STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555862	A. Building B. Wing	02/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Scalabrini Special Care	10631 Vinedale Street Sun Valley, CA 91352

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident`s dignity and respect in full recognition of their individuality when Certified Nursing Assistant 1 (CNA 1) was standing over a resident while assisting the resident during a meal for one of three sampled residents (Resident 25). This deficient practice had the potential to negatively affect the resident`s psychosocial wellbeing and loss of dignity. Findings: During a review of Resident 25's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 9/3/2020, and readmitted on [DATE], with diagnoses including absolute glaucoma (a condition marked by complete vision loss and uncontrolled eye pressure), dysphagia (difficulty swallowing), and history of falling. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 25 was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 25's Nutritional Care Assessment Form dated 5/3/2024, the assessment form indicated that the resident was dependent to staff for eating. During a concurrent observation and interview on 2/15/2025 at 8:30 a.m., inside Resident 25`s room, Certified Nursing Assistant 1 (CNA 1) was standing over Resident 25 while feeding her. CNA 1 stated that she always stands over residents and feed them because it is easier for her.  During a concurrent observation and interview on 2/15/2025 at 8:40 a.m. with the facility`s Director of Nursing (DON), inside Resident 25`s room, observed CNA1 standing over Resident 25 while assisting her with her breakfast. The DON stated staff are required to assist residents with feeding in a sitting position to promote the resident's dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility`s Policy and Procedure (P&P) titled Resident`s Dignity, last reviewed 1/15/2025, the P&P indicated each resident shall be cared for in manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Promote resident independence and dignity while dining by avoiding staff standing over the residents while assisting them to eat.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44309 Based on observation, interview, and record review, the facility failed to ensure that the call light (an alerting device for nurses to assist a patient when in need) was within a resident`s reach while in bed for one of one sampled resident (Resident 18) reviewed under the environment task. This deficient practice had the potential to result in Resident 18 not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect resident's comfort and well-being Findings: During a review of Resident 18's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 10/9/2020, with diagnoses including vascular dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/7/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 18 was dependent to staff (helper does all of the effort) for toileting hygiene, showering and bathing, lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 18's care plan (written guide that organizes information about the resident's care) for communication problem related to dementia initiated on 10/16/2020 and last revised on 2/10/2025, the care plan indicated a goal that the resident`s need will be rendered daily through review date. The care plan interventions were to ensure that the resident`s environment is safe, and the call light is answered promptly (immediately). During a concurrent observation and interview on 2/14/2025 at 6:43 p.m., inside Resident 18`s room, the resident was observed sitting on her bed with her call light hanging on the wall behind her head. Resident 18 stated that there is a button she presses when she needs help, and she started searching for it. Resident 18 was not able to find the call light and stated sometimes she screams for help. During a concurrent observation and interview on 2/14/2025 at 6:45 p.m., with Licensed Vocational Nurse 2 (LVN 2) inside Resident 18`s room, LVN 2 stated that Resident 18's call light was hung on the wall behind the resident`s head away from her reach. LVN 2 stated the call light should be always within the resident's reach so she can call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/16/2025 at 2:04 p.m., with the Director of Nursing (DON), the DON stated residents` call lights are required to be accessible to the residents at all times. The DON stated the potential outcome of staff not placing the call lights within residents` reach is the inability of residents to call for help when they need it. During review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light, reviewed on 1/15/2025, the P&P indicated to explain the call light to the new residents, be sure that the call light is plugged in at all times and when the resident in in bed or confined to a chair be sure the call light is within easy reach of the resident.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to maintain privacy of confidential information for one of one sampled residents (Resident 48), when Licensed Vocational Nurse 1 (LVN 1) left the resident's electronic health record (EHR- a digital version of a patient's paper chart) open and unattended. This deficient practice violated the residents' right to privacy and confidentiality of medical records. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated that the facility initially admitted Resident 48 on 9/11/2023 with diagnoses including body myositis(IMB- a muscle disease where muscles gradually weaken over time due to the build-up of abnormal protein clumps inside the muscle fiber), generalized anxiety disorder (persistent and excessive worry that interferes with daily activities), and essential hypertension (a condition in which blood pressure is higher than [NAME]). During a review of Resident 48's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/2/2024, the MDS indicated that the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 48 required moderate-to-maximal assistance of one-to-two helpers for showering, toileting and personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During a concurrent medication pass observation and interview on 2/16/2025 at 8:02 a.m., in the main dining room, observed Licensed Vocational Nurse 1 (LVN 1) left the computer screen open, displaying Resident 8's medication list, while stepping away from the medication cart to administer the resident's medications. During an interview, LVN 1 stated that she should have ensured that Resident 48`s EHR was not accessible and open while she stepped away from the medication cart LVN 1 stated that it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to have the resident's health information visible to unauthorized persons. During a review of The Health Insurance Portability and Accountability Act (HIPAA) of 1996, it indicated the HIPAA Security Rule protects specific information cover the Privacy Rule law applies fully to nursing homes, requiring them to protect the privacy of residents' health information (PHI) by implementing appropriate safeguards, including technical, administrative, and physical measures to prevent unauthorized access, use, or disclosure of this information, particularly electronic protected health information (ePHI). During a review of the facility's policy and procedure (P&P), titled, Data Privacy and Security, last reviewed on 1/15/2025, the policy indicated that the policy outlines the requirements and guidelines for ensuring the privacy and security of sensitive data within the healthcare organization`s IT systems .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan (CP- a plan for an individual's specific health needs and desired health outcomes) for three of three sampled residents (Resident 33, 34, and 45) by failing to: 1. a. Monitor Resident 33 for signs and symptoms of bleeding as indicated in the care plan. This deficient practice placed Resident 33 at risk for undetected blood loss due to lack of monitoring. 1.b. Develop a person-centered Care Plan (CP- a plan for an individual's specific health needs and desired health outcomes) for Resident 33 who was assessed as high risk for fall. This deficient practice placed the resident at risk for recurring falls with injuries. 2. Provide Resident 34 with bilateral (both sides) floormats (padding placed on the floor to help prevent injuries related to falls) as indicated in the care plan. This deficient practice placed Resident 34 at risk for injury in the event of a fall. 3. Develop and implement a comprehensive person-centered care plan addressing Resident 45`s Restorative Nursing Assistant program (RNA-nursing aide program that helps residents to maintain their function and joint mobility).  This deficient practice had the potential to result in Resident 45`s inadequate care. Findings: 1. During review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 10/31/2024, with diagnoses including history of falling and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 33's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/14/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The resident required substantial/maximal assistance for eating, oral hygiene, upper body dressing and totally dependent on staff for toileting hygiene, shower, lower body dressing and personal hygiene. During a review of Resident 33`s Order Summary Report, included an order for Apixaban (used to treat and prevent blood clots) Oral Tablet 5 milligram (mg), to give 1 tablet two times a day for Deep Vein Thrombosis (a condition where a blood clot forms in a deep vein, typically in the legs), dated 10/31/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 02/15/25 at 4:23 p.m., with the Director of Nursing (DON), Resident 33`s Medication Administration Record (MAR- includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for the month of January 2025 and February 2025 and care plans. The CP for Anticoagulant Therapy dated 2/16/2025, indicated a goal that the resident will free be from discomfort or adverse reactions related to anticoagulant use. The DON stated one of the care plan interventions was to monitor the resident for signs and symptoms of bleeding. The DON stated that there is no documentation in any of the resident`s clinical record, including the MAR for January and February 2025 indicating that signs and symptoms of bleeding were monitored. The DON stated monitoring for signs and symptoms of bleeding is important so that timely intervention can be implemented such as notifying the provider to obtain an order to continue or hold the Apixaban. The DON stated that Resident 33 may experience bleeding due to anticoagulant use, and without monitoring, this could lead into hemorrhage. During a review of Resident 33`s Care Plan Report for Anticoagulant Therapy, initiated on 11/12/2024 and last revised on 2/16/2025, the CP goal is for the resident to be free from discomfort or adverse reaction related to anticoagulant use through the review date. The CP interventions included, but not limited to, monitor for signs and symptoms of bleeding such as easy bruising, syncope (a temporary loss of consciousness that occurs when the brain does not receive enough blood flow) and hematuria (a condition where blood is present in the urine). During a review of the facility`s policy and procedure titled Care Plan Policy, last reviewed on 1/15/2025, the policy and procedure indicated that The comprehensive Care Plan is based through assessment that includes, but is not limited to, the MDS Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident`s condition change .reflect treatment goals, timetables and objectives and measurable outcomes . 1.b. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 10/31/2024, with diagnoses including history of falling and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 33's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/14/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The resident required substantial/maximal assistance for eating, oral hygiene, upper body dressing and totally dependent on staff for toileting hygiene, shower, lower body dressing and personal hygiene. The MDS indicated that Resident 33 had a history of fall in the last 2-6 months and sustained a fracture prior to admission. The MDS further indicated that care planning for fall is necessary to address the problem. During a concurrent observation and interview on 02/14/2025 at 06:40 p.m., observed Resident 33 lying in bed awake. The resident's bed had padded side rails and there was a landing mat on the floor. Resident 33 had a cut approximately measuring 2 centimeter on her forehead, that appeared to be healing. Resident 33 stated that the cut on her forehead resulted from a fall while she was trying to go to the toilet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 02/15/25 09:16 a.m., with the Director of Nursing (DON), reviewed Resident 33`s Admission Fall Risk assessment dated [DATE], SBAR dated 02/03/2025, and MDS Section J and MDS Section V- Care Area Assessment (CAA) Summary. Resident 33`s Admission Fall Risk assessment dated [DATE], the assessment indicated a score of 20, high risk for falls. Resident 33`s Situation, Background, Assessment, Recommendation (SBAR- an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication) form dated 02/03/2025, indicated that Resident 33 was found on the floor in her room at around 6:35 a.m. with a cut over the forehead measuring 2 centimeters (cm) by 2 cm, and able to move all extremities with no change in the level of consciousness. The DON stated that Resident 33 had a recent fall incident and sustained a laceration on her forehead. The DON stated that when the resident fell there was no floor mat on the floor next to the resident's bed. The DON stated that the resident was not sent out for further evaluation because there was no change in her level of consciousness and was able to move her extremities. The DON stated if there was a floor mat when she fell , the laceration on her forehead could be minimal as the floor mat will soften the impact. The DON stated that based on the Fall Risk Assessment and the history of fall as documented in the MDS, there should have been a care plan and interventions addressing the resident's fall risk. The DON stated that the x-ray results of Resident 33`s head was normal with no fractures. The DON the care plan for Resident 33's risk for fall was not done.  During a review of the facility`s policy and procedure titled Policy and Procedure on Falls, last reviewed on 1/15/2025, the policy indicated that The fall policy at the facility is designed to minimize the risk of falls or accidents and reduce the risk of serious injury associated with such events .Care Plan: Residents identified as at risk for falls must have a care plan that outlines their specific risk factors and appropriate interventions,. 2. During review of Resident 34's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/11/2021 and readmitted on [DATE], with diagnoses that included repeated falls and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 34's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/13/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The resident is totally dependent on staff for activities of daily living (refer to basic tasks that individuals perform to maintain their daily life and personal care). During an interview and record review on 02/15/2025 at 6:34 p.m., with Minimum Data Set Nurse 1 (MDSN 1), reviewed Resident 34`s CP for High Risk for Unavoidable Falls, initiated on 10/14/2021 and revised 02/14/2025. The CP for High Risk for Unavoidable Fall indicated a goal for Resident 34 to be free of minor injury through the review date. The CP for High Risk for Unavoidable Falls outlined several interventions, including but not limited to, providing floor mats at bedside and frequent visual check throughout the shift. MDSN 1 stated that floor mats can lessen or minimize the impact if the resident would have a fall incident. MDSN 1 stated without a floor mat, Resident 34 can sustain serious injury if she falls directly into the concrete. During an observation on 02/15/2025 at 6:50 p.m., with the MDSN1 , observed and verified with MDSN 1 that Resident 34 has no floor mat. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s Policy and Procedure on Falls, last reviewed on 1/15/2025, the policy indicated that the fall policy is designed to minimize the risk for falls or accidents and reduce the risk of serious injury associated with such events .Care Plan: Residents identified as at risk for falls must have a care plan that outlines their specific risk factor and appropriate interventions . During a review of the facility`s policy and procedure titled Care Plan Policy, last reviewed on 1/15/2025, indicated that The comprehensive Care Plan is based through assessment that includes, but is not limited to, the MDS Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident`s condition change .reflect treatment goals, timetables and objectives and measurable outcomes . 44309 3. During a review of Resident 45's Admission Record, the Admission Record indicated that the facility admitted the resident on 12/25/2024, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), lack of coordination, and repeated falls. During a review of Resident 45's Minimum Data Set (MDS-a resident assessment tool) dated 12/31/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 45 was dependent on the staff (helper does all of the effort) for showering and bathing. The MDS indicated that Resident 45 required partial/moderate assistance (helper does less than half effort) for toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 45's Physician`s Order Summary Report dated 1/2/2025, the Physician`s Order Summary Report indicated an order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) program for ambulation with hand-held assistance every day, five times a week as tolerated during day shift. During a review of Resident 45's Restorative Treatment Record (program that help residents to maintain their function and joint mobility) dated 1/3/2025- 2/14/2025, the record did not indicate any entries for treatment. During a review of Resident 45`s care plans, the care plans did not indicate a documented evidence of a comprehensive care plan with goals and person-centered interventions addressing Resident 45`s RNA program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/16/2025 at 9:37 a.m., with MDS Nurse 1 (MDSN 1), Resident 45`s physician orders, care plans, and restorative treatment records were reviewed. MDSN 1 stated Resident 45`s physician ordered for RNA ambulation program every day, five times a week on 1/2/2025. MDSN1 stated Resident 45`s restorative treatment records dated 1/3/2025-2/14/2025 did not indicate any entries for treatment. MDSN1 stated that she (MDSN 1) is unsure if Resident 45 received RNA treatment during that time. MDSN 1 further indicated that licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s RNA program. MDSN 1 stated a care plan with person-centered intervention is required to monitor Resident 45`s ROM improvement. MDSN 1 stated the potential outcome of not developing a person-centered care plan with goal and intervention is the lack of care and the inability to implement the specific services and monitoring that resident requires. During a concurrent interview and record review on 2/16/2025 at 11:51 a.m., with the Director of Rehabilitation (DOR), Resident 45`s RNA ambulation task log dated 1/20/2024-2/14/2025 was reviewed. The DOR stated that he referred Resident 45 to begin an RNA ambulation program after the resident was discharged from physical therapy treatment. The DOR stated Resident 45`s physician ordered RNA program for ambulation with hand-held assistance every day, five times a week as tolerated during day shift on 1/2/2025. However, Resident 45 did not receive any RNA ambulation treatment since 1/3/2025. The DOR stated licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s RNA program. The DOR stated a care plan with person-centered intervention is required to monitor Resident 45`s ROM and ambulation. The DOR stated the potential outcome of not developing a person-centered care plan with goal and intervention is the lack of care and the inability to implement the specific services and monitoring that resident requires. During an interview on 2/16/2025 at 2:15 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to develop a person-centered care plan based on the residents` needs and identified problems. The DON stated licensed staff did not develop a care plan with goal and interventions for Resident 45`s RNA treatment. The DON stated that the potential outcome of not developing a care plan with goal and interventions is the inability to monitor for decline or improvement in the resident`s condition, resulting in inadequate care for the resident.  During review of the facility's Policy and Procedure (P&P) titled, Care Plan-Comprehensive, last reviewed 1/15/2025, the P&P indicated that the facility`s care planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident`s comprehensive care plan is designed to incorporate identified problem areas, risk factors associated with identified problems, reflect treatment goal, timetables and objectives in measurable outcomes. Care plans are reviewed by the care planning team at least quarterly. The Interdisciplinary team will review the attending physician`s orders (e.g. dietary needs, medications, and routine treatments, etc.) and implement a nursing care plan to meet the resident`s immediate care needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47883 Based on observation, interview, and record review, the facility failed to obtain a physician order for a resident's Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries) setting for one of three sampled residents (Resident 1) reviewed under the pressure ulcer/injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) care area. This deficient practice had the potential to place Resident 1 at risk for discomfort and development of pressure ulcers/injuries. Findings: During a review of Resident 1's admission record, the admission record indicated the facility admitted Resident 1 on 4/13/2021 and readmitted the resident on 9/20/2024 with diagnoses including quadriplegia (a form of paralysis that affects all four limbs, plus the torso), epilepsy (a broad term used for a brain disorder that causes seizures [may cause loss of consciousness, falls, or massive muscle spasms]), and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). During a review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 11/7/2024, the MDS indicated Resident 1 was cognitively severely impaired (never/rarely made decisions) and was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 1's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) initiated on 4/15/2021 and revised on 2/11/2025, the care plan indicated Resident 1 had potential for impairment to skin integrity (a condition where the skin is damaged or broken) related to decreased mobility. The care plan indicated an intervention to provide LALM to Resident 1. During a concurrent observation and interview on 2/14/2025 at 7:15 AM, with the Director of Nursing (DON), in Resident 1's room, the resident's LALM setting was at 350 pounds (lbs. - weight measurement). The DON stated the LALM was supposed to be set at around 180 lbs. She stated the LALM is an intervention to promote wound healing and prevent pressure injuries. The DON stated if the LALM is not set at the correct setting then it will not be effective to prevent further pressure injuries. During a concurrent record review and interview on 2/15/2024 at 2:25 PM, with Minimum Data Set Nurse 1 (MDSN1) reviewed Resident 1's physician orders for 2/2025. MDSN 1 stated that there was no physician order for Resident 1 to use the LALM. MDSN 1 reviewed Resident1's chart and stated an order was initially placed on 2/22/2022 to use a LALM for skin integrity but was discontinued on 9/24/2024 when Resident 1 was transferred to the hospital. MDSN 1 stated a licensed nurse should have called the physician to renew the order for Resident 1's LALM. MDSN 1 stated the LALM setting should be set according to Resident 1's weight, which was 180 lbs., to be effective in maintaining the resident's skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Policy and Procedure on Pressure Ulcer, dated 1/152025, the policy and procedure indicated, A program of prevention, care and treatment of pressure ulcers is carried out all residents to prevent skin breakdown and promote healing .Institute a preventive plan for any residents who has the potential for developing pressure ulcers. This plan may include the following: Reduce pressure by placing resident on therapeutic foam mattress, alternative pressure mattress, turn and positioned as needed by resident. During a review a Med-Air8 Alternating Pressure Mattress Replacement System with Low Air Loss user manual, the manual indicated, Users can adjust the pressure level of the air mattress, using the analog pressure dial, to desired firmness based on personal comfort or weight setting.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44309 Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 45) received treatment and services to prevent decrease in range of motion (ROM- full movement potential of a joint) by failing to Provide Restorative Nursing exercises as ordered by the physician. This deficient practice had the potential to place the resident in further decline of her range of motion and developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: During a review of Resident 45's Admission Record, the Admission Record indicated that the facility admitted the resident on 12/25/2024, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), lack of coordination, and repeated falls. During a review of Resident 45's Minimum Data Set (MDS-a resident assessment tool) dated 12/31/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 45 was dependent on the staff (helper does all of the effort) for showering and bathing. The MDS indicated that Resident 45 required staff partial/moderate assistance (helper does less than half effort) for toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 45's Physician Order Summary Report dated 1/2/2025, it indicated an order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) program for ambulation with hand-held assistance every day, five times a week as tolerated during day shift. During a review of Resident 45's Restorative Treatment Record (program that help residents to maintain their function and joint mobility) dated 1/3/2025- 2/14/2025, the record did not indicate any entries for treatment. During a concurrent interview and record review on 2/16/2025 at 9:37 a.m., with MDS Nurse 1 (MDSN 1), Resident 45`s physician orders, care plans, and restorative treatment records were reviewed. MDSN1 stated Resident 45`s physician ordered for Resident 45 to have an RNA ambulation program every day, five times a week on 1/2/2025. MDSN1 stated Resident 45`s restorative treatment records dated 1/3/2025-2/14/2025 did not indicate any entries for treatment. MDSN1 stated that she (MDSN1) is unsure if Resident 45 received RNA treatment during that time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/16/2025 at 11:51 a.m., with the Director of Rehabilitation (DOR), Resident 45`s RNA ambulation task log dated 1/20/2024-2/14/2025 was reviewed. The DOR stated that he referred Resident 45 to begin an RNA ambulation program after the resident was discharged from physical therapy treatment. The DOR stated that he was the one who placed an order for RNA ambulation. However, due an error in his computer entry, the RNA ambulation task was scheduled for the night shift instead of day shift resulting in night shift nurses documenting the administration of RNA ambulation as Not Applicable. The DOR stated Resident 45 has not received any RNA ambulation treatment since 1/3/2025. The DOR stated that he evaluated Resident 45 on 2/14/2025, and the resident will have physical therapy three times a week for four weeks thereafter. The DOR stated the potential outcome of not providing RNA treatment as ordered by the physician to a resident is decline in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and muscle weakness. During an interview on 2/16/2025 at 2:15 p.m., with the Director of Nursing (DON), the DON stated Resident 45 has not received RNA ambulation treatment as ordered by her physician since 1/3/2025. The DON stated the potential outcome of not providing RNA treatment to a resident is the decline in ADLs and decrease in ROM. During review of the facility's Policy and Procedure (P&P) titled, RNA Services, last reviewed 1/15/2025, the P&P indicated that it is the policy of the facility to provide range of motion and other activities during routine care and upon order for a resident in the RNA program. It is the policy of the facility to transition residents from therapy to RNA programs if indicated and pursuant to physician orders. RNA services will be per physician orders. For RNA ambulation or standing activities, any devices to be used may be included in addition to the frequency of the activity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38469 Based on observation, interview and record review, the facility failed to ensure the resident environment was free of accident hazards for two of eight residents (Resident 20 and 49) reviewed under the Accidents care area by failing to: 1. Ensure the television in the Resident 20's room is strapped or bolted to prevent it from falling. 2. Ensure licensed nurses did not leave Resident 20's medications at bedside and unattended. Resident 49 was not capable of self-administration of medications. These deficient practices placed the residents at risk for injury and harm. Findings: 1. During review of Resident 20's Admission Record, the Admission Record indicated the facility admitted the resident on 01/23/2023, with diagnoses including gastro esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining) and Alzheimer`s disease (a progressive disease that destroys memory and other important mental functions). During a review of Resident 20's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 09 /30/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The resident required substantial/maximal assistance for eating, upper body dressing and totally dependent on staff for oral hygiene, toileting hygiene, shower, lower body dressing and personal hygiene. During a concurrent observation and interview on 02/15/25 at 10:14 a.m., with the Director of Nursing (DON), in the resident's room, observed Resident 20`s television on top of a drawer cabinet with no strap or any anchor to prevent the television from falling. The DON stated that televisions in the residents` rooms should be secured with a strap to prevent it from falling, resulting to resident injury. During a review of the facility`s policy and procedure titled Television Policy, last reviewed on 1/15/2025, the policy indicated that All televisions must be securely mounted or placed on stable surfaces to prevent tipping or falling .in case of an emergency, ensure that television is secured to prevent falling . 2. During review of Resident 49 Admission Record, the Admission Record indicated the facility originally admitted the resident on 02/08/2023 and readmitted the resident on 05/15/2023, with diagnoses including emphysema (a long-term lung condition that causes shortness of breath) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 49's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01 /30/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired. The resident required substantial/maximal assistance for oral hygiene, upper body dressing and totally dependent on staff for toileting hygiene, shower, lower body dressing and personal hygiene. During a concurrent observation and interview on 02/14/25 at 06:51 p.m., observed Resident 49 sitting in bed, eating her dinner. Observed a white pill inside a medicine cup on the meal tray. Resident 49 stated the pill was salt pill and hates it because it doesn`t swallow easily. Resident 49 stated the white pill in the medicine cup was left by one of the nurses. During a concurrent observation and interview on 02/14/25 at 07:04 p.m., with the Director of Nursing, in the resident's room, the DON confirmed that there was a white round pill in a medication cup on the meal tray. The DON stated Resident 49`s medication is administered by the nurses since the resident does not have the capacity to self-administer medications based on their assessment criteria. The DON stated that nurses should not leave the medications with the residents so they can observe the residents taking their medications. The DON stated there is a potential for the resident to choke on the medication because the resident was not assessed as capable to self-administer medications. During a review of the facility`s policy and procedure titled Policy and Procedure for Self-Administration,, last reviewed on 1/15/2025, the policy indicated that Resident who desire to self-administer medications are permitted to do so if the facility`s interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44309 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 13) with an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) received proper care and services by failing to: 1. Update/revise the care plan (a document outlining a detailed approach to care customized to an individual resident's need) for Resident 13`s indwelling catheter after 6/3/2024. 2. Implement the care plan intervention of monitoring for sign and symptoms of Urinary Tract Infection (UTI-an infection in the bladder/urinary tract) such as pain, burning, blood-tinged urine (red or pink urine), and foul smelling (bad-smelling) urine. These deficient practices had the potential to result in Resident 13 receiving inadequate care and supervision at the facility. Findings: During a review of Resident 13's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 5/31/2024, with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), benign prostatic hypertension (BPH-a condition in which the prostate gland grows larger than normal), and uninhibited neuropathic bladder (lack of bladder control due to a brain, spinal cord or nerve problem). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 12/4/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 13 was dependent to staff (helper does all of the effort) for toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, eating, and personal hygiene. The MDS further indicated that Resident 13 had an indwelling catheter. During a review of Resident 13's Physician Order Summary Report dated 10/3/2024, the order summary report indicated to attach the resident`s indwelling catheter to a bag, change if dislodged (disconnected), pulled out, or removed. During a review of Resident 13's care plan for indwelling catheter initiated on 6/3/2024, the care plan indicated a goal that the resident will remain free from catheter related trauma through review date. The care plan interventions were to monitor resident`s fluid intake and urine output for 30 days, monitor for sign and symptoms of discomfort, and to monitor/record and report to the physician sign and symptoms of UTI such as pain, burning, blood tinged urine, urinary frequency (the need to urinate many times during the day), foul smelling urine, fever, chills, altered mental status, and change in behavior and eating patterns. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 13`s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 1/17/2025, the SBAR communication form indicated that Resident 13`s Family Member 1 (FM1) reported to the nurse that she observed blood inside the resident`s indwelling catheter bag.  During a concurrent interview and record review on 2/15/2025 at 4:00 p.m., with MDS Nurse 1 (MDSN 1), Resident 13`s care plans were reviewed. The MDSN 1 stated that she initiated Resident 13`s indwelling catheter care plan on 6/4/2024. The MDSN 1 stated Resident 13`s indwelling catheter care plan interventions were all initiated on 6/4/2024, but they have not been revised or updated since then. The MDSN 1 stated that one of the care plan interventions for Resident 13 was to monitor his fluid intake and urine output for 30 days. The MDSN 1 stated this intervention was developed upon the resident`s admission on 5/31/2024 and has been completed. However, this intervention remains as part of the resident`s current care plan. The MDSN 1 residents` care plans are required to be revised/updated after completion of a care plan intervention, quarterly, and after resident`s change of condition. The MDSN 1 stated residents` care plans are required to show the current interventions that are implemented for the resident. The MDSN 1 stated one of Resident 13`s indwelling catheter care plan intervention was to monitor/record and report to the physician sign and symptoms of UTI. The MDSN 1 stated there is no documentation regarding this monitoring anywhere in the resident`s chart. The MDSN 1 stated licensed staff are required to monitor Resident 13`s indwelling catheter for sign and symptoms of infection and document as indicated in his care plan. The MDSN 1 stated the potential outcome of not revising a resident`s care plan and not implementing care plan intervention is the inability to provide appropriate care and services to the resident. During a review of the facility's policy and procedure (P&P) titled Catheter Care-Indwelling urinary Catheter, last reviewed on 1/15/2025, the P&P indicated a resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. During review of the facility's Policy and Procedure (P&P) titled, Care Plan-Comprehensive, last reviewed 1/15/2025, the P&P indicated that the facility`s care planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident`s comprehensive care plan is designed to incorporate identified problem areas, risk factors associated with identified problems, reflect treatment goal, timetables and objectives in measurable outcomes and reflects currently recognized standards of practice for problem areas and conditions. Care plans are reviewed by the care planning team at least quarterly. The Interdisciplinary team will review the attending physician`s orders (e.g. dietary needs, medications, and routine treatments, etc.) and implement a nursing care plan to meet the resident`s immediate care needs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to maintain acceptable parameters of nutritional status for one of one sampled resident (Resident 25) reviewed under the nutrition task, by failing to assess and monitor the resident after having weight loss. This deficient practice had the potential to place Resident 25 at risk for further weight loss. Findings: During a review of Resident 25's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 9/3/2020, and readmitted on [DATE], with diagnoses including absolute glaucoma (a condition marked by complete vision loss and uncontrolled eye pressure), dysphagia (difficulty swallowing), and history of falling. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 25 was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 25 had either a weight loss of 5% or more within the last month or a weight loss of 10% or more in the last six months. During a review of Resident 25's Physician Order Summary Report dated 10/24/2024, the order indicated that the resident should be provided with a fortified (a food that has extra nutrients added to it), mechanical soft texture diet (a soft food diet focuses on easy digestion and easy chewing) with a nectar thick consistency fluid (fluids that are thicken than regular fluids, but still pour easily). During a review of Resident 25`s Nutritional Care Assessment Form dated 5/3/2024, the assessment form indicated the following:  1. Resident 25`s diet order was regular mechanical soft diet; 2. Resident 25`s meal intake percentage was 25-50%; and  3. Resident 25 did not have any recent weight changes.  The nutritional care assessment form further indicated that the RD would monitor Resident 25`s weight, meal intakes, and skin condition and will follow up as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25`s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 6/5/2024, the SBAR communication form indicated that the resident lost five pounds (lbs.- a unit of weight) in one month. The SBAR communication form indicated that Resident 25`s physician recommended the facility's Registered Dietician to evaluate the resident`s weight loss and changed Resident 25`s order from a regular to a fortified diet.  During a review of Resident 25`s SBAR Communication Form dated 7/4/2024, the SBAR communication form indicated that the resident lost six lbs. in the last month. The SBAR communication form indicated that Resident 25`s physician ordered 13 milligrams (mg-a unit of measure of mass) of Remeron (antidepressant [a type of medication used to treat depression] that can also raise your appetite and put you at risk for weight gain) by mouth to be administered at nights in order to manage her weight loss. During a review of Resident 25`s Nutritional Status care plan (written guide that organizes information about the resident's care) initiated on 4/23/2024 and last revised on 2/13/2025, the care plan indicated a goal that the resident will tolerate foods provided to her with 75-100% meal intake and will not have significant weight loss of 5% or more in 30 days or 10% or more in 180 days. The care plan interventions were to provide the diet as ordered by the physician, assist with feeding as needed, encourage adequate nutrition and fluid intake, monitor monthly weights and RD to evaluate the resident as needed. During a concurrent interview and record review on 2/15/2025 at 4:35 p.m. with the MDS Nurse 1 (MDSN 1), Resident 25`s physician orders, nutritional assessments and RD notes were reviewed. MDSN 1 stated that the last time Resident 25 was evaluated by an RD was on 5/3/2024. The MDSN 1 stated that there were no nutritional assessments or progress notes by RD after Resident 25`s change of conditions for weight loss on 6/5/2024 and 7/4/2024. The MDSN 1 stated that Resident 25`s physician managed the resident`s weight loss by changing her diet and adding new medication. However, there is no documentation regarding management of Resident 25`s weight loss by the facility`s RD in the resident`s medical record. During a telephone interview on 2/15/2025 at 5:15 p.m., with the current RD, the RD stated that she started working in the facility on 10/2024. The RD stated that she works at the facility onsite once a week. The RD stated that she has never assessed and saw Resident 25 and she does not know anything about the resident and her weight loss. During a concurrent interview and record review on 2/15/2025 at 6:00 p.m. with the Director of Nursing (DON), Resident 25`s physician orders, nutritional assessments and RD notes were reviewed. The DON stated that the RD is required to conduct an assessment for residents upon admission, quarterly, and when the resident loses weight. The DON stated that the last time RD assessed and evaluated Resident 25 was on 5/4/2024 prior to her significant weight loss. The DON stated that the RD did not perform any nutritional assessments for Resident 25 after her change of conditions for weight loss on 6/5/2024 and 7/4/2024. The DON stated that the facility had a high turnover rate for RDs. The DON stated that the high turnover rate may be the reason that there were no assessments or dietary notes developed by an RD after 5/4/2024 for Resident 25`s. The DON stated the potential outcome of an RD not assessing a resident`s weight loss is the inability to detect, care, and manage the increasing weight loss of a resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s Policy and Procedure (P&P) titled Nutritional Assessment, last reviewed on 1/15/2025, the P&P indicated that all residents would have a nutritional assessment completed within 14 days from admission. All residents are reviewed at least quarterly to update the nutritional assessment, care plan and to document resident changes. Residents at nutritional risk are identified and monitored closely to prevent or minimize deterioration. At risk residents are monitored, at least monthly by the Food Service Supervisor and/or Consultant Dietician. Nutrition interventions to prevent deterioration are selected based on resident`s individual needs. Interventions are periodically evaluated for effectiveness and results documented in the dietary progress note section. Interventions and overall goals are documented in the resident`s care plan and dietary progress notes.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Scalabrini Special Care	10631 Vinedale Street Sun Valley, CA 91352

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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. 47883 Based on observation, interview and record review the facility failed to ensure licensed nurses check for gastrostomy tube (G-tube, a tube inserted through the abdomen to deliver nutrition and medications directly to the stomach) placement (verifying that a G-tube, is positioned correctly in the stomach and not in another location by aspirating stomach contents through the tube using a syringe) before administration of medications as indicated in the resident's care plan for one of two sampled residents (Resident 4) reviewed under the Tube Feeding care area. This deficient practice had the potential to increase Resident 4's risk of aspiration (the accidental inhalation of foreign material, such as food, liquid into lungs). Findings: During a review of Resident 4's Admission Record, the Administration Record indicated that the facility initially admitted Resident 4 on 11/22/2021 and readmitted the resident on 07/02/2023 with diagnoses including gastrostomy tube, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/20/2025, the document indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 4's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) initiated on 11/21/2021 and revised on 1/21/2025, the care plan indicated that Resident 4 was unable to take food or fluids orally and was at risk for aspiration, The care plan interventions included to check placement and patency of feeding tube prior to administering formula, water and medication. During the review of Resident 47's Order Summary Report, the Order Summary Report indicated the following orders: 1.Eliquis (a medication used to treat blood clots) 2.5 milligram (mg - unit of measurement) via G tube two times a day, dated 11/14/2023. 2.Docusate sodium (a medication used to treat constipation) 100 milligram (mg - unit of measurement) 1 tab via G tube two times a day dated, 03/05/2022. 3.Metoprolol (a medication used to treat high blood pressure) 25 (mg - unit of measurement) 1 tab via G -Tube two times a day, 11/14/2023. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on 2/15/2025 at 5:07 p.m. in Resident 4's room, LVN 4 did not check for G-tube placement before administering the following medications via G-tube: 1.Eliquis 2.5 mg 2.Docusate sodium 100 mg 1 tablet 3.Metoprolol 25 mg 1 tablet During an interview on 2/15/2025 at 5:15 p.m., with LVN 4, LVN 4 stated that he (LVN 4) did not check the placement of G-Tube with stethoscope (medical instrument used to listen to sounds inside the body) of Resident 4's . LVN 4 stated that placement of G-Tube has to be checked before medication administration to achieve a medication therapeutic effect of medication. During an interview on 2/15/2025 at 7 p.m. with the Director of Nursing (DON), the DON stated that the LVN 4 should follow nursing procedure during medication administration and check the placement of Resident 4's G-Tube before administering medication. The DON stated that this deficient practice had the potential to increase the risk of aspiration for Resident 4. During a review of the facility policy named Enteral Feeding Tube Drug Administration, last reviewed on 1/15/2025, the policy stated: The facility assures the safety and effective administration of enteral formulas and medications via enteral tubes.

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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** 38469 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment (when a resident is trapped in the spaces in between or around the bed rails [adjustable metal or rigid plastic bars that attach to the bed that are available in a variety of types, shapes, and sizes], mattress, or bed frame), obtained an informed consent and a physician order for the use of bed rails for two of eight residents (Resident 14 and 50) reviewed under the Accidents care area and for one of one (Resident 11) resident reviewed under the Restraints care area. These deficient practices placed the residents at risk for potential accidents such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails and potentially violate the residents' rights. Findings: a. During review of Resident 14's Admission Record, the Admission Record indicated the facility admitted the resident on 1/23/2023 with diagnoses including Alzheimer`s disease (a progressive brain disorder that causes memory loss and other cognitive decline) and gastro esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 14's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/13/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The resident required maximal assistance from staff for toileting hygiene, shower, upper body dressing, lower body dressing and dependent on staff for shower. During an observation and interview on 02/14/2025 at 6:30 a.m., with Resident 14, observed Resident 14 seated upright in bed working on a puzzle and with half bed siderails up on both sides of the bed. The resident stated he did not have any concerns about his care. During a concurrent interview and record review with the Director of Nursing (DON) on 2/15/2025 at 5:20 p.m. , reviewed Resident 14 `s Side Rail Use Assessment (SRUA) dated 1/23/2023 and physician`s orders which included an order for both half bed rails while in bed for turn and repositioning, supporting self during care and getting out of bed. Also reviewed Resident 14's. The DON stated that this assessment is not the Risk for Entrapment Assessment. The DON verified that there is 1/2 side rail attached to the resident`s bed. The DON stated any resident using a bed siderails must be assessed for safety and risk for entrapment to prevent potential injury to the resident`s limbs. The DON stated that Resident 14 could suffer an injury if a part of her body is entrapped in the gaps of the siderails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s policy and procedures titled Policy Side Rails, last reviewed on 1/15/2025, the facility indicated that The policy for the use of side rails are as follows: Entrapment Assessment: If the bed rails are used for any reason, an assessment must be completed and documented. This assessment should be conducted at least semiannually, whenever the mattress is changed or an overlay is added, when new rails are installed, or when new resident occupies the bed. These assessments are maintained separately from the clinical record . b. During review of Resident 50's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/03/2023 with diagnoses b including major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life) and gastro esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 50 's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/28/2024, the MDS indicated the resident had the ability to sometime make self-understood and the ability to sometimes understand others. The resident is totally dependent on staff for self-care including, toileting hygiene, shower, upper body dressing, lower body dressing. During an observation on 02/14/2025 at 6:30 p.m., observed Resident 50 lying in bed sleeping with siderails up on both sides of the bed. During a record review and interview with the Director of Nursing (DON) on 2/15/2025 at 6:20 p.m., reviewed Resident 50 `s Side Rail Use Assessment (SRUA) dated 12/18/2024 and physician`s orders which included an order for both half bed rails while in bed for turn and repositioning, supporting self during care and getting out of bed, dated 12/17/2024. The DON stated that this assessment is not the same as the Risk for Entrapment Assessment. The DON verified there was a 1/2 side rail attached to the resident`s bed. The DON stated any resident using a bed siderails must be assessed for safety and risk for entrapment to prevent potential injury to the resident`s limbs. The DON stated that Resident 50 could suffer an injury if a part of her body is entrapped in the gaps on the siderails. During a review of the facility`s policy and procedures titled Policy Side Rails, last reviewed on 1/15/2025, the facility indicated that The policy for the use of side rails are as follows: Entrapment Assessment: If the bed rails are used for any reason, an assessment must be completed and documented. This assessment should be conducted at least semiannually, whenever the mattress is changed or an overlay is added, when new rails are installed, or when new resident occupies the bed. These assessments are maintained separately from the clinical record . 47883 c. During a review of Resident 11's admission record, the Admission Record indicated the facility admitted Resident 11 on 12/10/2020 and readmitted the resident on 11/25/2024 with diagnoses including multiple sclerosis (a chronic disease that damaged the central nervous system), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well), and type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 1/31/2025, the MDS indicated Resident 11 was cognitively severely impaired (never/rarely made decisions) and was totally dependent on staff on toileting hygiene, shower and lower body dressing, need supervision with eating and required maximal assistance with oral and personal hygiene. During a review of Resident 11's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) initiated on 12/15/2020, the Care Plan indicated Resident 11 has a seizure disorder. The Care Plan interventions indicated to protect the resident from injury. During a review of Resident 11 History and Physical (H&P), dated 1/23/2024, the HP indicated the resident did not have the capacity to understand and make decisions. During a review of a nursing note dated 02/12/2025, the note indicated that Resident 11 was transferred from room [ROOM NUMBER]A to room [ROOM NUMBER]A, and responsible party was informed and agreed. During an observation on 2/14/2025 at 6:57 PM, in Resident 11's room, the resident was observed in her bed with bilateral full side rails up. During a concurrent record review and interview on 2/15/2025 at 2:25 PM with Minimum Data Set Nurse 1 (MDSN 1), reviewed Resident 11's physician orders. MDSN 1stated that there was no physician order, assessment or consent for using full bed side rails for Resident 11. MDSN 1 reviewed Resident 1's chart and stated Resident 11 was transferred from another room on 01/12/2025 to current room and probably was accidently put in a bed with full side rails. MDSN 1 stated placing a resident in a bed with full side rails without a physician's order, consent and assessment put Resident 11 at risk for entrapment and injury. During an interview with the Director of Nursing (DON) on 12/15/ 2025 at 7 PM, the DON stated using a bed with full side rails bed without assessment and physician order can lead to resident injury and entrapment. During a review of the facility's policy and procedure titled, Policy and Procedure Restrains (Physical), dated 1/15/2025, the policy and procedure indicated: Physician restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . Assess resident's needs for restrain. Obtain physician order for restrain. During a review of the facility`s policy and procedures titled Policy Side Rails, last reviewed on 1/15/2025, the facility indicated that The policy for the use of side rails are as follows: Entrapment Assessment: If the bed rails are used for any reason, an assessment must be completed and documented. This assessment should be conducted at least semiannually, whenever the mattress is changed or an overlay is added, when new rails are installed, or when new resident occupies the bed. These assessments are maintained separately from the clinical record .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38469 Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals were stored in accordance with accepted professional principles by failing to: 1. Ensure an insulin (hormone that lowers the level of glucose [sugar] in the blood) pen that was past the discard date, was not stored in one of two three medication carts (Medication Cart 1) affecting one of one sampled resident (Resident 53). This deficient practice had the potential for an expired insulin to be administered to Resident 53 which could result in uncontrolled blood glucose (the primary sugar in the blood and the body's main source of energy). 2.a. Ensure an expired vaginal cream (topical medication inserted into the vagina to treat infection) belonging to a discharged resident was removed and disposed of in one of two Treatment Carts inspected (Treatment Cart 1). 2.b. Ensure an expired povidone-iodine swab sticks (used to kill germs and prevent infection in small skin cuts and burns) were removed and disposed of in one of two Treatment Carts inspected (Treatment Cart 1). These deficient practices had the potential for the administration and use of a less effective medication or supply which may not produce the expected results. Findings: 1.During a review of Resident 53's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis including diabetes mellitus (DM - high blood sugar) and hypertension (high blood pressure). During a review of Resident 53`s Admission History and Physical (H&P- a medical exam that includes a patient interview, physical exam, and documentation of findings) dated 4/5/2024, the H&P indicated that Resident 53`s cognitive functions are intact. During a review of Resident 53's Order Summary Report indicated a physician's order dated 1/03/2025 to administer Insulin Lispro Injection Solution (Humalog- a fast-acting insulin for adults and children with diabetes) 100 unit per milliliters (ml) per sliding scale (varies the dose of insulin based on blood glucose level) subcutaneously (administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) one time a day for DM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication cart inspection on 2/15/2025 at 2:44 p.m. with Licensed Vocational Nurse 2 (LVN 2), inspected Medication Cart 1 (MC 1). Resident 53's Humalog Insulin Lispro pen labeled with the open date of 12/29/2025, was observed inside the cart. LVN 2 stated that insulin in vials or pens are supposed to be used only for 28 days and if it is past the 28 days the insulin may have lost its efficacy. LVN 2 stated that the insulin used to manage Resident 53`s diabetes, may not be effective, and the resident may experience hyperglycemia (high blood sugar) which could lead to complications such as nausea and vomiting, blurred vision and could potentially result to falls or injuries. During an interview on 2/15/2025 at 3:13 p.m., with the Director of Nursing (DON), the DON stated if an insulin is used beyond 28 days, it might no longer be effective in managing Resident 53`s diabetes. The DON stated that Resident 53`s blood sugar may not be controlled and may result in hyperglycemia (high blood sugar) which can lead to serious complications. During a review of the Humalog (Insulin lispro) manufacturer's literature (provided by the facility) indicated that once opened, Humalog vials, prefilled pens, and cartridges should be thrown away after 28 days even if it still contains insulin. 44309 2. During the Treatment Cart 1 inspection and observation, on 2/16/2025 at 3:24 p.m., and a concurrent interview with Licensed Vocational Nurse 3 (LVN 3), an expired vaginal cream was observed stored in the cart. LVN 3 confirmed that the observed vaginal cream did expire on 9/2024 and belonged to a resident who has already been discharged from the facility. The LVN 3 stated that licensed staff is required to immediately remove all expired medications from treatment carts. During a concurrent observation and interview on 2/16/2025 at 3:28 p.m. with LVN 3, four expired povidone-iodine swab sticks were observed inside Treatment Cart 1. LVN 3 stated these povidone-iodine swab sticks were expired on 10/2023, and should have been removed and disposed of. The LVN 3 stated that the potential outcome of using expired medical supplies is the inability to ensure the intended result of a valid and unexpired medical supply. During an interview on 2/16/2025 at 3:40 p.m., with Registered Nurse 1 (RN 1), the RN 1 stated licensed nurses are required to inspect the medication and treatment carts during every shift and remove the expired medications and supplies and replace them. The RN 1 stated this is important to avoid a medication error by the administration of the expired medication or expired medical supplies. The RN 1 stated the potential outcome of not disposing expired medication and supplies from the treatment cart is the administration and use of a less effective medication or supply which may not produce the expected result. During a review of the facility`s Policy and Procedure (P&P) titled Storage of Medication, last reviewed 1/15/2025, the P&P indicated outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure adequate oversight of the Food and Nutrition Services by qualified personnel when two of two sampled resident (Resident 25 and Resident 53) reviewed under the nutrition task were not assessed and evaluated by a Registered Dietitian (RD- a health professional who has special training in diet and nutrition) after having weight loss. This deficient practice had a potential to result in ineffective nutrition intervention and goals and an increased weight loss for Resident 25 and Resident 53. Findings: a. During a review of Resident 25's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 9/3/2020, and readmitted on [DATE], with diagnoses including absolute glaucoma (a condition marked by complete vision loss and uncontrolled eye pressure), dysphagia (difficulty swallowing), and history of falling. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 25 was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 25 had either a weight loss of 5% or more within the last month or a weight loss of 10% or more in the last six months. During a review of Resident 25's Physician Order Summary Report dated 10/24/2024, the order indicated that the resident should be provided with a fortified (a food that has extra nutrients added to it), mechanical soft texture diet (a soft food diet focuses on easy digestion and easy chewing) with a nectar thick consistency fluid (fluids that are thicken than regular fluids, but still pour easily). During a review of Resident 25`s Nutritional Care Assessment Form dated 5/3/2024, the assessment form indicated the following:  1. Resident 25`s diet order was regular mechanical soft diet; 2. Resident 25`s meal intake percentage was 25-50%; and  3. Resident 25 did not have any recent weight changes.  The nutritional care assessment further indicated that the RD would monitor Resident 25`s weight, meal intakes and skin condition and will follow up as needed. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25`s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 6/5/2024, the SBAR communication form indicated that the resident lost five pounds (lbs.- a unit of weight) in one month. The SBAR communication form indicated that Resident 25`s physician recommended the facility's Registered Dietician to evaluate the resident`s weight loss and changed Resident 25`s order from a regular to a fortified diet.  During a review of Resident 25`s SBAR Communication Form dated 7/4/2024, the SBAR communication form indicated that the resident lost six lbs. in the last month. The SBAR communication form indicated that Resident 25`s physician ordered 13 milligrams (mg-a unit of measure of mass) of Remeron (antidepressant [a type of medication used to treat depression] that can also raise your appetite and put you at risk for weight gain) by mouth to be administered at nights in order to manage her weight loss. During a review of Resident 25`s Nutritional Status care plan (written guide that organizes information about the resident's care) initiated on 4/23/2024 and last revised on 2/13/2025, the care plan indicated a goal that the resident will tolerate foods provided to her with 75-100% meal intake and will not have significant weight loss of 5% or more in 30 days or 10% or more in 180 days. The care plan interventions were to provide the diet as ordered by the physician, assist with feeding as needed, encourage adequate nutrition and fluid intake, monitor monthly weights and RD to evaluate the resident as needed. During a concurrent interview and record review on 2/15/2025 at 4:35 p.m. with the MDS Nurse 1 (MDSN 1), Resident 25`s physician orders, nutritional assessments and RD notes were reviewed. MDSN 1 stated that the last time Resident 25 was evaluated by an RD was on 5/3/2024. MDSN 1 stated that there were no nutritional assessments or progress notes by RD after Resident 25`s change of conditions for weight loss on 6/5/2024 and 7/4/2024. MDSN 1 stated that Resident 25`s physician managed the resident`s weight loss by changing her diet and adding new medication. However, there is no documentation regarding management of Resident 25`s weight loss by the facility`s RD in the resident`s medical record. During a telephone interview on 2/15/2025 at 5:15 p.m., with the facility current RD, the RD stated that she started working in the facility on 10/2024. The RD stated that she works at the facility onsite once a week and works remotely for the rest of her shifts. The RD stated that she has never assessed and visited Resident 25 and she does not know anything about the resident and her weight loss. During a concurrent interview and record review on 2/15/2025 at 6:00 p.m. with the Director of Nursing (DON), Resident 25`s physician orders, nutritional assessments and RD notes were reviewed. The DON stated that the RD is required to conduct an assessment for residents upon admission, quarterly and when the resident loses weight. The DON stated that the last time RD assessed and evaluated Resident 25 was on 5/4/2024 prior to her significant weight loss. The DON stated that the RD did not perform any nutritional assessments for Resident 25 after her change of conditions for weight loss on 6/5/2024 and 7/4/2024. The DON stated that the facility had a high turnover rate for RDs. The DON stated that the high turnover rate may be the reason that there were no assessments or dietary notes developed by an RD after 5/4/2024 for Resident 25`s. The DON stated the potential outcome of an RD not assessing a resident`s weight loss is the inability to detect, care, and manage the increasing weight loss of a resident. (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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/16/2025 at 6:20 p.m., with the Administrator (ADM), the ADM stated that the facility faced staffing challenges for contracted RDs in the facility since last summer. The ADM stated that he is trying his best to ensure there is sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services in the facility. The ADM stated that Registered Dietitians are required to complete initial and quarterly assessments for all residents, especially residents who have lost weight. The ADM stated RDs are required to access the effectiveness of nutritional interventions developed for the residents. The ADM stated that the potential outcome of not always having an available RD in the facility, or a high RD turnover rate is the inability to timely monitor and access the residents and prevention of further weight loss. During a review of the facility`s Procedure titled Job Description-independent Dietician, last reviewed on 1/15/2025, the job description indicated that the key responsibilities of the dieticians are to conduct comprehensive nutritional assessments for new admission, quarterly reviews, and as needed for residents with significant changes in health status, monitor residents` nutritional progress and adjust care plans as needed, document assessments, care plans, and progress notes in compliance with regulatory standards and advise on therapeutic diets and special dietary modifications.  During a review of the facility`s Policy and Procedure (P&P) titled Nutritional Assessment, last reviewed on 1/15/2025, the P&P indicated that all residents would have a nutritional assessment completed within 14 days from admission. All residents are reviewed at least quarterly to update the nutritional assessment, care plan and to document resident changes. Residents at nutritional risk are identified and monitored closely to prevent or minimize deterioration. At risk residents are monitored, at least monthly by the Food Service Supervisor and/or Consultant Dietician. Nutrition interventions to prevent deterioration are selected based on resident`s individual needs. Interventions are periodically evaluated for effectiveness and results documented in the dietary progress note section. Interventions and overall goals are documented in the resident`s care plan and dietary progress notes. 47883 b. During a review of Resident 53's Admission Record, the Admission Record indicated that the facility admitted Resident 53 on 3/22/2024 and readmitted the resident on 12/26/2024 with diagnoses including type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), legal blindness (having vision that is 20/200 or worse even with prescription eyewear), and hypertension (a condition in which blood pressure is higher than normal). During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 01/27/2025, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 53 needed moderate-to- maximal assistance with all Activities of Dayli Living (ADL- activities such as bathing, dressing and toileting a person performs daily). During a review Resident 53's Nutritional Status care plan last reviewed on 02/06/2025, the Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) indicated that the resident lost 13 lb. in one month. The care plan indicated an intervention for the Registered Dietician (RD) to evaluate resident as needed and increase health shake to three times a day. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/15/2024 at 2:25 PM, with the Minimum Data Set Nurse 1 (MDSN 1), reviewed Resident 53 's registered dietitian notes and weight log. MDSN 1 stated that Resident 53's weight on 01/01/2025 was 120 lbs. and on 02/05/2025 was 107 pounds (lb.- measurement of the weight). MDSN 1 stated Resident 53 lost 13 lbs. 10 percent of the resident's weight in one month, and it is considered a severe weight loss. The MDSN stated than RD assessed Resident 53 on 4/21/2024. The MDSN stated she could not find any other RD notes. During a concurrent interview and record review on 2/15/2025 at 2:25 p.m. with Minimum Data Set Nurse 1 (MDSN 1), Resident 53`s physician orders, nutritional assessments and RD notes were reviewed. MDSN 1 stated that the last time Resident 53`s was evaluated by an RD was on 4/21/2024. MDSN 1 stated there are no Nutritional assessments or progress notes from RD after Resident 53 had weight loss on 12/26/2024 . The MDSN 1 stated that Resident 53`s physician managed the resident`s weight loss by increasing health shake in her diet to three times a day. However, there is no documentation regarding managing Resident 53`s weight loss by the facility's RD in the resident's medical record. During a telephone interview on 2/15/2025 at 4:26 p.m., with the facility's current RD, the RD stated that she started working in the facility in October 2024. The RD stated she works onsite in the facility once a week and does remote documentations the rest of the week. The RD stated that she has never assessed and visited Resident 53, and she does not know anything about the resident and her weight loss. During a concurrent interview and record review on 2/15/2025 at 7:00 p.m. with the facility`s Director of Nursing (DON), Resident 53`s SBAR communication Form, nutritional assessments and RD notes were reviewed. The DON stated the RD is required to conduct an assessment for residents who have lost weight. The DON stated the last time the RD assessed and evaluated Resident 53 was on 4/21/2024 before she had a significant weight loss. The DON stated the RD did not perform any nutritional assessments for Resident 53 after she had weight loss on 12/26/2024 and RD was not part of SBAR dated 2/6/2025. The DON stated that the facility had a quick turnover rate for RDs during 06/2024 and 07/2024. The DON stated this might be the reason that there was no assessments or notes developed by RDs to manage Resident 53`s weight loss and all the interventions to prevent weigh loss were initiated by the resident`s physician. The DON stated the potential outcome of RD not assessing residents who lost weight or are at risk for weight loss is the inability to detect, care, and manage resident`s increased weight loss. During an interview on 2/16/2025 at 6:00 p.m., with the Administrator (ADM), the ADM stated that the facility faced challenges to staff contracted RDs to work in the facility since last summer. The ADM stated he is trying his best to ensure there is sufficient and qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services in the facility. The ADM stated Registered Dietitians are required to complete initial and quarterly assessments for all residents, especially residents who have lost weight. The ADM stated RDs are required to access the effectiveness of nutritional interventions developed for the residents. The ADM stated the potential outcome of not having a contracted RD in the facility or changing RDs quickly in the facility is the inability to monitor and access the residents on time and causing unwanted weight loss. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s Procedure titled Job Description-independent Dietician, last reviewed on 1/15/2025, the job description indicated that the key responsibilities of the dieticians are to conduct comprehensive nutritional assessments for new admission, quarterly reviews, and as needed for residents with significant changes in health status, monitor residents` nutritional progress and adjust care plans as needed, document assessments, care plans, and progress notes in compliance with regulatory standards and advise on therapeutic diets and special dietary modifications.  During a review of the facility`s Policy and Procedure (P&P) titled Nutritional Assessment, last reviewed on 1/15/2025, the P&P indicated that all residents would have a nutritional assessment completed within 14 days from admission. All residents are reviewed at least quarterly to update the nutritional assessment, care plan and to document resident changes. Residents at nutritional risk are identified and monitored closely to prevent or minimize deterioration. At risk residents are monitored, at least monthly by the Food Service Supervisor and/or Consultant Dietician. Nutrition interventions to prevent deterioration are selected based on resident`s individual needs. Interventions are periodically evaluated for effectiveness and results documented in the dietary progress note section. Interventions and overall goals are documented in the resident`s care plan and dietary progress notes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47883 Based on observation, interview, and record review, the facility failed to ensure proper food storage practices by failing to ensure food stored in the facility's dry storage and refrigerator were labeled with an expiration date and opened dated. This deficient practice had the potential to place three of 53 residents who receive food from the facility's kitchen at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent kitchen observation and interview on 2/15/2025 at 7:30 a.m., with Dietary Supervisor 1 (DS 1) in the facility's kitchen, observed in the dry storage room, one jar of olives without an expiration date and a five (5) pound (lb. - unit of measurement) bag of buttermilk mix without an open date. Observed in the refrigerator, one (1) gallon of regular milk without an open date. DS 1 stated all food items are to be dated upon receipt with month, day and year. DS 1 stated that the jar of olives should have an expiration date, and the milk and buttermilk mix should have an open date to assure that food will be discarded after the expiration date. This deficient practice put facility's resident at risk for foodborne illnesses. During a review of the facility's policy and procedure titled, Recommended Storage Practices, last reviewed on 1/30/2025, the policy indicated in the procedure to Do not store scoops in food containers .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse 4 (LVN 4) washed their hands before administering eye drops to one of five sampled residents (Resident 4). 2. Ensure LVN 4 removed their isolation gown prior to leaving a resident's room for one of five sampled residents (Resident 4) who was on enhanced barrier precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes). 3. Ensure a resident's urinal (a container used to collect urine) was labeled with the resident's name for one of two sample residents (Residents 48). These deficient practices had the potential to cause cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) and increase the risk of spreading infection to other residents and staff members. Findings: 1. During a review of Resident 4's Admission Record, the Admission Record indicated that the facility initially admitted Resident 4 on 11/22/2021 and readmitted the resident on 7/2/2023 with diagnoses including gastrostomy (G-tube- a tube inserted through the abdomen that delivers nutrition directly to the stomach), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/20/2025, the MDS indicated that the resident had severely impaired cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs- activities related to personal care). During a review of Resident 4's Order Summary Report dated 2/2025, the Order Summary Report indicated a physician order for lubricate eye drops solution 0.4-0.3% (eye drops used to treat eye dryness) instill one (1) drop in both eyes two times a day for eye dryness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/15/2025 at 5:07 p.m., with LVN 4, observed Resident 4's room with signage that indicated Resident 4 was on EBP. Observed LVN 4 administering medication to Resident 4 via g-tube, then observed LVN 4 not remove their gloves before administering lubricate eye drops solution to Resident 4's eyes. Observed LVN 4 exit Resident 4's room while still wearing an isolation gown. Observed one of LVN 4's gowned arms touch the medication cart. When asked why LVN 4 was still wearing the isolation gown after exiting a resident's room on EBP precautions, LVN 4 stated LVN 4 should have removed the isolation gown before exiting Resident 4's room. LVN 4 stated it is important to follow EBP guidelines to prevent the spread of infection. LVN 4 stated he (LVN 4) should have removed his gloves and washed his hands after administering the g-tube medications and before administering the eye drops to Resident 4. During an interview on 2/15/2025 at 6:25 p.m., with the Infection Preventionist (IP), the IP stated that LVN 4 should have washed their hands before administering eye drops to Resident 4. The IP stated staff who provide care for residents who are on EBP should remove the isolation gown and gloves before leaving a resident's room. The IP stated LVN 4 should have removed the gown before exiting Resident 4's room. The IP stated this was important to prevent the spread of infection. During a review of the facility's policy and procedure titled, Eye Drop Administration, last reviewed on 1/15/2025, the policy indicated to wash hands to administer ophthalmic solution into and around eye in safe and accurate manner. During a review of the facility's policy and procedure titled, Hand Hygiene Program, last reviewed on 1/15/2025, the policy indicated, It is the policy of this facility to promote an environment that minimizes the risk of transmission of bacteria between residents, staff, and visitors. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, last reviewed on 1/15/2025, the policy indicated, Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. 2. During a review of Resident 48's Admission Record, the Admission Record indicated that the facility initially admitted Resident 48 on 9/11/2023 with diagnoses including body myositis (IMB- a muscle disease where muscles gradually weaken over time due to the build-up of abnormal protein clumps inside the muscle fiber), generalized anxiety disorder (persistent and excessive worry that interferes with daily activities), and essential hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 48's MDS dated [DATE], the MDS indicated that the resident had intact cognition. The MDS further indicated that Resident 48 required moderate-to-maximal assistance of one-to-two helpers for showering, toileting and personal hygiene, dressing and chair-to-bed transfer, and was not able to walk. During a review of Resident 48's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) indicated that Resident 48 was at risk for bladder incontinence (loss of bladder control). The care plan interventions indicated to provide urinal at bedside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/14/2025 at 7:12p.m., with the Director of Nursing (DON), Resident 48 was observed lying in the bed with a urinal on the bedside table with no name and room number on it. The DON stated that the urinal should be marked with the resident's name and room number to prevent cross contamination. During an interview on 2/15/2025 at 6:25 p.m., with the IP, the IP stated urinals should be marked with a resident's name to prevent cross contamination.