteral feeding pump. The label on the Jevity was dated 6/28/2024 with the start time of 2 PM. During a concurrent observation of Resident 21's Jevity and interview on 6/28/2024 at 11:49 AM with Registered Nurse 4 (RN 4), RN 4 stated the start time for Resident 21's GT feeding was at 2 PM and continued until 10 AM. RN 4 stated Resident 21's feeding ran a total of 20 hours a day. RN 4 stated she labeled the Jevity with a date of 6/28/2024 and start time at 2 PM. RN 4 stated she had eight residents and needed to adjust her time when she passed out the feedings for the residents. During an interview on 6/30/2024 at 2:53 PM with the Director of Nursing (DON), the DON stated the feeding solution could be set up an hour prior to the start time based on the physician's order. The DON stated the licensed nurse should date and time the feeding tube solution at the time the licensed nurse opened the bottle by spiking and priming the solution through the feeding tube. The DON stated correct labeling for feeding solution ensured that the physician's orders were being followed for the resident's diet. The DON stated the policy did not and should have included time frame when enteral feedings needed to be administered since it was based on the physician's orders just like medication administration. The DON stated the feeding solution was set up prior to the one-hour allowance time. The DON stated tube feeding with a start time of 2 PM should be started at 2 PM to avoid mixing up the time when the feeding tube needed to be changed or turned off. During an interview on 6/30/2024 at 5:54 PM with the DON, the DON stated the facility should be scanning the feeding solution when administered which should also be included in the policy. A review of the facility's Policy and Procedure (P&P) titled, Enteral and Oral Feedings, revised 3/2023, indicated enteral feedings will be available for patients who are unable to meet their nutritional requirements via oral route. Nursing staff is responsible for administration of enteral feeding following nursing enteral tube feeding policy and procedures. Policy will include a product hanging time of no more than 24-hours for closed-system with the date and time initiated. Licensed nurse shall mark the hanging time and date on the ready to hang or enteral bag using permanent waterproof ink. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Medication Administration, reviewed 10/2019, indicated medication will be administered to the patient within a one-hour period before the scheduled dosage for all non-time critical medication (non-time critical medications are those where early or delayed administration within a specified range should not cause harm or result in substantial sub-optimal therapy or pharmacological effect). A review of the facility's P&P titled, Nursing Scope of Practice, approval dated, 4/2017, indicated the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which as associated with their actual or potential health or illness problems of the treatment thereof which requires a substantial amount of scientific knowledge or technical skill and includes direct patient care services including the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention ordered by and within the scope of the licensure of a physician. 45456 2. A review of Resident 19's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 19's H&P, dated 11/10/2022, indicated Resident 19's diagnoses included anoxic encephalopathy (or hypoxic-ischemic brain injury, a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning [for example, carbon monoxide or drug overdose], vascular injury or insult, or cardiac arrest), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide) ventilator dependent (if a resident is unable to wean off a ventilator and breathe independently), and left middle cerebral artery (MCA, stroke occurs when blood flow from the MCA, one of the largest arteries of the brain is suddenly interrupted [ischemia] or altogether stopped [infarction]) ischemic stroke. A review of Resident 19's MDS, dated [DATE], indicated Resident 19 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 19 was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. A review of Resident 19's Physician's Order, dated 6/25/2024, indicated to flush GT with water at 50 milliliters (ml, unit of measurement) per hour (/hr) for 20 hours daily from 2 PM to 10 AM [NAME] Enteral Dual Pump (pumps that have a dual flow feature, which allows for the delivery of both formula and water that is used for flushing and hydration) During a concurrent observation in Resident 19's room and interview with Registered Nurse 1 (RN 1) on 6/28/2024 , at 12:20PM, Resident 19 was awake. There was no label on the water bag containing 300 milliliters (ml, unit of measurement) of water that was hung on the intravenous (IV) pole. 50 cubic centimeters (cc, unit of measurement) per hour (h) was written directly on the water bag. RN 1 stated, We need to label the water bag every time we change it to communicate with the staff. During an interview with Registered Nurse 4 (RN 4) on 6/30/2024, at 8:51 AM, RN 4 stated, We need to label the water bag to make sure everything has the correct information and we do not rely on the machine to prevent any mistakes. We always label the bag every time we change it. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 6/30/2024 at 5:30 PM, DON stated, Water bag flush should be labeled to make sure the staff were following policy regarding changing the bags. It is important to label the bag to make sure that we are routinely changing the water bags. A review of the facility's P&P titled, Enteral and Oral Feedings, dated, 5/2023, indicated Nursing staff is responsible for administration of enteral feeding following nursing enteral tube feeding policy and procedures. Licensed nurse shall mark the hanging time and date on ready to hang (RTH) or enteral bag using permanent waterproof ink.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for three (3) of three sampled residents (Residents 21, 1, and 19) by failing to ensure: 1. Resident 21's nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril) tubing was changed weekly. 2. Resident 19's suction tubing was not touching the floor. 3. Resident 1's suction tubing was not touching the floor. These deficient practices had the potential for the residents to develop a respiratory infection. Findings: 1. A review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE]. A review of Resident 21's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 4/23/2024, indicated Resident 21 had diagnoses of chronic respiratory failure ventilator (a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs) dependent (when resident is unable to wean off a ventilator and breathe independently), status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), s/p gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), and quadriplegia (paralysis of all four limbs). A review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/2/2024, indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 21 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 21 and the activities were not performed prior to the current illness, exacerbation, or injury. The MDS indicated Resident 21 received oxygen therapy. A review of Resident 21's Physician's Monthly Orders, dated 9/5/2023, indicated Passy Muir Valve (PMV, a medical device used by tracheostomy and ventilator residents that redirects airflow through the vocal folds, mouth, and nose, enabling voice and improved communication) 7 AM to 10 PM, oxygen at two (2) liters (L) NC while on PMV. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/28/2024at 11:49 AM in Resident 21's room, Resident 21 was receiving 2 L of oxygen via nasal cannula. The nasal cannula tubing was not labeled. During a concurrent observation of Resident 21's nasal cannula tubing and interview on 6/28/2024 at 12:07 PM with Registered Nurse 4 (RN 4), RN 4 stated she did not see a date on Resident 21's nasal cannula tubing. RN 4 stated the respiratory therapist was in charge of the nasal cannula tubing. RN 4 stated the nasal cannula tubing was not and should have been labeled with the date the NC tubing w as changed by the respiratory therapist. During an interview on 6/30/2024 at 6:07 PM with the Director of Nursing (DON), the DON stated residents' nasal cannula tubing should be changed weekly. The DON stated Resident 21's nasal cannula tubing should be dated to know when the tubing was last changed. The DON stated the facility did not have a policy to indicate when residents' nasal cannula should be changed. The DON stated the facility should have a policy indicating nasal cannula tubing were to be changed weekly. The DON stated changing the nasal cannula tubing weekly could prevent the resident's from getting an infection. The DON stated the longer the residents continued using the nasal cannula tubing without being changed, this posed a greater risk of infection for the residents since these residents had respiratory conditions. During an interview on 6/30/2024 at 7:21 PM with the Respiratory Therapist 3 (RT 3), RT 3 stated there was not specific date when the nasal cannula tubing was changed. RT 3 stated the nasal cannula tubing needed to be labeled when used for a resident. RT 3 stated nasal cannula tubing were changed every three days and also changed earlier if needed. RT 3 stated changing the nasal cannula every three days or as needed when dirty was done to avoid the residents' from getting an infection. A review of the facility's Policy and Procedure titled, Sub-Acute Infection Control Policies, dated 9/2021, indicated each staff member assigned in the unit is responsible for ensuring that infection prevention and control procedures are performed. 45456 2. A review of Resident 19's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 19's H&P, dated 11/10/2022, indicated Resident 19's diagnoses included anoxic encephalopathy (or hypoxic-ischemic brain injury, a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning [for example, carbon monoxide or drug overdose], vascular injury or insult, or cardiac arrest), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide) ventilator dependent (if a resident is unable to wean off a ventilator and breathe independently) and Left middle cerebral artery (MCA, stroke occurs when blood flow from the MCA, one of the largest arteries of the brain, is suddenly interrupted [ischemia] or altogether stopped [infarction]) ischemic stroke. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 19's MDS, dated [DATE], indicated Resident 19 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 19 was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. During an observation in Resident 19's room on 6/29/2024 at 9:24 AM, Resident 19 was sleeping. The ventilator was turned on. The suction tubing connected on the ventilator was touching the floor. During a concurrent observation in Resident 19's room and interview with LVN 2 on 6/29/2024 at 5:08 PM, Licensed Vocational Nurse 2 (LVN 2) stated, The suction tubing should not be touching the floor because the floor was dirty. It can cause respiratory infection to the resident. We have to change it right away. 3. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 1's H&P, dated 2/27/2024, indicated Resident 1's active diagnoses included chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and asthma (a condition in which your airways narrow and swell and may produce extra mucus) A review of Resident 1's MDS, dated [DATE], indicated Resident 1 was comatose (persistent vegetative state/ no discernible consciousness). The MDS also indicated Resident 1 was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and chair/bed-to-chair transfer. During a concurrent observation in Resident 1's room and interview with LVN 2 on 6/29/2024, at 5:03 PM, LVN 2 observed Resident 1's suction tubing was laying on the floor. LVN 2 stated, The suction tubing should not be touching the floor because the floor was dirty. It can cause respiratory infection to the resident. We have to change it right away. During an interview with the DON on 6/30/2024, at 5:29 PM, the DON stated, There should be no suction on the floor. Any medical equipment that is used on the residents should never be touching the floor because of infection control issue. It is a potential infection risk for the residents. A review of the facility's Policy and Procedure titled, Sub-Acute Unit Respiratory Services, approval dated, 11/2018, indicated all tubing should not be touching the floor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, and administering of all drugs and biologicals to meet the needs of each resident for one (1) of 10 sampled residents (Residents 21) by failing to: a. Ensure Resident 21 received the correct dose of Mylicon (medication used to relieve painful pressure caused by excess gas in the stomach and intestines) per physician order. This deficient practice had the potential to place Resident 21 to receive an ineffective medication dose. b. Ensure Resident 21's Mylicon was not left unattended on the medication cart in the hallway. These deficient practices had the potential to result in unsafe access of Resident 21 and 1's medications by staff and visitors which could lead to adverse reactions from ingestion of unnecessary medication and a potential loss of medication. Findings: A review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE]. A review of Resident 21's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 4/23/2024, indicated Resident 21 had diagnoses of chronic respiratory failure ventilator (a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs) dependent (when resident is unable to wean off a ventilator and breathe independently), status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), s/p gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), and quadriplegia (paralysis of all four limbs). A review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/2/2024, indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 21 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 21 and the activities were not performed prior to the current illness, exacerbation, or injury. The MDS indicated Resident 21 had a feeding tube. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 21's Physician's Monthly Orders, dated 6/25/2024, indicated Simethicone (Mylicon Infant Drops) 80 milligrams (mg, unit of measurement) via gastrostomy tube (GT, a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) four times a day for abdominal gas. A review of Resident 21's care plan, dated 5/2/2024, indicated Resident 21 had an abdominal distention and flatulence (gas) problem related to a history of colon cancer. Staff interventions were to monitor tolerance to feeding, assess for signs and symptoms of pain or abdominal discomfort and give medication as ordered. a. During a medication pass observation on 6/30/2024 at 8:33 AM, Licensed Vocational Nurse 3 (LVN 3) was observed preparing Resident 21's medications. LVN 3 drew up 0.6 milliliters (ml, unit of volume) of Mylicon into the syringe and placed the liquid medication into the medicine cup on top of the medication cart. During a concurrent record review of Resident 21's electronic Medication Administration Record (eMAR, a medical record used by healthcare providers to document the administration of a medication) and interview on 6/30/2024 at 9:04 AM with LVN 3 after LVN 3 administered Resident 21's medications, LVN 3 stated she had measured 0.6 ml of Mylicon to give to Resident 21. LVN 3 stated she was supposed to measure out 2 ml which equaled 80 mg of Mylicon for Resident 21. LVN 3 stated for Resident 21, she only administered 0.6 ml (40 mg) and needed to give him 0.6 ml more of the Mylicon for a total of 80 mg (2 ml). LVN 3 stated Resident 21 would not receive the result he needed for his abdominal gas when he received given less than the prescribed dose ordered by the physician. During an interview on 6/30/2024 at 2:32 PM with the Pharmacy Director (PHD), PHD stated the licensed nurses needed to administer medications as ordered by the physician. A review of the facility's Policy and Procedure (P&P) titled, Administration of Medications, revised 10/2016, indicated each time a licensed nurse administers a medication, he/she shall first identify the patient to ascertain that the patient receives the correct medication as prescribed. To assure medication safety, the nurse will cross check the following reference points for confirmation of the correct dosage and interval of the most recent physician order, electronic medication administration record, and label on the drug container. A review of the facility's P&P titled, Medication Administration, reviewed 10/2019, indicated before administering a medication, the health care professional administering the medication verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. b. During an observation of Resident 21's medication pass on 6/30/2024 at 8:33 AM with LVN 3, LVN 3 had prepared a total of six (6) medications on top of the medication cart. LVN 3 drew up the last medication, Mylicon, and left the Mylicon on top of the medication cart. LVN 3, then entered Resident 21's room with the 6 medications and closed Resident 21's door. The Mylicon medication was left on top of the medication cart in the hallway as LVN 3 was inside Resident 21's room to discuss and administer his medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of the medication cart and interview on 6/30/2024 at 9:01 AM with LVN, 3 after administering Resident 21's medication, LVN 3 stated the Mylicon was currently on top of the medication cart. LVN 3 stated the Mylicon was supposed to go back inside the drawer of the medication cart after she had measured the medication. LVN 3 stated she did not place the Mylicon in the drawer of the medication cart and left the Mylicon on top of the cart during Resident 21's medication administration. During an interview on 6/30/2024 at 2:32 PM with PHD, PHD stated when nurses administer medications to the residents, the medications were not supposed to be left on top of the medication cart unattended. PHD stated all medications needed to be stored and locked. PHD stated the unit had a lot of visitors and wanted to make sure medications were not accessible to non-medical personnel for security purposes. During an interview on 6/30/2024 at 5:32 PM with the Director of Nursing (DON), the DON stated the licensed nurses were designated to handle medications and the medications should be placed in the locked drawers. The DON stated medications left on top of the medication cart during medication pass had the risk of getting lost, falling on the floor, being taken by a passerby, and was a safety concern for everyone in the unit. A review of the facility's P&P titled, General Medication Policy-Inpatient Medication: Nursing Station Supply and Storage, dated 10/2019, indicated inpatient medication are stored at nursing units in the medication carts. A lockable cabinet on wheels containing multiple cassettes assigned to individual patients. It may also contain separate lockable drawers for storage of controlled drugs, floor stock medications and/or necessary supplies for medication administration. It is the policy that unattended medication carts, mediations rooms, and medication cabinets remain locked at all times.

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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** 44636 Based on interview and record review, the facility failed to act upon a pharmacist's recommendation, as approved by the physician, in the Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with their medications) for one (1) of five sampled residents (Resident 15) in accordance with the facility policy. This deficient practice resulted in a recommended blood test not performed for Resident 15, which could result in adverse consequence (a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status) due to potential for incorrect dosage of resident's medication. Findings: A review of Resident 15's Admission Record indicated Resident 15 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), status post (S/P, a term used in medicine to refer to a treatment [often a surgical procedure], diagnosis or just an event, that a resident had experienced) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), and seizure disorder (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably). A review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/28/2024, indicated Resident 15 was comatose and in a persistent vegetative state (condition where resident has woken from a coma but still lacks awareness)/no discernible consciousness. The MDS indicated Resident 15 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands), and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 15 and the activities were not performed prior to the current illness, exacerbation, or injury. The MDS also indicated Resident 15 had a seizure disorder. A review of Resident 15's Pharmacy Monthly Review, dated 5/20/2024, indicated the physician agreed to the pharmacist recommendation as follows: -Resident was currently on Keppra (medication used to treat certain types of seizures) 750 milligrams (mg, unit of measurement) via gastrostomy tube (GT, a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) twice a day for seizure disorder. Last Keppra level done on 1/2/2024 = 12.6. Consider checking Keppra level and/or adding Keppra level to routine labs. The Pharmacy Monthly Review indicated Resident 15 had monthly labs ordered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 15's Physician's Monthly, dated 6/25/2024, indicated Keppra level every six months (next in November 2024) and Keppra liquid 750 mg via GT twice a day for seizure disorder. A review of Resident 15's Seizure Care Plan, dated 12/22/2023, indicated Resident 15 had a potential for seizure. Staff interventions were to monitor sign and symptoms of seizure every shift, give medication as ordered by physician, inform the physician if episode of seizure activity observed, and perform labs if ordered by the physician. During an interview on 6/30/2024 at 2:17 PM with the Pharmacist (PHR), PHR stated the licensed nurse would input the order in the electronic health record once the doctor approved the recommendation on the MRR. During a concurrent record review of Resident 15's MRR and interview on 6/30/2024 at 2:24 PM with PHR, PHR stated on 5/20/2024 PHR made the recommendation to check Resident 15's Keppra level. PHR stated the physician had approved the MRR recommendation. PHR stated the expectation was to draw Resident 15's Keppra level with the next set of labs. PHR stated Resident 15's Keppra levels should be checked every six months. PHR stated Resident 15's last Keppra level was drawn in January 2024. During a concurrent record review of Resident 15's electronic health record and interview on 6/30/2024 at 2:30 PM with PHR, PHR stated Resident 15 did not have her Keppra level checked after January 2024. PHR stated there was no order for Resident 15 to have her Keppra levels checked. PHR stated the expectation of an order by the physician from the MRR was for the licensed nurses to put in the order right away for the next lab draw to include the Keppra level. PHR stated the purpose to monitor Resident 15's Keppra levels was because Resident 15 had a seizure disorder and took Keppra medication. PHR stated if the Keppra levels were too high or too low, then the neurologist (a medical specialist in the diagnosis and treatment of disorders of the nervous system) would be consulted to adjust the medication. During an interview on 6/30/2024 at 2:32 PM with the Pharmacy Director (PHD), PHD stated Resident 15's Keppra level should be monitored to see if Keppra levels fell within the therapeutic range to make sure Resident 15's seizure disorder could be controlled. During a concurrent record review of Resident 15's electronic health record and interview on 6/30/2024 at 5:59 PM with the Director of Nursing (DON), the DON stated Resident 15 did not have any Keppra levels drawn since January 2024. The DON stated Resident 15's electronic record did not have Keppra levels ordered to be drawn at a future date. The DON stated a Keppra level check had not been done since the physician ordered the Keppra lab during the MRR on 5/20/2024. The DON stated the Keppra level ordered should have been followed up and ordered immediately at the end of the MRR meeting. The DON stated the charge nurse did not follow up with the Keppra level ordered by the physician on 5/20/2024. The DON stated the Monthly Recap of Physician's Order was done with the MRR, therefore the Keppra level order should have been entered into the electronic system. A review of the facility's Policy and Procedure titled, Monthly Recap of Physician's Order, reviewed on 10/2016, indicated it is the responsibility of the licensed personnel to recap all current orders at the monthly team conference, verify correctness of the recap orders, and to document that completeness. Any discrepancies noted during recapping shall be investigated at that time and resolved.

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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** 44636 Based on observation, interview, and record review, the facility failed to store one of 12 sampled residents (Resident 3) respiratory inhaler in accordance with the facility's policy. This deficient practice had the potential for unauthorized persons to access the medication. Findings: A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated [DATE], indicated Resident 3 had diagnoses of chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), s/p gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), chronic vegetative state (condition where resident has woken from a coma but still lacks awareness), and anoxic encephalopathy (a brain injury that results from a lack of oxygen to the brain tissue). A review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 3 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 3 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands), roll left and right, and chair/bed-to-chair transfer. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 3 and the activities were not performed prior to the current illness, exacerbation, or injury. A review of Resident 3's Physician's Monthly Orders, dated [DATE], indicated Albuterol hydrofluoroalkane (Proventil HFA, medication used to prevent and treat wheezing [a high-pitched, lung sound produced by airflow through an abnormally narrowed or compressed airway], difficulty breathing, chest tightness, and coughing caused by lung diseases) three puffs every six (6) hours for bronchodilation (expansion of the airways). During an observation in Resident 3's room on [DATE] at 9:05 AM, an inhaler was noted in a clear bag dated [DATE] hanging on the wall at the head of Resident 3's bed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 3's room and interview on [DATE] at 9:38 AM with Registered Nurse 2 (RN 2), RN 2 stated the Respiratory Therapists (RTs) were responsible for administering the inhaler to Resident 3. RN 2 verified the inhaler was Resident 3's Albuterol inhaler. RN 2 stated it was okay to store Resident 3's inhaler in a bag at the bedside. During an observation in Resident 3's room on [DATE] at 8:21 AM, an inhaler was noted in a clear bag hanging on the wall at the head of Resident 3's bed. During a concurrent observation in Resident 3's room and interview on [DATE] at 9:47 AM with RT 1, RT 1 stated Resident 3's Albuterol inhaler was stored in the set-up bag. RT 1 stated there was a drawer in the supply room for the RTs to keep medications. RT 1 stated placement of Resident 3's medication in the supply room would result in cross contamination, therefore Resident 3's inhaler was kept at the bedside and not in the RT medication supply room. RT 1 stated Resident 3 did not have an order to keep the inhaler at the bedside. RT 1 stated during the covid pandemic (global outbreak of coronavirus - an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-Co-2), the physician, pharmacist, and staff agreed to keep the inhaler medications at the residents' bedside. During an interview on [DATE] at 2:32 PM with the Pharmacy Director (PHD), PHD stated based on the standard of practice of medication storage, the resident's inhalers should be stored in the medication room. PHD stated the residents in the unit were not alert to administer the inhalers themselves, therefore the inhalers should not be kept at the bedside. PHD stated all medications needed to be stored and locked. PHD stated there were a lot of visitors in the unit and they wanted to make sure the medications were not accessible to non-medical personnel for security purposes. A review of the facility's Policy and Procedure (P&P) titled, General Medication Policy-Inpatient Medication: Nursing Station Supply and Storage, dated ,d+[DATE], indicated inpatient medications are stored at nursing units in lockable medication cabinets for unit-dosed respiratory medication cassettes for individual residents on each nursing unit. Respiratory Therapist to keep respiratory medication cassette cabinet locked at all times while unattended. A review of the facility's P&P titled, Medication Administration, reviewed ,d+[DATE], indicated medications will not be left unattended at the resident's bedside except for the meds that are ordered by the physicians to be kept at the bedside. 45456 2. During a concurrent observation of the Medication Cart 1 and interview with Registered Nurse 1 (RN 1) on [DATE], at 5:52 PM, The top surface of the Medication Cart 1 was observed with dust, adhesives/tapes, and had grayish discoloration. RN 1 stated, We need to clean the medication carts more. We should remove the plastic cover because it has adhesive tapes on it. During a concurrent observation of the Medication Cart 2 and interview with RN 1 on [DATE] at 5:54 PM, the top surface of the Medication Cart 2 had white powder, which was from the mortar placed on top of Medication Cart 2. RN 1 stated, We need to clean the medication carts more and clean this mortar after using it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of the Medication Cart 1 and interview with RN 1 on [DATE], at 5:56 PM, Medication Cart 1's drawer was observed to be dusty. RN 1 stated, We have to clean the drawers to prevent the spread of infection. During a concurrent observation and interview with RN 1 on [DATE], at 6:04 PM, Medication Cart 1 bottom drawer had the following items: 1. 1 expired enteral feeding tube clog remover, expiration date ,d+[DATE] 2. ball pen 3. 2 rubber bands RN 1 stated, We do not open the bottom drawer because we are busy which explains why it has unnecessary items inside. During a concurrent observation with RN 1 on [DATE], at 6:14 PM, Three IV connectors dated [DATE] and 1 catheter adapter without any expiration date were found in the medication storage cabinet. During an interview with the Director of Nursing (DON) on [DATE], at 6:34 PM, the DON stated, If there was no expiration date, we cannot use it. We have to throw it away. We have to follow manufacturer's date. During an interview with the DON on [DATE] at 6:35 PM, DON stated, We have to always clean the medication drawers. If medications were contaminated with dust, we have to throw it away. The staff has to clean the mortar and pestle after using it because if it has a trace of medications left on the equipment, it can contaminate other medications. During an interview with the Pharmacist (PHR) on [DATE] at 2:40 PM, PHR stated, The staff should clean up all the equipment after they used it for medication administration to prevent the spread of infection. A review of facility's P&P titled, General Medication Policy-Inpatient Medication: Nursing Station Supply and Storage, dated ,d+[DATE], indicated to establish a standardized procedure in the dispensing, delivery, storage, and administration of inpatient medications. A review of facility's P&P titled, Material Shelf Life Control (Supply) Distribution), dated ,d+[DATE], indicated to establish the procedure to control shelf life of identified material and to ensure that no outdated supplies are utilized for patient care purposes. All expired items will be removed from inventory or their current place of storage and destroyed or returned to vendor. A review of facility's P&P titled, Sub- Acute Infection Control Policies, approval date ,d+[DATE], indicated all used equipment must be considered contaminated and is collected/ handled in a safe manner in order to protect other patients .

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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** 44636 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: a. Label foods in the kitchen with item 'use by' date (the last date recommended for the use of the product) or open date. b. Discard expired food in the kitchen. c. Ensure drainpipe (a pipe that carries wastewater away from the building) had a 1 inch and more gap from the drain (plumbing fixture installed in the floor designed to direct water to a sewer or municipal storm drain so floor stays dry, and rooms do not flood). d. Ensure a container of salsa was discarded when found in a bin with labeling supplies. e. Ensure drainage on kitchen floor was clear of debris and trash. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea (loose watery stool that occurs more frequently than usual), and fever and can lead to other serious medical complications and hospitalization . Findings: During a concurrent observation in the kitchen and interview with the Registered Dietician (RD) on [DATE] at 9:43 AM, the following were observed: a. An open one-gallon bottle of vinegar not labeled with date opened and used by date. b. An open container of turmeric not labeled with open date and used by date. c. An open container of cinnamon stick labeled with used by date [DATE]. d. An open container of large black pepper grind not labeled with open date and used by date. e. An opened one-gallon bottle of Brand 1 cooking wine not labeled with open date and used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RD stated when food items were opened, the food items needed to be labeled with the open date and used by date. RD stated there were no labels to indicate when the items were opened and a used by date to indicate when the items (vinegar, turmeric, ground pepper and cooking wine) needed to be discarded. RD stated once a food item was opened the food item needed to be used within a specific time- period and not by the container's original expiration date, therefore the food item's shelf-life date needed to be written on the used by label. RD stated the cinnamon sticks should have been discarded since the cinnamon sticks were expired since [DATE]. RD stated the cooks should not use expired food items to be served to the residents. RD stated all expired food items needed to be discarded for the safety of the residents. During a concurrent observation in the kitchen and interview with RD on [DATE] at 9:52 AM, RD stated the container of salsa was placed with the kitchen labeling supplies. An unlabeled clear container with green salsa covered with a lid was found lying with the dietary staff's labeling supplies. RD stated the salsa was not supposed to be stored with the labeling supplies. RD stated the container of salsa needed to be discarded since it was mixed with non-food items and was not stored properly. During a concurrent observation in the kitchen and interview with the Engineer Supervisor (ES) on [DATE] at 10:03 AM, ES stated the drainpipe should have a one-inch gap from the drain ES measured the drainpipe and stated there was half an inch between the drainpipe and the drain. ES stated the guidelines indicated the drainpipe should be one inch away from the drain. During a concurrent observation in the walk-in freezer in the kitchen and interview with the Lead [NAME] (LC) on [DATE] at 9:43 AM, the following were observed: a. A clear bag of waffles with no label of item name and used by date. b. An opened clear bag of chicken patties with no label of item name, open date, and used by date. c. An opened bag of green beans with no label of open date and used by date. d. An opened bag of bacon bits with no label of open date and used by date. LC stated food items needed to be labeled with item name, open date, and expiration date when removed from the original packaging. LC stated the bag of chicken, green beans, and bacon bits were opened and were not labeled with item name, open date, and used by date. LC stated the foods needed to be discarded since the food items were opened and expiration date was not written. During a concurrent observation in the kitchen and interview with the RD on [DATE] at 10:20 AM, RD stated there was trash in the kitchen floor drain. A disposable container lid, creamer container, rubber band, and debris were noted lying on top of the drain. RD stated nothing was supposed to be on the drain. RD stated the drain was supposed to be clean and cleared of any trash so water could easily drain in case of any spills. (continued on next page)

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Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled, Food Receiving, Storage, and Discard, revised , d+[DATE], indicated all food should be wrapped, labeled, and dated before placed in storage. The P&P also indicated, check expiration date for food items in its original packaging, if it is not visible, rewrite expiration date on its outer box. In addition, the P&P indicated, dry food storage item should be labelled with the open date on the bag or container and discarded by the shelf-life discard date, and any item passed the storage period should be discarded. A review of the facility's P&P titled, Safety Guidelines, Department Specific, undated, indicated check all drain lines air gaps, they shall not be less than one inch. A review of the facility's P&P titled, Safety Policies for Food Service Employee, dated ,d+[DATE], indicated Director of Food and Nutrition Services in accordance with Kitchen Supervisor implements safety and sanitation procedures in all working areas.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to provide education, offer, and document influenza immunization (flu shots, vaccine that protect against infection by the flu virus) as consistent with professional standards and current guidelines for two (2) of five sampled residents (Residents 22 and 23). This deficient practice placed Residents 22 and 23 at higher risk of acquiring and transmitting complications from the influenza disease and violated the residents or responsible parties' rights to make an informed decision. Findings: a. A review of Resident 22's Admission Record indicated Resident 22 was admitted to the facility on [DATE]. A review of Resident 22's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 5/16/2024, indicated Resident 22 had diagnoses of respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body) with ventilator dependence (when resident is unable to wean off a ventilator and breathe independently), Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), seizure disorder (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably), and cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply). A review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/28/2024, indicated Resident 22 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state (condition where resident has woken from a coma but still lacks awareness)/no discernible consciousness. The MDS indicated Resident 22 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands), and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 22 due to medical condition or safety concerns. A review of Resident 22's Immunization Summary Report, dated 7/2/2024, indicated Resident 22's last influenza vaccination was on 9/22/2021. A review of Resident 22's Immunization Records did not indicate a consent, refusal, or administration of the influenza vaccination for the season. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 22's Medical Records and interview on 6/29/2024 at 5:55 PM with the Director of Nursing (DON), the DON stated Resident 22 was admitted to the unit on 5/12/2024. The DON stated the influenza vaccination was only offered to residents during the influenza season months of October to March. The DON stated since Resident 22 was admitted after March, she was not offered the influenza vaccination. The DON stated Resident 22's Medical Records did not indicate any documentation that Resident 22 /Responsible Party was educated, offered, or received the influenza vaccination. A concurrent record review of Resident 22's chart with the DON, indicated there was no declination form for the influenza vaccination. The DON stated Resident 22's Medical Records did not indicate a declination form for the influenza vaccination. b. A review of Resident 23's Admission Record indicated Resident 23 was admitted to the facility on [DATE]. A review of Resident 23's H&P, dated 3/19/2024, indicated Resident 23 had diagnoses of respiratory failure with ventilator support, CVA, and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A review of Resident 23's MDS, dated [DATE], indicated Resident 23 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 23 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 23 due to medical condition or safety concerns. A review of Resident 23's Immunization Summary Report, dated 7/2/2024, indicated Resident 23 did not have any immunization record for influenza. A review of Resident 23's Immunization Records did not indicate a consent, refusal, or administration of the influenza vaccination. During a concurrent record review of Resident 23's medical records and interview on 6/29/2024 at 5:59 PM with DON, the DON stated Resident 23 was readmitted to the unit on 3/18/2024. The DON stated Resident 23 was readmitted during the influenza season and the influenza vaccination was offered throughout the month of March. The DON stated there was no documentation in Resident 23's Immunization Record that Resident 23 was given or have declined the influenza vaccination. The DON stated Resident 23's Medical Records did not indicate a declination form for the influenza vaccination. During an interview on 6/29/2024 at 6:15 PM with the Infection Control Director (ICD), the ICD stated every year, the unit offered the influenza vaccination to its residents. The ICD stated when the residents are admitted to the facility and had not received the influenza vaccination, regardless of the influenza season, the influenza vaccination must be offered to the residents. The ICD stated the influenza vaccination protected the residents from any influenza acquired infections. The ICD stated when the residents received the influenza vaccination and became infected, the vaccine would prevent the resident from complications of the disease and keep the resident with mild symptoms. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/29/2024 at 6:25 PM with ICD, the ICD stated the influenza vaccination was strongly recommended and should be offered to the residents at any time of the year. The ICD stated the vaccination was not to prevent the resident from getting the influenza virus, but to allow the residents' system to fight against the symptoms more than an unvaccinated resident. The ICD stated if the resident was eligible to receive the vaccination, the influenza vaccine should be offered. The ICD stated all newly admitted resident who were eligible to receive the influenza vaccination should be offered the influenza vaccination on the day of admission. During a concurrent record review of the influenza policy and interview on 6/29/2024 at 7:38 PM with the DON, the DON stated the influenza vaccination should be offered annually, prior to the start of the influenza season, and throughout the season. The DON stated Residents 22 and 23 should have been offered the influenza vaccination. The DON stated the admitting licensed nurse should have followed up to obtain an order for the vaccination from the physician. The DON stated the importance of educating and offering the influenza vaccination was to follow the infection control policy and prioritize the resident's overall wellbeing. The DON stated there was a log for the influenza vaccination only from the month of October to November 2023. The DON stated Residents 22 and 23 were not documented on the influenza vaccination log. The DON stated when resident consented to the influenza vaccination, the vaccination would be administered to the resident and documented. The DON stated when the resident refused the vaccination, then the consent declination form would be completed and signed. The DON stated the resident's declination form would be placed in the resident's chart. A review of the facility's Policy and Procedure titled, Sub-Acute Infection Control Policies, revised 9/2021, indicated influenza vaccine will be offered to all residents annually prior to and throughout the influenza season (November to March). Newly admitted residents who are admitted during influenza season or during the vaccination period (September to March) will be assessed for prior receipt of the influenza vaccine. If vaccine was given in July immediately preceding the influenza season or later, the resident will be considered vaccinated and will not be indicated for another dose. Documentation of vaccination should be made in the medical record. If the resident did not receive vaccine during the recent vaccination period, influenza vaccine will be offered. Residents who chose to be vaccinated will sign (or representative to sign) a consent form. Those who decline the vaccine will be required to sign a declination form.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to provide education, offer, and document Covid-19 (Coronavirus Disease 19, a respiratory viral infection that affects primarily the lungs and result in cough and difficulty breathing) vaccinations for three (3) of five (5) sampled residents (Residents 15, 22, and 23). This deficient practice placed the residents and staff at risk for possible Covid-19 infection due to missed vaccination dosage and violated the residents or responsible parties' rights to make an informed decision. Findings: 1. A review of Resident 15's Admission Record indicated Resident 15 was admitted to the facility on [DATE]. A review of Resident 15's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 12/22/2023, indicated Resident 15 had diagnoses of chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), status post (s/p, a term used in medicine to refer to a surgical procedure, diagnosis or just an event) tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing), and seizure disorder (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably). A review of Resident 15's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/28/2024, indicated Resident 15 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state (condition where resident has woken from a coma but still lacks awareness)/no discernible consciousness. The MDS indicated Resident 15 was dependent (helper does all of the effort. resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands), and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, toilet transfer, and tub/shower transfer was not attempted for Resident 15 and the activities were not performed prior to the current illness, exacerbation, or injury. A review of Resident 15's Immunization Summary Report, dated 7/2/2024, indicated Resident 15's last covid vaccination was on 7/19/2021. A review of Resident 15's Immunization Records did not indicate a consent, refusal, or administration for the updated covid vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 15's Medical Records and interview on 6/29/2024 at 6:06 PM with the Director of Nursing (DON), the DON stated Resident 15 was admitted to the unit on 12/22/2023. The DON stated Resident 15 did not receive the updated covid vaccination. The DON stated there was no indication in Resident 15's records that Resident 15's responsibly party was educated, informed, or offered the updated covid vaccine. The DON also stated Resident 15's chart did not indicate a declination form for the covid vaccination. b. a. A review of Resident 22's Admission Record indicated Resident 22 was admitted to the facility on [DATE]. A review of Resident 22's H&P, dated 5/16/2024, indicated Resident 22 had diagnoses of respiratory failure with ventilator dependence (when resident is unable to wean off a ventilator and breathe independently), Type 2 Diabetes Mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), seizure disorder (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably), and cerebrovascular accident (CVA - stroke; damage to the brain from interruption of its blood supply). A review of Resident 22's MDS, dated [DATE], indicated Resident 22 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 22 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 22 due to medical condition or safety concerns. A review of Resident 22's Immunization Summary Report, dated 7/2/2024, indicated Resident 22's last covid vaccination was on 5/28/2021. A review of Resident 22's Immunization Records did not indicate a consent, refusal, or administration for the updated covid vaccination. During a concurrent record review of Resident 22's Medical Records and interview on 6/29/2024 at 5:55 PM with the DON, the DON stated Resident 22 was admitted to the unit on 5/12/2023. The DON stated Resident 22 did not receive the updated covid vaccination. The DON stated there was no indication in Resident 22's records that Resident 22's responsibly party was educated, informed, or offered the updated covid vaccine. The DON also stated Resident 22's chart did not indicate a declination form for the covid vaccination. c. A review of Resident 23's Admission Record indicated Resident 23 was admitted to the facility on [DATE]. A review of Resident 23's H&P, dated 3/19/2024, indicated Resident 23 had diagnoses of respiratory failure with ventilator support, CVA, and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 23's MDS, dated [DATE], indicated Resident 23 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 23 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and roll left and right. The MDS also indicated sit to lying, lying to sitting on bedside, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer was not attempted for Resident 23 due to medical condition or safety concerns. A review of Resident 23's Immunization Records did not indicate a consent, refusal, or administration for the updated covid vaccination. A review of the Immunization Summary Report indicated Resident 23 did not have a covid vaccination record. During a concurrent record review of Resident 23's Medical Records and interview on 6/29/2024 at 5:59 PM with the DON, the DON stated Resident 23 was admitted to the unit on 3/18/2024. The DON stated Resident 23 did not have any covid vaccination information in his immunization record. The DON stated there was no indication in Resident 23's records that Resident 23's responsibly party was educated, informed, or offered the updated covid vaccine. The DON also stated Resident 23's chart did not indicate a declination form for the covid vaccination. During an interview on 6/29/2024 at 6:15 PM with the Infection Control Director (ICD), the ICD stated the updated covid vaccination was available for the residents. The ICD stated the updated covid vaccinations should have been administered to the residents. The ICD stated the unit started offering the updated covid vaccination in the beginning of October 2023. The ICD also stated for residents who are [AGE] years and older, who have received the initial updated covid vaccination were eligible to receive another dose of the updated covid vaccination. During an interview on 6/29/2024 at 6:25 PM with ICD, the ICD stated the facility needed to follow the unit's infection control policy for covid vaccination. The ICD stated in the beginning, the covid vaccination was a requirement and now was strongly recommended and should be offered to the residents at any time of the year. The ICD stated the vaccination was not to prevent the residents from getting covid, but to allow the residents' system to fight against the symptoms more than the unvaccinated resident. The ICD stated if the resident was eligible to receive the vaccination, the updated covid vaccine should be offered. The ICD stated all newly admitted residents who were eligible to receive the covid vaccination should be offered the covid vaccination on the day of admission. During a concurrent review of the infection control policy and interview on 6/29/2024 at 7:38 PM with the DON, the DON stated the updated covid vaccinations should be offered to each resident. The DON stated on admission, the residents should be screened for eligibility to receive the updated covid vaccination. The DON stated the importance of educating and offering the covid vaccination was to follow the infection control policy and prioritize the resident's overall wellbeing. The DON stated when residents consent to the covid vaccination, the vaccination would be administered to the resident and documented. The DON stated if the resident refused the vaccination, the consent declination form would be completed and signed. The DON stated the resident's declination form would be placed in the resident's chart. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure titled, Sub-Acute Infection Control Policies, dated revised 9/2021, indicated all Subacute residents will be offered the COVID-19 vaccine and will be prioritized for receipt. All new admissions to the Subacute unit will be screened for prior COVID-19 vaccination history and offered the vaccine if they have not yet completed the full vaccination series. Resident that chooses to receive the vaccine will be given information of the approval of the COVID-19 vaccine and will be asked to give consent. Residents may decline to receive the COVID-19 vaccine but may choose to accept the vaccine at any time after declination. Declinations should be documented in the medical record. A review of the Centers for Disease Control and Prevention (CDC) titled, Stay Up to Date with COVID-19 Vaccines, dated 5/14/2024, indicated the CDC recommends the 2023-2024 updated Covid-19 vaccines to protect against serious illness from Covid-19. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#preferential