STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555859	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Potential for minimal 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** 48332 Based on observation, interview, and medical record review, the facility failed to ensure the resident's right was promoted for one of 12 final sampled resident (Resident 10). * Resident 10's catheter drainage bag was not placed in the dignity bag. This failure had the potential to affect the privacy and dignity of the resident. Findings: Medical record review for Resident 10 was initiated on 11/20/24. Resident 10 was admitted to the facility on [DATE]. Resident 10 had a diagnosis of neuromuscular dysfunction of the urinary bladder Review of Resident 10's physician's order dated 9/26/24, showed Resident 10 had an order for an indwelling urinary catheter, size Fr 16 with 10 ml balloon, to drainage bag, related to the above diagnosis. In addition, there was a physician's order dated 9/26/24, for a privacy bag, indwelling urinary catheter bag in a privacy bag every shift. On 11/20/24 at 0951 hours, an observation was conducted on Resident 10's indwelling urinary catheter. Resident 10's indwelling urinary catheter bag was observed with 100 ml of urine. The indwelling urinary catheter bag was observed not placed inside the dignity bag. The dignity bag was at the left side of the bed while the catheter bag with urine was at the right side of the bed. A concurrent observation and interview regarding Resident 10's indwelling urinary catheter was conducted with RRT 1. RRT 1 verified the indwelling urinary catheter bag was not inside the dignity bag. RRT 1 stated the indwelling urinary catheter bag should be inside the dignity bag. On 11/20/24 at 1615 hours, an interview was conducted with RN 2. RN 2 was asked about the use of dignity bag. RN 2 stated for the urine not to be seen for privacy. RN 2 further stated all the residents with an indwelling urinary catheter have the catheter bag with a separate blue bag that served as a dignity bag for privacy. On 11/20/24 at 1632 hours, an interview was conducted with the DON. The DON stated the facility provided dignity bag to all the residents with an indwelling urinary catheter. The DON stated the indwelling urinary catheter bag with urine must be placed inside the provided dignity bag otherwise it would violate the privacy.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the proper GT care was provided for three of eight final sampled residents (Residents 17, 24, and 32) and one nonsampled resident (Resident 15) reviewed for enteral tubing. * The facility failed to ensure Residents 15 and 24 had the proper labeling of name and date of the GT feeding bottle, water irrigation bag and irrigation set. * The facility failed to ensure Residents 17 and 32's GT dressings were changed daily as ordered. These failures posed the risk for developing complications related to the residents' GT. Findings: Review of the facility's P&P titled Administration of Enteral Nutrition revised ,d+[DATE] showed gather and prepare the necessary equipment. Label formula bag with two identifiers, feeding rate and hang date and time. Visually inspect the enteral formula for damage to the container, altered formula if the intgrity is compromised or expired. Label flush bag with date and contents i.e. water, ,d+[DATE] normal saline, normal saline 1. Medical record review was initiated for Resident 15 on [DATE]. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Physician Order Sheet for the month of [DATE] showed an order dated [DATE], Jevity 1.5 at 55 ml/hour for 16 hrs, on at 1800 hours and off at 1000 hours or until dose completed, total dose 880 ml/1320 kcal. If Jevity 1.5 unavailable substitute with Vital 1.2 or Jevity 1.2 at 70 ml/hour for 16 hours, 1120 ml/ 1344 kcal. Another physician's order dated [DATE], showed to change enteral irrigation syringe daily. On [DATE] at 1509 hours, a concurrent observation of Resident 15 and interview was conducted with LVN 5. During the observation, a GT feeding formula of Jevity 1.5 was hung infusing at 55 ml/hour via enteral feeding pump. Resident 15 's GT feeding formula, water irrigation bag, and irrigation set were observed to have no label of name and date. LVN 5 verified all should have been labeled with the name and date. 2. Medical record review was initiated for Resident 24 on [DATE]. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Physician Order Sheet for the month of [DATE] showed an order dated [DATE], Glucerna 1.5 at 55 ml/hr for 20 hrs daily via GT via enteral pump to yield 1100 ml/1650 cal, on at 1200 hours and off at 0800 hours, or until dose limit reached. Another physician's order dated [DATE], showed to change the enteral feeding syringe daily. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1510 hours, a concurrent observation of Resident 24 and interview was conducted with LVN 5. During the observation, a GT feeding formula of Glucerna 1.5 was hung infusing at 55 ml/hr via enteral feeding pump. Resident 24's GT feeing formula, water irrigation bag, and irrigation set were observed to have no label of name and date. LVN 5 acknowledged the GT feeding bottle, water irrigation bag and irrigation set should have been labeled with the name and date. On [DATE] at 1320 hours, an interview was conducted with the DON. The DON verified the above findings. 49258 3. Medical record review for Resident 17 was initiated on [DATE]. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated [DATE], showed Resident 17 did not have capacity to understand choices and make healthcare decisions. Review of Resident 17's Physician Order Sheet for [DATE] showed a physician's order dated [DATE], for enteral tube site care, to cleanse with NS, pat dry, and apply t-drain daily for maintenance. On [DATE] at 0900 hours, a concurrent wound care observation and interview was conducted with LVN 5. Resident 17 was observed awake and lying in bed. Resident 17's GT dressing was dated [DATE]. LVN 5 verified the GT dressing was not changed daily as ordered. LVN 5 further stated she missed to change Resident 17's GT dressing yesterday, [DATE]. 4. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated [DATE], showed Resident 32 did not have the capacity to understand choices and make healthcare decisions. Review of Resident 32's Physician Order Sheet for [DATE] showed a physician's order dated [DATE], for enteral tube site care, to cleanse with NS, pat dry, and apply t-drain daily for maintenance. On [DATE] at 0945 hours, a concurrent wound care observation and interview was conducted with LVN 5. Resident 32 was observed awake and lying in bed. Resident 32's GT dressing was dated [DATE]. LVN 5 verified the GT dressing was not changed daily as ordered. LVN 5 further stated she missed to change Resident 32's GT dressing yesterday, [DATE]. On [DATE] at 1058 hours, a concurrent interview and medical record review for Residents 17 and 32 was conducted with RN 1. RN 1 stated the GT dressings for Residents 17 and 32 should be changed daily and as needed. RN 1 further stated the GT dressing should be changed daily as ordered for continuous assessment of site for signs and symptoms of infection. On [DATE] at 1625 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 17 and 32.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one nonsampled resident (Resident 30). * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in the medical record for Resident 30. In addition, the facility failed to develop a plan of care for the use of PICC line. These failures had the potential to delay the identification of catheter related complications for the resident. Findings: Review of the facility's P&P titled Central Line Placement, Maintenance and Dressing Change dated 6/2023 showed to measure the length of the external PICC line access device and arm circumference with each dressing change and compare with the length documented at insertion. Discrepancies in the measurements from one assessment from to next requires notification to physician. Medical record review for Resident 30 was initiated on 11/20/24. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 10/18/24, failed to show the information of the measurement and assessment of the PICC line was documented when the resident was admitted to the facility. Review of Resident 30's Comprehensive Nursing assessment dated [DATE], showed under the section for IV Line Assessment, Resident 30 had a peripheral IV site on the right upper arm, double lumen. However, the date of IV insertion, length of insertion site, and the IV site appearance information were not documented. Review of Resident 30's Physician Order Sheet for November 2024 showed a physician's order dated 10/17/24, to change the PICC line catheter site dressing on admission one time and weekly with transparent dressing, with site change: to measure external catheter length with each dressing change and PRN one time a day every seven days; measure the mid arm circumference three inches or ten cm above intended insertion site; and document circumference in inches. Further review of the medical record failed to show a documented evidence the measurements of the length of the PICC line catheter above the insertion site and arm circumference were obtained upon admission. Review of Resident 30's plan of care failed to show a documented evidence a care plan problem was developed to address the use of PICC line. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1055 hours, an observation and concurrent interview for Resident 30 was conducted with LVN 3 at Resident 30's room. LVN 3 verified Resident 30's use of the PICC line on the right upper arm with a transparent dressing dated 11/15/24. LVN 3 stated the RNs were responsible for the care of the IV access of the residents. On 11//21/24 at 1124 hours, an interview and concurrent medical record review for Residents 30 was conducted with RN 4. RN 4 stated Resident 30 had a PICC line on the right upper arm and with a dry dressing, two lumen catheters, and with a label of the date of the dressing was changed. RN 4 stated the dressing change for the PICC was performed once a week and as needed. RN 4 verified Residents 30's medical record did not show the PICC line external catheter and arm measurements upon admission to the facility. RN 4 stated there should have been a measurements of the length of catheter and arm circumference upon admission of the resident for a comparison. In addition, RN 4 verified there was no specific care plan developed for the use of PICC line. On 11/21/24 at 1552 hours, an interview and concurrent medical record review for Resident 30 was conducted with the DON. The DON was informed and verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of 12 final sampled residents (Residents 13, 23, 25, and 33) and seven nonsampled residents (Resident 2, 8, 12, 19, 26, 30, and 27) reviewed for respiratory care were provided with the appropriate respiratory care when: * The facility failed to ensure the nasal cannula was dated and properly stored for Residents 12 and 33. There was no signage for oxygen usage for Resident 33's room. * The facility failed to ensure the nebulizer mask, tubing, and bag were labeled with the date when it was changed and properly stored for Resident 23. * The facility failed to ensure Residents 2, 13, 25, 26,and 30's nasal cannula tubings were labeled, dated, and not touching the floor. In addition, there should date and label the set-up bags for nasal cannula tubings and nebulizer mask. * The facility failed to ensure the manufacture's maintenance care was followed for the BiPap for Resident 26. * The facility failed to ensure Residents 8 and 27's oxygen tubings were labeled and dated. In addition, there was no signage for oxygen usage in the residents' room. * The facility failed to ensure Resident 19's nasal cannula tubing was labeled with the date it was changed and the oxygen humidifier was changed weekly. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility P&P title Pulmonary/Respiratory Care dated 10/2022 showed the maintenance of the equipment for the respiratory care in accordance with the manufacturer specifications consistent with federal, state, and local laws and regulations. Routine machine maintenance and care occurs on equipment used by the residents included to clean the equipment per manufacturer's recommendation. 1. Medical record review for Resident 12 was initiated on 11/20/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Physician Order Sheet for the month of November 2024 showed an order dated 12/2/24, for oxygen at 2 liters per minute via nasal cannula for SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1035 hours, a concurrent observation and interview was conducted with LVN 3. Resident 12's nasal cannula was observed to have no label of the date when it was changed. In addition, there was no plastic bag to store the resident's nasal cannula when not in use. LVN 3 acknowledged Resident 12's nasal cannula should have been labeled with the date when it was changed, and there should be a plastic bag labeled with the resident's name to use for nasal cannula storage. On 11/22/24 at 1320 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 2. Medical record review for Resident 23 was initiated on 11/20/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Order Sheet for the month of November 2024 showed an order dated 9/6/24, for nebulizer equipment change, change and date weekly for the nebulizer mask/tubing, nebulizer medication cup, tubing, and bag. On 11/20/24 at 1013 hours, a concurrent observation on Resident 23 and interview was conducted with LVN 1. Resident 23's nebulizer mask, tubing, and bag were observed to have no label of the date when it was last changed. In addition, there was no plastic bag to store the resident's nebulizer mask when not in use. LVN 1 acknowledged the nebulizer mask and tubing should have been dated when it was last changed and with available plastic bag with the resident's name for storage. 3. Medical record review for Resident 33 was initiated on 11/20/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Social History assessment dated [DATE], showed Resident 33 had a BIMS of 15 (indicates intact cognition). Review of Resident 33's Physician Order Sheet for the month of November 2024 showed the following physician's orders: - dated 11/18/24, for oxygen administration at 2-3 liters per minute via nasal cannula. - dated 11/18/24, to change oxygen tubing, humidification bottle, and clean filter every Saturday night shift. Review of Resident 33's care plan showed the resident had a potential for respiratory distress, difficulty breathing, and alteration in breathing pattern; and an intervention dated 11/4/24, was to administer oxygen as prescribed. a. On 11/20/24 at 0922 hours, a concurrent observation and interview was conducted for Resident 33 with LVN 3. Resident 33's nasal cannula was observed to have no label of the date when it was last changed. In addition, there was no plastic bag to store the resident's nasal cannula when not in use. When LVN 3 was asked when it was last changed, LVN 3 had no idea when it was last changed and stated there should have a plastic bag available for the storage of the nasal cannula labeled with the resident's name. LVN 3 acknowledged the above findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 11/20/24 at 1015 hours, during the initial tour observation, Resident 33 was observed lying in bed with oxygen via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute, with tubing unlabeled and undated, and no signage for oxygen usage by the room. On 11/20/24 at 1039 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the oxygen tubing was unlabeled and undated, and there was no signage for oxygen usage in the resident's room. LVN 3 stated the oxygen tubing should be changed weekly on Saturday and should have been dated and labeled to know when it was changed. LVN 3 furthermore stated there should have been an oxygen signage in the resident's room due to hazard precaution. On 11/22/24 at 1320 hours, an interview was conducted with the DON. The DON verified the above findings. 39670 4. O n 11/20/24 at 0832 hours, Resident 26 was observed in bed awake, alert, and with a BiPAP machine at the bedside on top of the drawer. The BiPAP machine (ResMed AirCurve 10) was turned off with the mask and strap were placed inside a clear plastic bag, and the oxygen concentrator machine was turned on. Resident 26 stated he used the BiPAP machine at night and the nurse put it on him and the RT removed in the morning. Medical record review for Resident 26 was initiated on 11/20/24. Resident 26 was admitted to the facility on [DATE]. Review oft Resident 26's H&P examination dated 9/12/24, showed Resident 26 had the capacity to understand choices and make health care decisions. Review of Resident 26's Physician Order Sheet for November 2024 showed a physician's order dated 10/8/24, for the respiratory equipment cleaning instructions. Another physician's order for the BiPAP machine settings: Home BiPAP at 16 cmH2O, Inspiration. 5 cmH20 Expiration with oxygen at Lpm/Bi-PAP scheduled for night and as needed. However, further review of the medical record failed to show documented evidence of a physician's order specific for cleaning and maintenance of the BiPAP machine per the manufacturer's recommendation. Review of the ResMed AirCurve 10 (BiPAP machine) user guide (undated) showed under the caring for the device section to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health of the resident. On 11/20/24 at 1057 hours, an observation and concurrent interview for Resident 26 was conducted with LVN 3 inside Resident 26's room. LVN 3 verified the oxygen concentrator machine was still turned on and the Bi-PAP machine was turned off and not placed on the resident. LVN 3 stated the RT was responsible for the removing and turning off the BiPAP machine when the resident was awake, and the machine was not in use. LVN 3 verified there was no specific order for the cleaning and maintenance of the BiPAP machine per the manufacturers manual instructions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 1529 hours, an interview and concurrent medical record review for Resident 26 was conducted with the Respiratory Manager. The Respiratory Manager verified the respiratory staff cleaned all the respiratory equipment every day. The Respiratory Manager verified Resident 26's use of BiPAP machine and the RT was responsible for care and maintenance of the respiratory equipment including the BiPAP machine. The Respiratory Manager verified there was no specific order for the BiPAP machine care and maintenance per the manufacturer's instruction guide. 5. During the initial tour of the facility on 11/20/24 at 0819 and 1048 hours, Resident 2 was observed in bed receiving oxygen at 3 liters per minute via nasal cannula attached to an oxygen machine. Resident 2's oxygen nasal cannula tubing was observed unlabeled and touching the trash bin at the bedside. Medical record review for Resident 2 was initiated on 11/20/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2' Physician Order Sheet for November 2024, showed the following physician's orders: - dated 11/13/24, to administer oxygen at 2 to 5 liters per minute via nasal cannula continuously two times daily, and - dated 11/13/24, to change oxygen tubing, humidification, bottle, and clean filter weekly. 6. During the initial tour of the facility on 11/20/24 at 0830 hours and 1055 hours, Resident 30 was observed in bed receiving oxygen at 2 liters per minute via nasal cannula attached to an oxygen machine. Resident 30's oxygen nasal cannula tubing was observed unlabeled and touching the floor. Medical record review for Resident 30 was initiated on 11/20/24. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30' Physician Order Sheet for November 2024, showed the following physician's orders: - dated 11/19/24, to administer oxygen at 2 liters per minute via nasal cannula continuously every shift, and - dated 11/19/24, to change oxygen tubing, humidification, bottle, and clean filter weekly. 7. During the initial tour of the facility on 11/20/24 at 0843 and 1045 hours, Resident 13 was observed in bed. Resident 13's nebulizer machine was at the bedside with the part of the tubing was touching the floor. Medical record review for Resident 13 was initiated on 11/20/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13' Physician Order Sheet for November 2024, showed the following physician's orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/31/24, to administer oxygen at 1 to 2 liters per minute as needed, and - dated 10/31/24, to change the nebulizer mask/tubing, nebulizer medication cup, tubing, and bag weekly. 8. During the initial tour of the facility on 11/20/24 at 0845 and 1050 hours, Resident 25 was observed in bed. Resident 13's nebulizer machine was at the bedside with tubing unlabeled and touching the floor. Medical record review for Resident 25 was initiated on 11/20/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25' Physician Order Sheet for November 2024 showed the following physician's orders: - dated 7/16/24, to administer oxygen at 1 to 3 liters per minute as needed, and - dated 8/19/24, to change the nebulizer mask/tubing, nebulizer medication cup, tubing, and bag weekly. On 11/20/24 at 1057 hours, an observation and concurrent interview for Resident 2, 13, 25, 26, and 30 was conducted with LVN 3 inside the residents' room. LVN 3 verified the nasal cannula oxygen tubing were unlabeled, undated, and touching the floor. LVN 3 stated they would have to date and label the set-up bags for nasal cannula tubing and nebulizer mask. On 11/21/24 at 1552 hours, an interview and concurrent medical record review for Resident 2, 13, 25, 26, and 30 was conducted with the DON. The DON was informed and verified the above findings. 43119 9. On 11/20/24 at 1044 hours, during the initial tour observation, Resident 8 was observed lying in bed with oxygen via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute, tubing unlabeled and undated and no signage for oxygen usage by the room. Medical record review for Resident 8 was initiated on 11/20/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 10/2/24, showed Resident 8 had no capacity to understand choices and make health care decisions. Review of Resident 8's Physician Order Sheet showed the following physician's orders dated 11/20/24: - for oxygen administration at 2-3 liters per minute via nasal cannula to maintain SPO2 at least 92% or higher. - to change oxygen tubing, humidification bottle, and clean filter every Saturday night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's care plan showed the resident had acute respiratory failure with hypoxia; and an intervention dated 10/1/24, was to administer oxygen as ordered and monitor for effectiveness. On 11/20/24 at 1044 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the oxygen tubing was unlabeled and undated, and there was no signage for oxygen usage in the resident's room. LVN 3 stated the oxygen tubing should be changed weekly on Saturday and should have been dated and labeled to know when it was changed. LVN 3 furthermore stated there should have been an oxygen signage in the resident's room due to hazard precaution. On 11/20/24 at 1054 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the oxygen machine concentrator was set at 4 liters per minute and the physician's order for the oxygen was to administer at 2-3 liters per minute for Resident 8. LVN 3 stated the physician's order should be followed. 10. On 11/20/24 at 1108 hours, during the initial tour observation, Resident 27 was observed lying in bed with oxygen on via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute, tubing unlabeled and undated, and no signage for oxygen usage by the room. Medical record review for Resident 27 was initiated on 11/20/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 9/16/24, showed Resident 27 had the capacity to understand choices and make health care decisions. Review of Resident 27's Physician Order Sheet showed the following physician's orders: - dated 9/15/24, to change oxygen tubing, humidification bottle, and clean filter every Saturday night shift. - dated 9/26/24, for oxygen administration at 2-6 liters per minute via nasal cannula to keep SPO2 > 92%. Review of Resident 27's care plan showed the resident had a potential for respiratory distress, difficulty breathing, and alteration in breathing pattern; and an intervention dated 9/18/24, was to administer oxygen as ordered and monitor for effectiveness. On 11/20/24 at 1122 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified the oxygen tubing was unlabeled and undated, and there was no signage for oxygen usage in the resident's room. LVN 3 stated the oxygen tubing should be changed weekly on Saturday and should have been dated and labeled to know when it was changed. LVN 3 furthermore stated there should have been an oxygen signage in the resident's room due to hazard precaution. 49258 11. Review of the facility's document titled Respiratory Equipment Change and Cleaning Guidelines, undated, showed the following in the Oxygen Equipment section: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nasal cannula should be changed weekly and PRN. Discard and replace if heavily soiled. Date and initial. Discard in regular waste container and store in a plastic bag when not in use; and - Oxygen bubble concentrator humidifier should be changed weekly and PRN. Discard and replace if heavily soiled. Date and initial. Discard in regular waste container. During the initial tour of the facility on 11/20/24 at 1232 hours, Resident 19 was observed awake and lying in bed. Resident 19 did not answer when asked how he was doing. Resident 19 was observed receiving oxygen at 2 liters per minute via nasal cannula. Resident 19's nasal cannula tubing was observed undated and oxygen humidifier was dated 11/12/24. Medical record review for Resident 19 was initiated on 11/20/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 10/8/24, showed Resident 19 did not have capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed the following physician's orders: - dated 10/16/24, for oxygen at 2-5 liters per minute via nasal cannula and titrate FiO2 to keep SpO2 greater than 92%; and - dated 11/18/24, to change oxygen tubing, humidification, bottle, and clean filter one time weekly. On 11/20/24 at 1250 hours, an interview was conducted with RN 5 and RRT 3. RN 5 verified Resident 19's nasal cannula tubing was undated, and the oxygen humidifier was last changed more than a week ago. RRT 3 stated the nasal cannula should be changed weekly every Tuesday night and it should be labeled with the date when it was last changed, and the oxygen humidifier should be changed weekly as well. RRT 3 further stated the RTs changed the oxygen humidifier every Saturday night. On 11/21/24 at 1625 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 19.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the least restrictive alternatives were attempted prior to the use of side rails for six of 12 final sampled residents (Residents 10, 17, 25, 32, 33, and 239) and five nonsampled residents (Residents 8, 12, 19, 27, and 28) reviewed for side rails use. This failure had the potential to put the residents at risk for entrapment and serious injury. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Restraints-Bed Rails dated 11/2022 showed if the bed or side rails were used, the facility will attempt appropriate alternatives before installing the bed rails. 1. On 11/20/24 at 0825 and 1048 hours, Resident 12 was observed lying in bed with the bilateral upper side rails were elevated. Medical record review for Resident 12 was initiated on 11/20/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Physician Order Sheet for November 2024 showed a physician's order dated 1/21/23, to apply the bilateral side rails as enabler for turning and repositioning. Review of Resident 12's Side Rail Evaluation dated 11/1/24, under the side rails determination section showed Resident 12's condition did not indicate the need for the side rails at this time. Further review of Resident 12's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 1500 hours, an interview for Resident 12 was conducted with CNA 4. CNA 4 verified Resident 12's use of the upper side rails while in bed. CNA 4 stated the resident was able to grab the rails when asked to reposition in bed. On 11/21/24 at 1504 hours, an observation, interview, and concurrent medical record review for Resident 12 was conducted with LVN 1. LVN 1 verified Resident 12 was in bed with the bilateral side rails elevated. LVN 1 verified Resident 12's medical record did not show the least restrictive alternatives were attempted prior to the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross reference to F909, example #1. 2. On 11/20/24 at 0844 hours and 11/21/24 at 0802 hours, Resident 25 was observed lying in bed with all four side rails were elevated. Medical record review for Resident 25 was initiated on 11/20/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Physician Order Sheet for November 2024 showed a physician's order dated 2/29/24, to apply all the side rails for safety and as enabler. Review of Resident 25's Side Rail Evaluation dated 9/11/24, showed Resident 25's use of side rails as enabling device to turn and reposition in bed. Further review of Resident 25's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 1510 hours, an interview for Resident 125 was conducted with CNA 4. CNA 4 verified Resident 25's use of all the side rails while in bed. CNA 4 stated the resident was able to use the rails when repositioning in bed. On 11/21/24 at 1515 hours, an observation, interview, and concurrent medical record review for Resident 25 was conducted with LVN 1. LVN 1 verified Resident 25 was in bed with all the four side rails elevated. LVN 1 verified Resident 25's medical record did not show the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 1519 hours, an interview and concurrent medical record review for Residents 12 and 25 was conducted with RN 4. RN 4 stated the side rail assessment form was the only form used to show the least restrictive measures prior to the use of side rails. RN 4 verified the side rail assessment forms for Residents 12 and 25 did not show the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 1552 hours, an interview and concurrent medical record review for Residents 12 and 25 was conducted with the DON. The DON was informed and verified the findings. Cross reference to F909, example #2. 48332 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's P&P titled Restraints, Category Freedom from Abuse, Neglect and Exploitations, release date 10/2022. Rationale: Patients are assessed prior to application of restrictive devices to determine medical symptoms that may require the use of restraints, to determine how the use of restraints would treat the medical symptom, protect the patient's safety and assist the patient in attaining or maintaining highest practicable level of physical and psychosocial well-being. On admission, develop a plan of care individualized to patient's need as it relates to alternatives to restraining devices or least restrictive restraining devices and/or restraint reduction or elimination include interventions to address risks and negative outcomes. Complete the restraint assessment to determine the least restrictive. Obtain a physician order for the least restrictive restraints and frequency of use. On 11/20/24 at 0942 hours, Resident 10 was observed in bed with bilateral bed side rails (also known as bed guards, serves are barriers designed to prevent falls from the bed) elevated. Resident 10 was asked if aware of having side rails. Resident 10 stated, I requested it, I'm more secured to have it, I might roll. Medical record review for Resident 10 was initiated on 11/20/24. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Physician Order Sheet for November 2024 dated 8/17/24, showed a physician's order for the upper and lower bilateral side rails, may have all four side rails up as requested by resident for safety and enablers for bed mobility. Further review of the resident's medical record failed to show documented evidence for a less restrictive measures were attempted prior to the use of the four side rails. On 11/20/24 at 1005 hours, interview was conducted with LVN 1. LVN 1 verified Resident 10 had bilateral upper and lower side rails elevated. LVN 1 stated there was a number indicator at the head of the bed along the wall showing number 4 which meant two upper side rails and two lower side rails were used. LVN 1 stated the four side rails were requested by Resident 10 for safety and feeling more secured if she had it. LVN 1 was asked if she discussed or offered other options which was less restrictive like bed bolster or other types. LVN 1 stated no, because Resident 10 requested for the four side rails. LVN 1 verified the above findings. Cross reference to F909, example #3. 43119 4. On 11/20/24 at 1044 hours and 11/21/24 at 0929 hours, Resident 8 was observed lying in bed with the bilateral upper and lower side rails were elevated. Medical record review for Resident 8 was initiated on 11/20/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 10/2/24, showed Resident 8 had no capacity to understand choices and make health care decisions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's Physician Order Sheet for November 2024 showed a physician's order dated 10/10/24, to apply the upper and lower bilateral side rails as an enabler for turning and repositioning. Review of Resident 8's Side Rail Evaluation dated 10/10/24, showed Resident 8's use of the side rails as an enabling device to turn and reposition in bed. Further review of Resident 8's medical record failed to show documented evidence the least restrictive alternatives was attempted prior to the use of the side rails. On 11/21/24 at 1018 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 8 was in bed with the bilateral upper and lower side rails elevated and stated the side rails were used for Resident 8 due to attempts to get out of the bed unassisted. On 11/21/24 at 1532 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 4. RN 4 stated the Side Rail Evaluation was the only form that the facility used to show the least restrictive measures attempted prior to the use of side rails. RN 4 verified the Side Rail Evaluation form for Resident 8 did not show the least restrictive alternatives were attempted prior to the use of the side rails and stated the least restrictive intervention prior to the side rails used should have been attempted to prevent the risk of entrapment. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings . Cross reference to F909, example #4. 5. On 11/21/24 at 0944 hours and 1520 hours, Resident 27 was observed lying in bed with the bilateral upper and lower side rails were elevated. Medical record review for Resident 27 was initiated on 11/20/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 9/16/24, showed Resident 27 had the capacity to understand choices and make health care decisions. Review of Resident 27's Physician Order Sheet for November 2024 showed a physician's order dated 9/15/24, to apply the upper and lower bilateral side rails for bed mobility. Review of Resident 27's Side Rail Evaluation dated 9/15/24, showed Resident 27's use of the side rails as an enabling device to turn and reposition in bed. Further review of Resident 27's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of the side rails. On 11/21/24 at 1452 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 27's use of all the side rails while in bed. CNA 4 stated the resident was able to use the side rails when turning and repositioning in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 1600 hours, an interview and concurrent medical record review for Resident 27 was conducted with RN 4. RN 4 stated the Side Rail Evaluation was the only form used by the facility to show the least restrictive measures attempted prior to the use of side rails. RN 4 verified the Side Rail Evaluation form for Resident 27 did not show the least restrictive alternatives was attempted prior to the use of side rails and stated the least restrictive intervention prior to the side rails used should have been attempted to prevent the risk of entrapment. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings . Cross reference to F909, example #5. 6. On 11/20/24 at 1015 hours, and 11/21/24 at 0953 hours, Resident 33 was observed lying in bed with three side rails elevated. Medical record review for Resident 33 was initiated on 11/20/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Social History assessment dated [DATE], showed Resident 33 had a BIMS score of 15 (indicates intact cognition). Review of Resident 33's Physician Order Sheet for November 2024 showed a physician's order dated 11/21/24, to apply the upper bilateral and left lower side rails as per the request. Review of Resident 33's Side Rail Evaluation dated 11/5/24, showed Resident 33's use of the side rails as enabling device to turn and reposition in bed and to transfer independently. Further review of Resident 33's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 1500 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 33's use of three side rails while in bed and stated the resident was able to use the rails when turning and repositioning in bed. On 11/21/24 at 1522 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 33's used of the three side rails. On 11/21/24 at 1612 hours, an interview and concurrent medical record review for Resident 33 was conducted with RN 4. RN 4 stated the Side Rail Evaluation was the only form used by the facility to show the least restrictive measures prior to the use of side rails. RN 4 verified the Side Rail Evaluation form for Resident 33 did not show the least restrictive alternatives were attempted prior to the use of side rails and stated the least restrictive intervention prior to the side rails used should have been attempted to prevent the risk of entrapment. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings. Cross reference to F909, example #6. 49258 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During the initial tour of the facility on 11/20/24 at 1031 hours, Resident 17 was observed sleeping and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 17 was initiated on 11/20/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 7/12/24, showed Resident 17 had no capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 7/10/24, to apply the upper bilateral side rails as per the family's request. Review of Resident 17's Side Rail Evaluation dated 10/21/24, under the side rails determination section showed Resident 17's condition did not indicate the need for the side rails at this time, but Resident 17's family requested for it. Further review of Resident 17's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 0830 hours, Resident 17 was observed awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 17's use of the bilateral upper side rails while in bed. CNA 2 stated the resident was able to grab the rails during repositioning. Cross reference to F909, example #7. 8. During the initial tour of the facility on 11/20/24 at 1232 hours, Resident 19 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 19 was initiated on 11/20/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 10/8/24, showed Resident 19 had no capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 10/8/24, to apply the bilateral upper side rails for assistance with turning and repositioning and per family's request. Review of Resident 19's Side Rail Evaluation dated 10/7/24, under the side rails determination section showed Resident 19's condition did not indicate the need for the side rails at this time. Further review of Resident 19's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 0800 hours, Resident 19 was observed sleeping and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 0820 hours, an interview was conducted with CNA 6. CNA 6 verified Resident 19's use of the bilateral upper side rails while in bed. CNA 6 stated the resident was able to grab the rails during repositioning. Cross reference to F909, example #8. 9. During the initial tour of the facility on 11/20/24 at 1245 hours, Resident 28 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 28 was initiated on 11/20/24. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 10/11/24, showed Resident 28 had no capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 10/10/24, to apply the bilateral upper side rails as enablers for bed mobility, turning, and repositioning. Review of Resident 28's Side Rail Evaluation dated 10/10/24, under the side rails determination section showed Resident 28 used the side rails as enabling device to turn and reposition self in bed. Further review of Resident 28's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 0854 hours, Resident 28 was observed sleeping and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 28's use of the bilateral upper side rails while in bed. CNA 2 stated the resident used the side rails to grab during repositioning. Cross reference to F909, example #9. 10. During the initial tour of the facility on 11/20/24 at 1113 hours, Resident 32 was observed sleeping and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 32 was initiated on 11/20/24. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated 10/10/24, showed Resident 32 had no capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 10/8/24, to apply the bilateral upper side rails as per the family member's request. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 32's Side Rail Evaluation dated 10/8/24, under the side rails determination section showed Resident 32's condition did not indicate the need for the side rails at this time. Further review of Resident 32's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 0815 hours, Resident 32 was observed awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 0820 hours, an interview was conducted with CNA 6. CNA 6 verified Resident 32's use of the bilateral upper side rails while in bed. CNA 6 stated the resident was able to grab the rails during repositioning. Cross reference to F909, example #10. 11. During the initial tour of the facility on 11/20/24 at 0956 hours, Resident 239 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 239 was initiated on 11/20/24. Resident 239 was admitted to the facility on [DATE]. Review of Resident 239's H&P examination dated 11/15/24, showed Resident 239 had capacity to understand choices and make healthcare decisions. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 11/14/24, to apply the bilateral upper side rails as per the family's request. Review of Resident 239's Side Rail Evaluation dated 11/14/24, under the side rails determination section showed Resident 239's condition did not indicate the need for the side rails at this time. Further review of Resident 239's medical record failed to show documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 11/21/24 at 0806 hours, Resident 239 was awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 239's use of the bilateral upper side rails while in bed. CNA 2 stated the resident was able to grab the rails during repositioning. Cross reference to F909, example #11. On 11/21/24 at 1503 hours, a concurrent interview and medical record review for Residents 17, 19, 28, 32, and 239 was conducted with RN 4. RN 4 stated the licensed nurses performed the side rail evaluation assessment. RN 4 verified Residents 17, 19, 28, 32, and 239's medical records did not show the least restrictive alternatives were attempted prior to the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 1625 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 17, 19, 28, 32, and 239.

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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** 49324 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the medications were properly stored and labeled. * The facility failed to ensure accuracy and complete records of the Medication Room and Medication Refrigerator temperature log. * The facility failed to dispose of an empty bottle of Hy[DATE] (Sodium Hypochlorite Solution) in the Treatment Cart. * The facility failed to ensure Medication Cart 1 was maintained in a sanitary condition. * The facility failed to ensure the medications were labeled with an opened date in accordance with the facility's policy for Resident 22. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Medication Storage and Delivery revised 3/5/24, showed to ensure that all medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, safety and security. 1. On 11/20/24 at 1042 hours, a concurrent observation, facility document review, and interview was conducted with RN 5. There were missing document records for the temperature log of the Medication Room and Medication Refrigerator Temperature on the following dates: 7/11, 7/12, 7/15, and 7/29/24. RN 5 stated the temperatures of the Medication Room Storage and Medication Refrigerator should have been recorded. On 11/22/24 at 1320 hours, an interview was conducted with the DON. The DON verified the findings. 2. On 11/22/24 at 1145 hours, a concurrent observation and interview was conducted with LVN 5. The Hy[DATE] bottle was observed to be empty and still stored in the Treatment cart. LVN 5 stated the Hy[DATE] bottle solution should have been disposed. On 11/22/24 at 1320 hours,an interview was conducted with the DON. The DON verified the findings. 3. On 11/20/24 at 1127 hours, a concurrent observation and interview with LVN 4. The first drawer on the left side of Medication Cart 1 was observed to have medication residue spillage. LVN 4 acknowledged the medication residue spillage should have been cleaned for infection prevention control. On 11/22/24 at 1320 hours,an interview was conducted with the DON. The DON verified the findings. (continued on next page)

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Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51539 4. Review of the facility's P&P titled Storage and Expiration Dating of Medications, Biologicals, syringes, and Needles revised 8/1/24, showed the facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Medical review of Resident 22 was initiated on 11/20/24. The resident was admitted to the facility on [DATE]. Review of Resident 22's November 2024 Physician Order Sheet dated 11/30/23, showed an order for Water Flush Enteral Tube- Medication Administration; Notes: Flush feeding tube with 15-30 ml of water before and after medication administration and 15-30 millimeters between each individual medication. On 11/20/24 at 1010 hours, an observation and concurrent interview was conducted with LVN 1. A bottle of 1000 ml of 0.9% sodium chloride irrigation was found opened and undated on Resident 22's overhead table. LVN 1 was asked if the sodium chloride irrigation bottle had an opened dated. LVN 1 verified the bottle did not have an opened date on it and should have either been discarded after the first use or dated by the staff. On 11/22/24 at 0925 hours, an interview with the DON. The DON was informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43119 Based on observation, interview, and facility document review, the facility failed to ensure the pureed recipes were followed for two residents who received pureed food from the kitchen. * The facility failed to ensure the puree recipe for steamed green beans was followed. This failure had the potential for not providing nutritional meals to meet the needs of residents who were on a pureed diet. Findings: Review of the facility's document titled Patient Diet List dated 11/20/24, showed two residents received pureed food prepared from the kitchen, with no restrictions to steamed green beans. Review of the facility's diet spreadsheet titled Menu Plan Fall Winter 2024 showed the lunch menu included steamed green beans for PU4 pureed diet. Review of the facility's pureed recipe titled Steamed [NAME] Beans PU4, Version 12, undated, showed to remove the number of portions required from the regular recipe. Blend until smooth adding on three tablespoon of food thickener per 10 servings to achieve a smooth textured product. Final product should be smooth, pudding like, but not runny. One tablespoon of food thickener provides an additional 15 calories, four grams carbohydrate, and 10 mg sodium. On 11/21/24 at 1111 hours, a concurrent observation of the puree preparation and interview was conducted with [NAME] 1, RD 2, and Culinary Service Manager present. The following was observed: - For pureed steamed green beans, 10 portions of six oz servings were placed in the blender and half quarts of the vegetable juice was added and processed with the steamed green beans. [NAME] 1 added three tablespoons of food thickener to the pureed steamed green beans. [NAME] 1 mixed the pureed steamed green beans using a whisk then added one tablespoon of food thickener to the pureed steamed green beans. On 11/21/24 at 1203 hours, a pureed texture meal tray was checked with RD 2. RD 2 verified the pureed steamed green bean did not hold a form and was runny. On 11/21/24 at 1216 hours, RD 2 verified the recipe for pureed steamed green beans was not followed and stated the pureed recipe should have been followed. RD 2 stated the pureed steamed green beans should hold a shape and should not be runny. RD 2 further stated not following the puree recipe and adding more food thickener could increase the calorie in the diet.

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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 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** 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. * The facility failed to ensure the microwave utilized to warm up the food was in sanitary condition and free of food residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting board was kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the countertop mounted can opener was in sanitary condition and free of residue. * The facility failed to ensure the sanitizer test strips had not expired. * The facility failed to ensure the expired foods were discarded. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Patient Diet List dated [DATE], showed 16 of 36 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Ice Production, Handling and Distribution revised date ,d+[DATE] showed to keep equipment clean, including draining, cleaning, and sanitizing the ice machine as needed and according to manufacturer's specifications, cleaning schedules, and preventative maintenance schedules. This includes but not limited to: 1) removing the build-up of mineral scale from the ice machine's water systems and sensors, 2) sanitizing the ice machine's water system and ice storage bin or dispenser, 3) cleaning or replacing the air filter and the air-cooled condenser, and 4) cleaning and sanitizing ice bin monthly by culinary staff. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2017, Section ,d+[DATE].11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On [DATE] at 0833 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Operational Engineer. The ice machine's interior top portion to the water curtain located directly above the ice bin, was observed with thick, yellowish residue. The Operational Engineer acknowledged the findings and stated the ice would not be used because it was dirty. 2. Review of the facility's P&P titled Cleaning and Sanitizing Equipment and Work Surfaces revised date , d+[DATE], showed food service equipment and food contact surfaces are clean and sanitized to prevent contamination of food and to minimize the risk of food borne illness. According to the USDA Food Code 2017, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The microwave on a countertop table was observed dirty with dry, white food residue inside the microwave's door and had dry food stains inside the microwave. The Culinary Service Manager verified the findings and stated the microwave was old and needed to be replaced. 3. Review of the facility's P&P titled Maintaining Equipment and Serviceware revised date ,d+[DATE] showed the ventilation hood is inspected and cleaned at least biannually. Check local regulations to ensure more frequent cleaning is not required. According to the USDA Food Code 2022 Section ,d+[DATE].11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On [DATE] at 0824 hours, during the kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The kitchen hood over the stove had black, grease residue. The Culinary Service Manager acknowledged the findings and stated the dietary staff cleaned the hood once a week and should have been cleaned due to fire hazard. 4. Review of the facility's P&P titled Maintaining Equipment and Serviceware revised date ,d+[DATE] showed kitchenware with non-stick coatings have coating intact with minimal scoring or scratches and does not have a flaky surface where particles can contaminate food. Utensils and kitchenware are constructed to be durable. They are free of breaks, open seams, cracks, chips, and inclusion pits. They should have smooth welds/ joints and be free of sharp corners/ edges. Any dish, utensil, kitchenware, or patient serviceware that does not meet standard and in poor repair is discarded and replaced. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section ,d+[DATE].11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts ,d+[DATE] and ,d+[DATE] or shall be discarded. According to the USDA Food Code 2022, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The following was observed and verified by the Culinary Service Manager: - One stainless steel ladle used for water transfer had crusted brownish residue. - One stainless steel potato masher with wooden handle had dry, crusted orange discoloration resembles a rust. - One stainless steel strainer was deformed and worn out. - One stainless steel pot had brownish discoloration inside the pot. - One black egg slicer was worn out, discolored, dirty, and had dry crusted white residue. - One scoop with green handle discolored and peeling. - One cutting knife with cream handle worn out and discolored. - One bread knife with black handle partially melted. - Three stainless steel spatulas with cream handles were discolored, partially melted, edges were uneven and deformed. - Three rubber spatulas with red handles were discolored, had chipped edges and one of the red handle was partially melted. - One dough cutter with cream handle was worn out and discolored. The Culinary Service Manager acknowledged the above findings and stated all will be discarded and replaced because it could get mix with the food. 5. Review of the facility's P&P titled Cleaning and Sanitizing Equipment and Work Surfaces revised date , d+[DATE] showed food service equipment and food contact surfaces are clean and sanitized to prevent contamination of food and to minimize the risk of food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The following was observed and verified by the Culinary Service Manager: - One Crock pot stored with the clean pots and pans was dirty and covered in white, flaky, dusty residue. - One stainless steel ladle used for water transfer was dirty and had dry, whitish/ brownish crusted residue. - Two stainless steel tongs were dirty and had dry, brownish/blackish discoloration. - Three stainless scoops with red, blue, and green handles were dirty and had dry, sticky food residue and water spots. - Three cutting knives with cream and black handles were dirty, fuzzy with cloudy film on the blades. - Three stainless steel spatulas with cream handles were dirty. - One blue peeler was dirty and had dry yellowish residue. - One dough cutter with cream handle was dirty and fuzzy with cloudy film. The Culinary Service Manager acknowledged the above findings and stated it needed to be washed and some needed to be replaced. 6. Review of the facility's P&P titled Maintaining Equipment and Serviceware revised date ,d+[DATE] showed the cutting boards must be made of nonporous material and be free of cracks, seams, and crevices. The boards with heavy wear must be replaced. According to the USDA Food Code 2022, Section ,d+[DATE].12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The brown, red, light blue, yellow and green cutting boards were observed fuzzy, heavily marred and had deep groves. The Culinary Service Manager verified the findings and stated the cutting boards were old and they had two new sets to replace it. 7. Review of the facility's P&P titled Maintaining Equipment and Serviceware revised date ,d+[DATE], showed can opener blade is cleaned between use. The blades that are rusted are replaced. According to the USDA Food Code 2017, Section ,d+[DATE].11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The countertop mounted can opener was observed with dry, crusted residue on the blade. The Culinary Service Manager verified the findings and stated the can opener should have been washed. 8. Review of the facility's P&P titled Cleaning and Sanitizing Equipment and Work Surfaces revised date , d+[DATE] showed prepare sanitizer solution per manufacturer's instructions. Before using and as needed, test concentration of sanitizer using the correct test strips. According to the USDA Food Code 2017, Section ,d+[DATE].116, Warewashing Equipment, Determining Chemical Sanitizer Concentration, concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On [DATE] at 1421 hours, an observation and concurrent interview was conducted with the Culinary Service Manager for the Sink and Surface Cleaner Sanitizer test. The Culinary Service Manager checked the concentration of the sanitizer solution using a paper test strip taken from a bottle of Sink and Surface Cleaner Sanitizer test strips. However, the sanitizer test strip container had an expiration date of ,d+[DATE]. The Culinary Service Manager verified the findings and stated the expired test strips would have given an inaccurate test result. 9. According to the FDA Food Code 2017, Section ,d+[DATE].17 Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking: Marking the date or day the original container is opened with a procedure to discard the food on or before the last date by which the food must be consumed. On [DATE] at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Culinary Service Manager. The 26 single cups of thickened apple juice stored in the Dry Storage Room were expired. The thickened apple juice had an expiration date of [DATE]. The Culinary Service Manager verified the findings and stated the expired items should have been discarded and not stored with the other food items.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 43119 Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in four of nine garbage dumpsters. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Waste Management for Nutrition and Culinary Service revised on 6/2022 showed in the outside dumpster area, to confirm lid or door is closed on the dumpster before leaving the area. Do not leave any trash alongside or on top of the dumpster. Notify supervisor or other designee if the dumpster is too full to dispose the trash or close the lid or door. According to the 2022 FDA (Food and Drug Administration) Food Code, outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 11/20/24 at 1005 hours, an observation with concurrent interview with the EVS Manager was conducted. Four of nine facility's outside garbage dumpsters were observed to have the lids partially propped open by garbage, preventing the lids from fully closing. The EVS Manager verified the findings. The EVS Manager stated all dumpsters lids should be fully closed to prevent animals from getting into the trash and it was an infection control issue.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for six of 12 final sampled residents (Residents 10, 17, 25, 32, 33, and 239) and five nonsampled residents (Residents 8, 12, 19, 27, and 28) reviewed for side rails use. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Restraints-Bed Rails dated 11/2022 showed if the bed or side rails were used, the facility ensures the correct installation, use, and maintenance by assessing the resident risk for entrapment and review the risks and benefits of bed rails prior to installation. Assessed the bed's dimension to ensure the side rails are appropriate for the resident's size and weights. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Restraints-Bed Rails, Category Quality of Care, Sub Category Bed Rails, release date November 2022 showed if the bed or side rail is used, the SAU ensures correct installation, use and maintenance of bed rails, including to but not limited to: assessing the patient for risk of entrapment and review possible risks and benefits of bed rails prior to installation or use. Assess the bed's dimensions to ensure they are appropriate for the patient's size and weight and follow the manufacturer's recommendations and specifications for installing. A concurrent observation, medical record review, and facility document review for Residents 8, 10, 12, 17, 19, 25, 27, 28, 32, 33, and 239 showed the residents' bed entrapment assessments were not completed or the bed inspection gap measurements for Zones 5 and 6 were recorded. For example: 1. On 11/20/24 at 0825 and 1048 hours, Resident 12 was observed lying in bed with bilateral upper side rails were elevated. Medical record review for Resident 12 was initiated on 11/20/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Physician Order Sheet for November 2024 showed a physician's order dated 1/21/23, to apply the bilateral side rails as enabler for turning and repositioning. Review of Resident 12's Side Rail Evaluation dated 11/1/24, showed under the side rails determination section, Resident 12's condition did not indicate the need for side rails at this time. Review of Resident 12's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 6/21/23, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 5 and 6. On 11/21/24 at 1500 hours, an interview for Resident 12 was conducted with CNA 4. CNA 4 verified Resident 12's use of the upper side rails while in bed. CNA 4 stated the resident was able to grab the rails when asked when repositioning in bed. On 11/21/24 at 1504 hours, an observation, interview, and concurrent medical record review for Resident 12 was conducted with LVN 1. LVN 1 verified Resident 12 was in bed with the bilateral side rails elevated. Cross reference to F700, example #1. 2. On 11/20/24 at 0844 hours and 11/21/24 at 0802 hours, Resident 25 was observed lying in bed with all the four side rails were elevated. Medical record review for Resident 25 was initiated on 11/20/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Physician Order Sheet for November 2024 showed a physician's order dated 2/29/24, to apply all side rails for safety and as enabler. Review of Resident 25's Side Rail Evaluation dated 9/11/24, showed Resident 25's use of the side rails as enabling device to turn and reposition in bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 25's Mattress and Side Rail Safety Measurements Worksheet and Directions dated 2/29/24, showed the measurements on each of the entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 5 and 6. On 11/21/24 at 1510 hours, an interview for Resident 25 was conducted with CNA 4. CNA 4 verified Resident 25's use of all the side rails while in bed. CNA 4 stated the resident was able to use the rails when repositioning in bed. On 11/21/24 at 1515 hours, an observation, interview, and concurrent medical record review for Resident 25 was conducted with LVN 1. LVN 1 verified Resident 25 was in bed with all the four side rails elevated. On 11/21/24 at 1519 hours, an interview and concurrent medical record review for Residents 12 and 25 was conducted with RN 4. RN 4 stated the admitting nurse was responsible in completing the side rail entrapment assessment. RN 4 stated the admitting nurse would complete the worksheet and document the measurements. RN 4 reviewed the completed entrapment assessment worksheets for Residents 12 and 25. RN 4 verified the document failed to show documented evidence the measurements for the entrapment Zones 5 and 6. On 11/21/24 at 1552 hours, an interview and concurrent medical record review for Residents 12 and 25 was conducted with the DON. The DON informed of the findings and verified the findings. Cross reference to F700, example #2. 48332 3. Medical record review for Resident 10 was initiated on 11/20/24. Resident 10 was admitted to the facility on [DATE]. On 11/20/24 at 0942 hours, during a tour of facility, Resident 10 was observed in bed with bilateral upper and lower side rails (adjustable metal or rigid plastic bars that attach to the bed, also known as bed guards, serves are barriers designed to prevent falls from the bed) elevated. Resident was asked if the resident aware of having side rails. Resident 10 stated, I requested it, I'm more secured to have it, I might roll. On 11/21/24 at 1612 hours, an interview was conducted with RN 1. RN 1 was asked who was doing the actual measurement of side rails and gaps between the mattress to identify areas of possible entrapment. RN 1 stated the engineering/maintenance department was responsible for it. RN 1 was asked if there was acknowledgment or signature from engineering indicating they did measurement on the bed rails. RN 1 stated the engineering/maintenance department did not sign the assessment form indicating the measurements were completed. There was no documentation the engineering did the measurements of the side rails. On 11/22/24 at 0932 hours, an interview with concurrent medical record review was conducted with RN 1. RN 1 was unable to find any assessment for at risk for the entrapment for use of side rails. RN 1 verified there was no assessment for the potential risk for Resident 10's entrapment in the medical record. (continued on next page)

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	555859	A. Building B. Wing	11/22/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 1007 hours, an interview was conducted with the Engineering Manager. The Engineering Manager was asked if their scope of responsibility in the facility included taking care of the beds. The Engineering Manager stated it was the Biomed [NAME], the contractor for Biomed company, the outside provider of the beds. The Engineering Manager stated they did not do any bed measuring services, and the nursing department would inform the company for any issue of the bed. On 11/22/24 at 1018 hours, an interview was conducted with the Biomed Technician (Biomed- third party outsource contract under [NAME] Healthcare). The Biomed Technician stated their main responsibility in the facility was to maintain repair and services of all the medical equipment. The Biomed Technician further stated there was another company, ARJO, that supplied the bed and manage the bed, but not sure if that company did any calibration regarding the beds. The Biomed Technician stated they did not touch or perform the measurements of the bed. On 11/22/24 at 1026 hours, an interview was conducted with RN 1. RN 1 stated the bed rail evaluation was performed by any licensed nurse. RN 1 stated, We don't do actual measurement of bed rails for gaps. Nursing just checks the gaps between the rails and mattress. There is no actual measurement done. Engineering used to do the measurement; we don't know why they stopped. RN 1 verified there was no assessment performed to identify areas of possible entrapment. Cross reference to F700, example #3. 43119 4. On 11/20/24 at 1044 hours, and 11/21/24 at 0929 hours, Resident 8 was observed lying in bed with the bilateral upper and lower side rails elevated. Medical record review for Resident 8 was initiated on 11/20/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 10/2/24, showed Resident 8 had no capacity to understand choices and make health care decisions. Review of Resident 8's Physician Order Sheet for November 2024 showed a physician's order dated 10/10/24, to apply the upper and lower bilateral side rails as an enabler for turning and repositioning. Review of Resident 8's Side Rail Evaluation dated 10/10/24, showed Resident 8's use of side rails as an enabling device to turn and reposition in bed. Review of Resident 8's Mattress and Side Rail Safety Measurements Worksheet & Directions dated 9/30/24, showed the measurements on each of the entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 1, 2, and 3. On 11/21/24 at 1018 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 8 was in bed with the bilateral upper and lower side rails elevated and stated the side rails were used for Resident 8 due to attempts to get out of bed unassisted. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 1532 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 4. RN 4 stated the admitting nurse was responsible in completing the side rail entrapment assessment. RN 4 stated the admitting nurse would complete the worksheet and document the measurements. RN 4 reviewed the completed entrapment assessment worksheet for Resident 8. RN 4 verified the document failed to show documented evidence of the measurements for entrapment Zones 1, 2, and 3. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings . Cross reference to F700, example #4. 5. On 11/21/24 at 0944 hours and 1520 hours, Resident 27 was observed lying in bed with the bilateral upper and lower side rails elevated. Medical record review for Resident 27 was initiated on 11/20/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 9/16/24, showed Resident 27 had the capacity to understand choices and make health care decisions. Review of Resident 27's Physician Order Sheet for November 2024 showed a physician's order dated 9/15/24, to apply upper and lower bilateral side rails for bed mobility. Review of Resident 27's Side Rail Evaluation dated 9/15/24, showed Resident 27's use of the side rails as an enabling device to turn and reposition in bed. Review of Resident 27's Mattress and Side Rail Safety Measurements Worksheet & Directions dated 9/15/24, showed the measurements on each of the entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 1452 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 27's use of all the side rails while in bed. CNA 4 stated the resident was able to use the side rails when turning and repositioning in bed. On 11/21/24 at 1600 hours, an interview and concurrent medical record review for Resident 27 was conducted with RN 4. RN 4 stated the admitting nurse was responsible in completing the side rail entrapment assessment. RN 4 stated the admitting nurse would complete the worksheet and document the measurements. RN 4 reviewed the completed entrapment assessment worksheet for Resident 27. RN 4 verified the document failed to show documented evidence of the measurements of entrapment for Zones 5 and 6. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings . Cross reference to F700, example #5. 6. On 11/20/24 at 1015 hours and 11/21/24 at 0953 hours, Resident 33 was observed lying in bed with all three side rails were elevated. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 33 was initiated on 11/20/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Social History assessment dated [DATE], showed Resident 33 had a BIMS score of 15 (indicates intact cognition). Review of Resident 33's Physician Order Sheet for November 2024 showed a physician's order dated 11/21/24, to apply upper bilateral and left lower side rails as per the request. Review of Resident 33's Side Rail Evaluation dated 11/5/24, showed Resident 33's use of side rails as enabling device to turn and reposition in bed and to transfer independently. Review of Resident 33's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 11/4/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 5 and 6. On 11/21/24 at 1500 hours, an interview was conducted with CNA 4. CNA 4 verified Resident 33's use of three side rails while in bed and stated the resident was able to use the rails when turning and repositioning in bed. On 11/21/24 at 1522 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 33's used of three side rails. On 11/21/24 at 1612 hours, an interview and concurrent medical record review for Resident 33 was conducted with RN 4. RN 4 stated the admitting nurse was responsible in completing the side rail entrapment assessment. RN 4 stated the admitting nurse would complete the worksheet and document the measurements. RN 4 reviewed the completed entrapment assessment worksheet for Resident 33. RN 4 verified the document failed to show documented evidence of the measurements for the entrapment for Zones 5 and 6. On 11/21/24 at 1656 hours, the DON and DSD were informed and acknowledged the above findings. Cross reference to F700, example #6. 49258 7. During the initial tour of the facility on 11/20/24 at 1031 hours, Resident 17 was observed sleeping and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 17 was initiated on 11/20/24. Resident 17 was admitted to the facility on [DATE]. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 7/10/24, to apply upper bilateral side rails as per the family's request. Review of Resident 17's Side Rail Evaluation dated 10/21/24, under the side rails determination section showed Resident 17's condition did not indicate the need for the side rails at this time but Resident 17's family requested for it. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 17's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 7/10/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 0830 hours, Resident 17 was observed awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 17's use of the bilateral upper side rails while in bed. CNA 2 stated the resident was able to grab the rails during repositioning. Cross reference to F700, example #7. 8. During the initial tour of the facility on 11/20/24 at 1232 hours, Resident 19 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 19 was initiated on 11/20/24. Resident 19 was admitted to the facility on [DATE]. Review of the Physician Order Sheet for November 2024, showed a physician's order dated 10/8/24, to apply bilateral upper side rails for assistance with turning and repositioning and per the family's request. Review of Resident 19's Side Rail Evaluation dated 10/7/24, under the side rails determination section showed Resident 19's condition did not indicate the need for the side rails at this time. Review of Resident 19's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 10/8/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 0800 hours, Resident 19 was observed sleeping and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 0820 hours, an interview was conducted with CNA 6. CNA 6 verified Resident 19's use of the bilateral upper side rails while in bed. CNA 6 stated the resident was able to grab the rails during repositioning. Cross reference to F700, example #8. 9. During the initial tour of the facility on 11/20/24 at 1245 hours, Resident 28 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 28 was initiated on 11/20/24. Resident 28 was admitted to the facility on [DATE]. Review of the Physician Order Sheet for November 2024 showed a physician's order dated 10/10/24, to apply bilateral upper side rails as enablers for bed mobility, turning, and repositioning. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's Side Rail Evaluation dated 10/10/24, under the side rails determination section showed Resident 28 used the side rails as enabling device to turn and reposition self in bed. Review of Resident 28's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 10/10/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 0854 hours, Resident 28 was observed sleeping and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 28's use of the bilateral upper side rails while in bed. CNA 2 stated the resident used the side rails to grab during repositioning. Cross reference to F700, example #9. 10. During the initial tour of the facility on 11/20/24 at 1113 hours, Resident 32 was observed sleeping and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 32 was initiated on 11/20/24. Resident 32 was admitted to the facility on [DATE]. Review of Physician Order Sheet for November 2024, showed a physician's order dated 10/8/24, to apply bilateral upper side rails as per wife's request. Review of Resident 32's Side Rail Evaluation dated 10/8/24, under the side rails determination section showed Resident 32's condition did not indicate the need for the side rails at this time. Review of Resident 32's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 10/8/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 0815 hours, Resident 32 was observed awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 0820 hours, an interview was conducted with CNA 6. CNA 6 verified Resident 32's use of the bilateral upper side rails while in bed. CNA 6 stated the resident was able to grab the rails during repositioning. Cross reference to F700, example #10. 11. During the initial tour of the facility on 11/20/24 at 0956 hours, Resident 239 was observed awake and lying in bed with the bilateral upper side rails elevated. Medical record review for Resident 239 was initiated on 11/20/24. Resident 239 was admitted to the facility on [DATE]. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician Order Sheet for November 2024, showed a physician's order dated 11/14/24, to apply bilateral upper side rails as per family's request. Review of Resident 239's Side Rail Evaluation dated 11/14/24, under the side rails determination section showed Resident 239's condition did not indicate the need for the side rails at this time. Review of Resident 239's Mattress & Side Rail Safety Measurements Worksheet & Directions dated 6/14/24, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of entrapment for Zones 5 and 6. On 11/21/24 at 0806 hours, Resident 239 was observed awake and lying in bed with the bilateral upper side rails elevated. On 11/21/24 at 1115 hours, an interview was conducted with CNA 2. CNA 2 verified Resident 239's use of the bilateral upper side rails while in bed. CNA 2 stated the resident was able to grab the rails during repositioning. Cross reference to F700, example #11. On 11/21/24 at 1503 hours, a concurrent interview and medical record review for Residents 17, 19, 28, 32, and 239 was conducted with RN 4. RN 4 stated the admitting nurse was responsible in completing the side rail entrapment assessment. RN 4 stated the admitting nurse would complete the worksheet and document the measurements. RN 4 verified the Mattress & Side Rail Safety Measurements Worksheet & Directions for Residents 17, 19, 28, 32, and 239 failed to show documented evidence of the measurements for the entrapment for Zones 5 and 6. On 11/22/24 at 1026 hours, an interview was conducted with RN 1. RN 1 stated the side rail entrapment assessment was to be completed by any licensed nurse. RN 1 stated no actual measurement of bed rails for gaps was being done to identify areas of possible entrapment. RN 1 stated they would just mark the worksheet with reference to how many side rails the resident had. RN 1 further stated the engineering department staff used to do the measurement for the entrapment zones. On 11/22/24 at 1600 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 17, 19, 28, 32, and 239.