STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555892	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Care Center	2108 Stillman Selma, CA 93662

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview, and record review, the facility failed to provide a safe, comfortable and homelike environment for two of 16 sampled Residents (Resident 9, Resident 23), when Resident 9 and Resident 23 were unable to access and use their personal belongings and medical equipment to the extent possible as needed. This failure resulted in Resident 9 and Resident 23 not having a safe homelike environment. Findings: During a concurrent observation and interview on 11/19/24 at 10:35 a.m. with Resident 9, in Resident 9's room, Resident 9 was observed dressed, laying in his bed with plastic grocery bags on his bed against the wall. A bed-side table with food and condiments was observed next to his bed and Resident 9's wheelchair was observed facing Resident 9 pushed up against his bed. Resident 9 stated he had been in the facility for one month due to an infection that went to his heart. Resident 9 stated there was not enough room to move around in his room. During a review of Resident 9's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24, the AR indicated Resident 9 was admitted to the facility from the acute care hospital on 10/16/24 with diagnoses of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of right leg above the knee, acquired absence of left leg below the knee, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and repeated falls. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/23/24, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 9 was cognitively intact. During an interview on 11/22/24 at 2:53 p.m. with Resident 9, Resident 9 stated he could not move around his room because wheelchairs and an oxygen machine were in his way. Resident 9 stated he had to keep his shirts under his pillow because he could not get to his dresser. Resident 9 stated he had to keep his toiletries and sodas in a bag hanging on the back of his wheelchair, kept next to his bed, and had food around him on his bed because it was easier for him to get to. Resident 9 stated he felt like he was in prison. Resident 9 stated his room was too small. Resident 9 stated his room was a very non-homelike environment. During a review of Resident 9's Care Plan (CP), undated, the CP indicated, . encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility . the resident needs activities that minimize the potential for falls while providing diversion and distraction . ensure resident has an unobstructed path to the bathroom . During a concurrent observation and interview on 11/19/24 at 12:27 p.m. with Resident 23 in Resident 23's room, Resident 23 was observed dressed sitting up in his bed watching television (TV). Boxes of food, papers, a drinking tumbler, and towels were observed on a bedside table next to the foot of Resident 23's bed and the wall, under Resident 23's TV. Resident 23 stated he was upset that his power strip was secured to the windowsill behind his bed, where he could not reach it. Resident 23 stated there was not enough room for two residents in his room. During a review of Resident 23's AR dated 11/25/24, the AR indicated Resident 23 was admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a condition of the lungs where the air sacs are damaged and enlarged, causing breathlessness [difficulty breathing]), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 23's MDS, dated [DATE], the MDS section C indicated Resident 23 had a BIMS score of 15, which indicated Resident 23 was cognitively intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/21/24 at 12:03 p.m. with Resident 23, in Resident 23's room, Resident 23 was observed sitting on his bed with his oxygen machine and bedside table between him and a dresser, which was across the room and a wheelchair at the foot of his bed placed in front of the closet. Resident 23 stated he could not get to his nebulizer which was placed on top of a dresser across the room. Resident 23 stated the table and oxygen machine were in his way. During an interview on 11/25/24 at 12:58 p.m. with Resident 23, Resident 23 stated it was terrible to be in a room this small. Resident 23 stated at times it was dangerous to move around his room. Resident 23 stated he would have to move things himself, such as his bed side table, oxygen machine, or wheelchair to get around in his room. Resident 23 stated his walker was put in the closet, which he could not get to because his wheelchair blocked the door of the closet. Resident 23 stated he did not do as much walking as he should. Resident 23 stated he did not walk or move around much because his room was too small, and he could not get around easily in the room. During an interview on 11/22/24 at 8:34 a.m. with the Infection Preventionist Nurse (IP), the IP stated Residents 9 and 23 were in a small space. The IP stated Residents 9 and 23 had a lot of clutter (a crowded or disordered collection of things, untidy) . The IP stated she had to move the wheelchairs out of the room to provide care. The IP stated items in the room would need to be moved to get to the residents. The IP stated small spaces were not good for the residents. The IP stated Residents 9 and 23 had to use their call light if they needed help or to get out of the room because space was limited. The IP stated Resident 23 would have to call for staff to get his nebulizer (a device that changes medication from a liquid to a mist so it can be inhaled into the lungs) which was on the dresser across the room if he needed to use it. During an interview on 11/22/24 at 8:55 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 9 and Resident 23's room was not a homelike environment. CNA 3 stated Residents 9 and Resident 23 had lots of stuff. CNA 3 stated Resident 9 and Resident 23's room was crowded. CNA 3 stated it was difficult to give Resident 9 and Resident 23 care. CNA 3 stated she would move Resident 9 and Resident 23's wheelchairs outside to go into the room to give care. During a concurrent observation and interview on 11/25/24 at 3:95 p.m. with the Maintenance Supervisor (MS) and Maintenance Director (MND) in Resident 9 and Resident 23's room. Resident 9 and Resident 23's room measurements were measured and verified by the MND. The MND stated measurements for Resident 9 and Resident 23 room size measured 110 square feet. A small dresser placed against the wall at the foot of Resident 9's bed, with one side in front of a large four-drawer dresser blocking the lower two drawers of large dresser was observed. The blocked lower two drawers of the large dresser were labeled Bed B. The lower two drawers of the large dresser were not able to be opened unless the small dresser was moved. The small dresser prevented Resident 9 access to the lower two drawers of the large dresser. The MND verified not all rooms had two residents with adaptive equipment. The MND verified an oxygen machine, two wheelchairs and three bedside tables were also located in the room. During an interview on 11/25/24 at 4:29 p.m. with the Director of Nursing (DON), the DON stated if there was a private room available, she could offer the room to Resident 9 or Resident 23 or move Resident 9 or Resident 23 to another room. The DON stated Resident 9 and Resident 23's room was not safe if there was an emergency and staff needed to get to Resident 9 or Resident 23 quickly. The DON stated Resident 9 and Resident 23's room was very small. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 5:21 with the Administrator (ADM), the ADM stated he went into Resident 9 and Resident 23's room to speak to the residents about their room and to move Resident 23's bed. The ADM stated his expectations were for residents to live in a safe environment. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms, dated 10/2022, indicated, . resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents . resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms . all resident bed rooms will have access to an exit corridor without passing through another bedroom . each resident bedroom will have an individual private closet space with clothes racks and shelves accessible to the resident . if resident uses a wheelchair, furniture will be placed at a height the resident can access and utilize (i.e., bed, dresser or shelves, etc.) . During a review of the facility's P&P titled, Resident Rights, dated 10/2022, indicated, . the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . the resident has a right to a safe, clean, comfortable and homelike environment . During a review of the facility's P&P titled, Safe and Homelike Environment, dated 10/2022, indicated, . in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . this includes ensuring that the . physical layout of the facility maximizes resident independence and does not pose a safety risk . Environment refers to any environment in the facility that is frequented by residents, including [but not limited to] the residents' rooms . a determination of homelike should include the resident's opinion of the living environment . orderly is defined as an uncluttered physical environment that is neat and well-kept .

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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 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** 48739 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for three of 16 residents (Residents 3, 9 and 23) when: 1. Resident 9's care plan was not developed to address the use and storage of Resident 9's Incentive Spirometer (IS - a hand-held device that helps people take slow deep breaths to improve lung functioning). This failure put Resident 9 at risk of infection and harm due to improper storage and use of the IS. 2. Resident 23's care plan was not developed to address the use and care of a nebulizer (a device that changes medication from a liquid to a mist so it can be inhaled into the lungs). This failure put Resident 23 at risk of infection and harm due to improper storage and use of Resident 23's nebulizer. 3. Resident 23's care plan was not developed and implemented to address Resident 23's non-compliance with the proper use and storage of Resident 23's oxygen tubing and nasal cannula (a tube that delivers oxygen through the nose to people who have low oxygen levels). This failure put Resident 23 at risk of infection and harm due to improper use and storage of Resident 23's oxygen tubing and nasal cannula. 4. Resident 9 and Resident 23's care plans were not developed and implemented to reflect assessments and interventions to address outside food stored on the bed and on the bedside tables longer than 3 days. This failure put Resident 9 and Resident 23 at risk of infection from food-born illness (illness caused by ingestion of contaminated food or beverages) due to cross- contamination (the transfer of harmful substances or disease- causing microorganisms to food) and may also provide an environment for attraction of pests. 5. Resident 3's care plan was not developed timely to address indwelling catheter (a thin, flexible tube that drains urine from the bladder into a collection bag outside the body). This failure did not allow the team to collaborate and communicate for Resident 3's needs, and had the potential for needs to go unmet. Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an observation on 11/22/24 at 8:49 a.m. in Resident 9's room, the Infection Prevention Nurse (IP) was observed waking Resident 9 up from sleeping to perform his Incentive Spirometer (IS) treatment. During a review of Resident 9's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24, the AR indicated Resident 9 was admitted to the facility from the acute care hospital on 10/16/24 with diagnoses of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of right leg above the knee, acquired absence of left leg below the knee, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and repeated falls. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/23/24, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 9 was cognitively intact. During a concurrent interview and record review on 11/22/24 at 4:41 p.m. with the Minimum Data Set Nurse (MDSN), Resident 9's Care Plan (CP), undated was reviewed. The CP indicated there was no care plan in place for the use and storage of Resident 9's IS. The MDSN stated there was no care plan in place for changing the breathing apparatus (mouthpiece) or the breathing tube on the IS. The MDSN stated the mouthpiece and breathing tube on the IS should have been changed periodically. The MDSN stated if the IS mouthpiece and tubing were not changed, they could be a risk for infection for Resident 9. During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 10/2022, indicated, . it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices . all Care Assessment Areas [CAAs] triggered by the MDS will be considered in developing the plan of care . other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care . the comprehensive care plan will describe, at a minimum . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 11/19/24 at 12:30 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 23's room, Resident 23's nebulizer was observed on the floor. CNA 1 stated Resident 23's nebulizer should not have been on the floor. CNA 1 stated Resident 23's nebulizer on the floor was an infection control problem. CNA 1 stated Resident 23 could have gotten sick. During a review of Resident 23's AR dated 11/25/24, the AR indicated Resident 23 was admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a condition of the lungs where the air sacs are damaged and enlarged, causing breathlessness [difficulty breathing]), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 23's MDS, dated [DATE], the MDS section C indicated Resident 23 had a BIMS score of 15, which indicated Resident 23 was cognitively intact. During a concurrent interview and record review on 11/22/24 at 4:20 p.m. with the MDSN, Resident 23's CP, undated was reviewed. The CP indicated no care plan for the use and storage of Resident 23's nebulizer. The MDSN stated there should have been a care plan in place for the use and storage of Resident 23's nebulizer. The MDSN stated it was not acceptable for Resident 23's nebulizer to be on the ground and not in a bag. The MDSN stated there was a risk of infection for Resident 23 if he used a dirty nebulizer. During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 10/2022, indicated, . it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices . all Care Assessment Areas [CAAs] triggered by the MDS will be considered in developing the plan of care . other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care . the comprehensive care plan will describe, at a minimum . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record . 3. During a concurrent observation and interview on 11/19/24 at 10:34 a.m. with Resident 23 in Resident 23's room, Resident 23's oxygen tubing was observed wrapped around Resident 23's bed rail, not placed in a bag. Resident 23 stated he wanted the oxygen tubing on the bed rail and would use it when he needed it. (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 observation and interview on 11/22/24 at 8:34 a.m. with the Infection Prevention Nurse (IP) in Resident 23's room, Resident 23 was observed putting his oxygen tubing cannula in his mouth. The IP stated she had given Resident 23 a bag to store his oxygen tubing and incentive spirometer, but Resident 23 had thrown them away. During an interview on 11/22/24 at 4:20 p.m. with the MDSN, the MDSN stated there should have been care plans for refusals of treatment and non-compliance. The MDSN stated the physician should have been notified of non-compliance. During an interview on 11/25/24 at 4:29 p.m. with the Director of Nursing (DON), the DON stated residents who were non-compliant should have had a care plan and interventions for non-compliance. The DON stated the resident's care plan would not be individualized if there was no care plan for non-compliance. During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 10/2022, indicated, . it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices . all Care Assessment Areas [CAAs] triggered by the MDS will be considered in developing the plan of care . other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care . the comprehensive care plan will describe, at a minimum . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record . 4. During an observation on 11/19/24 at 10:35 a.m. in Resident 9's room, Resident 9 was observed dressed lying in bed. Resident 9 was observed to have no lower limbs. Resident 9 was observed with bags of store-bought food on his bed against the wall, loose food items (cookies and fried pork rinds). Resident 9's bedisde table was observed with bottles of condiments (hot sauce, pickled chilis, pickles, and onion dip), bottles of lotion, hair gel, and mouth swabs. During an observation on 11/19/24 at 12:27 p.m. in Resident 23's room, Resident 23 was observed dressed sitting up in his bed watching television (TV). Resident 23's bedisde table was obsreved with boxes of food, papers, a drinking tumbler, and towels. During a concurrent observation and interview on 11/22/24 at 8:55 a.m. with CNA 3, in Resident 9 and Resident 23's room, open food items were observed on Resident 9's bed and bedside table, and on a bedside table between Resident 23's bed and wall. CNA 3 stated when residents had open food items, staff would label the items with the resident's name and date. CNA 3 stated residents could keep their own food with them. CNA 3 stated she did not know the policy for how long residents could keep open food items in their room. (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 record review and interview on 11/22/24 at 4:20 p.m. with the MDSN, Resident 9 and Resident 23's CPs, undated were reviewed. The care plans indicated there were no care plans for food brought into the facility for Resident 9 and Resident 23. The MDSN stated there should have been a care plan for food brought in and kept in Resident 9 and Resident 23's room. The MDSN stated residents could have food brought in, but the nurse should have been notified. The MDSN stated education should have been provided to Resident 9 to decrease certain foods due to Resident 9's diet. The MDSN stated Resident 9 was at risk for high blood sugar. The MDSN stated there was no CP for non-compliance in place for Resident 9. During an interview on 11/25/24 at 11:16 a.m. with the Director of Staff Development (DSD), the DSD stated the nurse was responsible for building the resident's care plan according to what the resident's needs were. The DSD stated resident care plans should have been completed when the nurse was talking to the resident, during the resident interview or assessment, or when the nurse was implementing the care plan. The DSD stated new residents should have had their care plans completed by the end of the nurse's shift. The DSD stated resident care plan revisions should have been completed right away to make the changes in resident care. The DSD stated care plans were revised by the MDSN, and nurses during their shift when they were able to see what was going on with the resident. The DSD stated the resident's care plan should have been ended, extended, or revised when a resident's goal was met. The DSD stated care plans were important because they gave guidelines and measurable goals for the resident. The DSD stated the care plan let staff know what was working and what was not working for the resident. The DSD stated the care plan was a map of resident care. The DSD stated Resident 9 and Resident 23's care plans were not individualized. During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 10/2022, indicated, . it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices . all Care Assessment Areas [CAAs] triggered by the MDS will be considered in developing the plan of care . other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care . the comprehensive care plan will describe, at a minimum . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555892	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Care Center	2108 Stillman Selma, CA 93662

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 3's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24 the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), paraplegia (loss of movement and/or sensation, to some degree, of the legs) arthritis (chronic condition that causes inflammation in the joints, tissues around the joints, or other connective tissues), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), acute kidney failure (sudden loss of kidney function that can occur within hours or days), chronic obstructive pulmonary disease (COPD-common lung disease that makes it difficult to breathe), unstageable pressure ulcer (bed sores, pressure sore or pressure injury-a localized area of damaged skin or tissue caused by prolonged pressure) right heel, unstable pressure injury to the left heel, chronic pain, muscle weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), colostomy (a surgical procedure that creates an opening in the abdominal wall to divert the colon, or large intestine, and allow stool to drain into a bag), edema medical condition that occurs when fluid builds up in the body's tissues, causing swelling) and obstructive uropathy (a condition that occurs when urine can't drain properly through the urinary tract, causing urine to back up and damage the kidneys). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/7/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3 was cognitively intact. During an observation on 11/19/24 at 1:15 p.m. in Resident 3 room, Resident 3 had an indwelling foley catheter handing on the side of his bed. Resident 3 stated he was taking antibiotic for a urinary tract infection (UTI- a bacterial infection that affects the urinary tract). During an interview on 11/22/24 at 2:20 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated, Care plan should be started right and should be complete within 48 hours after admission. During an interview on 11/20/24 at 2:39 p.m. with LVN 1, LVN 1 stated, nurses were responsible for inputting medication into resident chart. LVN 1 stated the DON and MDS were responsible for updating the care plans. During a concurrent interview and record review on 11/25/24 at 5:49 p.m. with the DON, Resident 3's Care Plan dated undated was reviewed. The DON stated the indwelling catheter care plan should have been done on 10/31/24 when resident was admitted to the facility. The DON stated the indwelling care plan was done on 11/14/24. The DON stated care plans were individualized and resident center. The DON stated care plans were done to direct resident goals and interventions of care. The DON stated it was important to develop the care plan within 24 hours after admission into the facility. The DON stated nurses should have done the care planning for Resident 3's indwelling catheter. The DON stated Resident's 3 care plan was not done on time. The DON stated Resident's 3 goals and interventions for his foley catheter could have been missed. The DON stated, We did not follow the policy and procedure. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 10/2022, indicated, . it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices . all Care Assessment Areas [CAAs] triggered by the MDS will be considered in developing the plan of care . other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care . the comprehensive care plan will describe, at a minimum . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment . the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record . During a review of the facility's P&P titled, Refusal of Treatment, dated 2/2015, indicated, . it is the policy of this facility to honor a resident's request not to receive medical treatment as prescribed by his/her physician . treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms . if a resident refuses treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing . the Care Plan Team will assess the resident's needs and offer the resident alternative treatments, if available . if the resident's refusal brings about a significant change, a reassessment will be made and such information will be incorporated into the resident's care plan . Documentation . shall include . the date and time the physician was notified as well as the physician's response . 49949

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview and record review, the facility failed to meet professional standards of practice for three of 16 sampled residents (Resident 23 and Resident 3) when: 1. Resident 23's oxygen flow rate was set to 3L (liters-a unit of measurement) instead of the ordered 2L. This failure had the potential to result in shortness of breath and respiratory distress (difficulty breathing) for Resident 23. 2. The Attending Physician (AP) was not notified of Resident 3's refusal of lidocaine (medication is used on the skin for pain) patch. This failure resulted in Resident 3 not receiving ordered pain medication. 3. Resident 3's physician order (a set of instructions written by a doctor for clinicians to follow when caring for a resident) for pain medication was not followed. This failure resulted in Resident 3's physician not being notified of his continued moderate pain (pain measuring at a four to six on the pain scale- a tool used to measure pain intensity and help doctors manage pain). Findings: 1. During a concurrent observation and interview on 11/19/24 at 10:34 a.m. with Resident 23 in Resident 23's room, observed Resident 23 dressed, sitting on his bed. Resident 23's oxygen delivery machine turned on, with the oxygen tubing (a tube that delivers oxygen through the nose to people who have low oxygen levels) wrapped around Resident 23's bed rail and not on Resident 23. Resident 23's oxygen rate was observed to be set to 3L (liters-a unit of measurement. Resident 23 stated he would wear the oxygen tubing when he needed oxygen. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24, the AR indicated Resident 23 was admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a condition of the lungs where the air sacs are damaged and enlarged, causing breathlessness [difficulty breathing]), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/5/24, the MDS section C indicated Resident 23 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 23 was cognitively intact. During a review of Resident 23's Medication Administration Record (MAR), undated, the MAR indicated, . O2 (oxygen) at 2 L/MIN via nasal cannula every shift for CHRONIC SHORTNESS OF BREATH and DYSPNEA (difficulty breathing) related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD- term for lung and airway diseases that restrict breathing) . SLEEP APNEA (sleep disorder) . During a concurrent observation and interview on 11/22/24 at 8:34 a.m. with the Infection Prevention Nurse (IP) in Resident 23's room, the IP verified Resident 23's oxygen machine was set at a rate of 3L. During a concurrent interview and record review on 11/22/24 at 9:00 with the IP, Resident 23's Medication Review Report (undated) was reviewed. The IP stated the Medication Review Report for Resident 23's oxygen administration rate was 2L. The IP stated Resident 23's oxygen rate should be set to 2L. The IP stated the nurse was responsible for the setting the rate on resident's oxygen administration. The IP stated if physician orders were not followed, residents could get hurt. During an interview on 11/25/24 at 4:29 p.m. with the Director of Nursing (DON), the DON stated she expected nurses to follow oxygen administration orders and physician orders. During a review of the facility job description document titled, Charge Nurse, dated 2023, the document indicated, . transcribes physician orders to medical record and carries out orders as written . 49949 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 11/22/24 at 4:33 p.m. with License Vocational Nurse (LVN) 2, LVN 2 stated Resident 3 refused lidocaine (medication is used on the skin to stop itching and pain) patch. LVN 2 stated Resident 3 stated the pain patch did not help with his pain and refused the medication. LVN 2 stated Resident 3's Attending Physician (AP) was not notified of the refusal of the lidocaine patch. LVN 2 stated, he should have notified the AP after Resident 3 refused the lidocaine patch three times. During an interview on 11/25/24 at 12: 13 p.m. with the Director of Staff Development (DSD), the DSD stated the AP should have been notified of Resident 3's refusal of lidocaine patch. The DSD stated the AP should have been notified so he can make changes or discontinue the medication. The DSD stated the AP was not notified of Resident 3's refusal of the lidocaine patch. During a concurrent interview and record review on 11/25/24 at 1:03 p.m. with the Director of Nursing (DON), Resident 3's [Facility Name] Care Center, LLC Progress Notes *New* (PN) was reviewed. The PN indicated, on 11/13/24, 11/14/24, 11/15/24, 11/16/24,11/17/24, 11/18/24, 11/20/24, 11/21/24, Resident 3 refused his lidocaine patch. The DON stated, the AP should have been notified of Resident 3's refusal of lidocaine patch. The DON stated the nurses should have notified the AP with reason Resident 3 refused the lidocaine patch. The DON stated the AP was not notified and did not have the opportunity to discontinue or change medication for Resident 3. The DON stated there was no documentation the nurses contacted the AP. During an interview on 11/25/24 at 3:58 p.m. with the AP, the AP stated he expected the nurses to contact him when Resident 3 refused his lidocaine patch. The AP stated he could have discontinued or changed the medication. During a review of Resident 3's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24 the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of osteomyelitis (inflammation of bone or bone marrow), paraplegia (loss of movement and/or sensation, to some degree, of the legs) arthritis (chronic condition that causes inflammation in the joints, tissues around the joints, or other connective tissues), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), acute kidney failure (sudden loss of kidney) chronic obstructive pulmonary disease (COPD-common lung disease that makes it difficult to breathe), unstageable pressure ulcer (bed sores) right heel, unstable pressure injury to the left heel, chronic pain, muscle weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), colostomy (a surgical procedure that creates an opening in the abdominal wall and allows stool to drain into a bag), edema medical condition that occurs when fluid builds up in the body's tissues, causing swelling) and obstructive uropathy (a condition that occurs when urine can't drain properly through the urinary tract). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/7/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3 was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Medication Administration Record (MAR) dated 11/2024, the MAR indicated, from 11/1/24 to 11/22/24, Resident 3's lidocaine patch was refused 32 times. During a review of the facility's policy and procedure (P&P) titled, Refusal of Treatment dated 2/24/2015, the P&P indicated, .8. The Attending Physician must be notified of refusal of treatment . 3. During an interview on 11/19/24 at 1:15 p.m. in Resident 3's room, Resident 3 stated he was getting oxycodone -acetaminophen for his pain. Resident 3 stated he was having pain eight on pain scale (a tool used to measure pain intensity and help doctors manage pain-level, one to three is mild, four to six is moderate and seven to ten is severe). During an interview with at 11/20/24 at 2:54 p.m. with LVN 1, LVN 1 stated, when Resident 3 complained of pain she would look at the physician order (PO-a set of instructions written by a doctor for clinicians to follow when caring for a resident) and administered medication according to the physician order. LVN 1 stated she would return one hour to check Resident 3's pain level. LVN 1 stated when pain was not managed it would affect Resident 3's quality of life. During an interview on 11/22/24 at 4:33 p.m. with LVN 2, LVN 2 stated Resident 3 would notify him when he was in pain. LVN 2 stated Resident 3 complained of pain at level five or six out of ten on the pain scale. LVN 2 stated she would administer Resident 3 oxycodone -acetaminophen 10/325mg (pain medication used for severe pain) for his pain. During an interview and record review on 11/25/24 at 12:13 p.m. with the Director of Staff Development (DSD), Resident 3's Medication Administration Record (MAR) dated [DATE] was reviewed. The MAR indicated on 11/1/2024 for 10:00 a.m. administration time, there were number 6 in the box for Resident 3's pain level to indicating Resident 3 had moderate pain. The DSD stated the physician order was not followed. The DSD nurses should have contacted the AP and do a pain assessment. The DSD stated nurses should not have given him oxycodone- acetaminophen for his pain level of a five or six. The DSD stated nurses should have contact the AP and asked for pain medication that matched his moderate pain level of five or six. The DSD stated assessing pain incorrectly could cause stress for the resident. The DSD stated it would affect the quality of life and could have cause Resident 3 to be angry, depressed, or withdrawn. The DSD stated, We should try to meet his need and improve his quality of life and pain is major factor in effecting your ADL [Activities of daily living (ADLs) are basic tasks that people need to do to live independently and function in a household]. During an interview on 11/25/24 at 1:03 pm with the Director of Nursing (DON) the DON stated the nursed should have let the AP know Resident 3 was receiving oxycodone -acetaminophen for moderate pain. The DON stated Resident 3 does not have any medication for moderate pain. The DON stated the nurses did not follow the PO and it was not acceptable to give medication indicated for severe pain for moderate pain. The DON stated the nurses should have contact the AP to get a new PO for moderate pain medication. The DON stated not following PO was not professional standard of practice. During an interview on 11/25/24 at 3:59 p.m. with the Attending Physician (AP), the AP stated, I expected the nurse to contact, and I will make the changes. The AP stated The nurse should be following the physician order. The AP stated they did not when they gave the medication for patient for moderate pain. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/24 the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), paraplegia (loss of movement and/or sensation, to some degree, of the legs) arthritis (chronic condition that causes inflammation in the joints, tissues around the joints, or other connective tissues), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), acute kidney failure (sudden loss of kidney function that can occur within hours or days), chronic obstructive pulmonary disease (COPD-common lung disease that makes it difficult to breathe), unstageable pressure ulcer (bed sores, pressure sore or pressure injury-a localized area of damaged skin or tissue caused by prolonged pressure) right heel, unstable pressure injury to the left heel, chronic pain, muscle weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), colostomy (a surgical procedure that creates an opening in the abdominal wall to divert the colon, or large intestine, and allow stool to drain into a bag), edema medical condition that occurs when fluid builds up in the body's tissues, causing swelling) and obstructive uropathy (a condition that occurs when urine can't drain properly through the urinary tract, causing urine to back up and damage the kidneys). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/7/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3 was cognitively intact. During a review of Resident 3's Medication Administration Record (MAR) dated 11/2024, the MAR indicated, . [box] [oxycodone -acetaminophen] Oral Tablet 10-325 mg give 1 tablet by mouth every 6 hours as needed for Severe pain, 7-10 .[box] Fri. [box] 1. [box] pain level. [box] 6. [box] Sat. [box] 2. [box] pain level. [box] 5. [box] pain level. [box] 6. [box] pain level. [box]6. [box] Sun. [box] 3. [box] pain level. [box] 5. [box] Mon. [box] pain level. [box] 6. [box] Tue. [box] pain level. [box] 5 . During a review of the facility's policy and procedure (P&P) titled, Physician Ordered Services dated 10/2022, the P&P indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services .'Professional Stand of Quality' means that care and services are provided according to accepted stands of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting . During a review of the professional reference titled, A grounded theory of the implementation of medical orders by clinical nurses retrieved from, https://pmc.ncbi.nlm.nih.gov/articles/PMC10863222/, the article indicated, .Nurses play a pivotal role in carrying out medical orders and bear responsibility and accountability for their accurate implementation. The process includes stages such as checking medical orders, prescribing medications, and documenting executed orders. Ensuring the proper implementation of medical orders by nurses is essential for ensuring patient safety. Maintaining patient safety relies significantly on clear and carefully reviewed medical orders by nurses, serving as mechanisms to prevent practice errors .

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on interview and record review the facility failed to ensure one of eight sampled residents (Resident 31) had a post-discharge plan of care (narrative document for communicating clinical information about what happened to the resident in the facility) when Resident 31 left AMA (Against Medical Advice- term used in healthcare when a patient leaves the hospital before their doctor recommends discharge). This failure resulted Resident 31's not having a post-discharge plan of care (document that summarizes a patient's health conditions, treatments, and other information) and had the potential to not adjust to new living environment. Findings: During a review of Resident 31's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/25/25, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), gas gangrene (life-threatening bacterial infection that destroys soft tissue and can develop rapidly), cellulitis (a bacterial infection that affects the deeper layers of the skin, including the dermis and subcutaneous fat) dyspnea (an uncomfortable feeling of not being able to breathe well enough), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), acute kidney failure (a sudden loss of kidney function that can occur within hours or days) and chronic pain. During a review of the Resident 31's Against Medical Advice Release Form dated 9/6/24, the Against Medical Advice Release form indicated, .2. Resident/Responsible Party Signature: [box] No signature .3. Date of Signature [box]9/6/24 .5. Witness 1 relationship to resident? [box]: Nurse .8. Witness 2 Relationship to Resident [box]CNA. 9. Date of Witness 2 Signature: [box]9/6/24 . During a concurrent interview and record review on 11/25/24 at 9:00 a.m. with the Medical Record (MR) Resident's 31 post discharge summary plan was requested for review. The MR validated there was no post discharge summary plan documents available. During an interview on 11/25/24 on 11:16 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 31 did not have a discharge summary plan of care. The DSD stated Resident 31 should have a discharge plan of care. The DSD stated the physician should have been notified and documented in the discharge summary care plan. The DSD stated it was not done. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/25/24 at 12:45 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Transfer and Discharge (including AMA), dated 10/2022, was reviewed. The P&P indicated, . 'Resident-initiated transfer or discharge' is a transfer or discharge in which the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment) .13. Discharge Against Medical Advice (AMA). a. The resident and family/legal representative should be informed of the risk involved, the benefit of staying at the facility, and the alternatives to both .b. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. C. Documentation of this notification should be entered in the nurses' notes by the nursing department .A member of the interdisciplinary team completes relevant sections of the Discharge summary. The nurse caring for the resident at the time of discharge is responsible to ensuring the Discharge Summary is complete .A post discharge plan of care that is developed with the participation of the resident, and the resident's representative (s) which will assist the resident to adjust to his or her new living environment . The DON stated the facility staff should have followed the P&P, but they didn't.

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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. 48739 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (a substance such as vaccines or drugs derived from a living organism used for treatment) were stored and labeled in accordance with currently accepted professional standards and practice when: 1. One of one bottle of folic acid (a mineral) did not have a readable expiration date on the bottle, and one of 161 pill packets (a packet that contains a set number of medication pills of the same brand in individual pop-out wrapping) was expired. These failures had the potential for residents to receive expired medications resulting in medication ineffectiveness (not producing any significant or desired effect). 2. One of 3 bottles of artificial tears (medication used to moisturize the eyes) and one of 15 inhalers (medications used to treat respiratory disease with a mist or spray that the patient breathes in through the nose or mouth) were not labeled with the resident's name or expiration date. These failures placed residents at risk for receiving the wrong medication which could lead to medication adverse (unintended) reactions. Findings: 1. During a concurrent observation and interview on 11/25/24 at 1:04 p.m. with Licensed Vocational Nurse (LVN) 2 in the nurses' station, the medication cart was observed to have one bottle of folic acid with no legible expiration date and one pill packet with an expiration date of 8/24/24. LVN 2 stated the pill packet and the bottle of folic acid needed to be discarded. LVN 2 stated he was unable to verify if the bottle of folic acid was expired. LVN 2 stated he did not want to give expired medications to residents. LVN 2 stated expired medications can lose efficacy (the ability to produce a desired or intended result) and some could develop fungus (a group of spore-producing organisms feeding on organic matter, including molds) if expired. 2. During a concurrent observation and interview on 11/25/24 at 1:20 p.m. with LVN 2 in the nurses' station, the medication cart was observed to have one bottle of artificial tears with no resident's name or expiration date and one inhaler was observed with no resident's name or expiration date. LVN 2 stated the bottle of artificial tears, and the inhaler should have been labeled with a resident's name and expiration date. During an interview on 11/25/24 at 4:29 with the Director of Nursing (DON), the DON stated her expectation was no expired medications should have been in the medication cart. The DON stated the LVNs should have been checking the medications for labels and expiration dates prior to administering medications to the residents. The DON stated if expired medications were given to the residents, they may not receive an proper dosage of medication. The DON stated if a medication was expired it could become weak. (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 review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 10/2022, indicated . the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49949 Based on observation, interviews and record review, the facility failed to ensure Dietary [NAME] (DC) 1 was competent to carry out the functions of the food and nutrition services safely and effectively when DC 1 thawed frozen meat without running cold water. This failure had the potential to result in unsafe food being served, consumed, and could have cause food borne illness (contamination of food and occur at any stage of the food production, delivery and consumption chain) to 29 residents who were served food from the kitchen. Findings: During a concurrent observation and interview on 11/20/24 at 11:17 a.m. in the kitchen, with Dietary [NAME] (DC) 1, frozen meat was submerged in a bucket of water. DC 1 stated she pulled out the frozen meat to make dinner for 11/20/24. DC 1 stated she worked as a cook for nine months. DC 1 stated, I had a rapid training from my previous supervisor that was three days of training. DC 1 stated she was trained to defrost meat submerged in water. DC 1 stated she was not aware of having cold water running when frozen meat was submerged in water. DC 1 stated she normally pulled meat one to two days in advance and would thaw it out in the refrigerator before cooking it. DC 1 stated the kitchen staff did not thaw the frozen meat and today she had to thaw the frozen meat in a bucket of water. DC 1 stated she would wait to about 1 or two hours or when the meat felt soft before cooking it. DC 1 stated she was not sure if the cold running water needed to thaw out frozen products. During an interview on 11/21/24 at 4:38 p.m. with the Certified Dietary Manager (CDM), the CDM stated the DC should have the meat submerged in running cold water. The CDM stated it was important to have the running cold water to prevent food borne illness. The CDM stated resident could have gotten foodborne illness if the frozen meat was not thawed out correctly. The CDM stated the frozen meat should have been thawed within a certain time frame and temperature to ensure bacteria did not grow and prevent food borne illness. The CDM stated there were plenty of days for DC 1 to take out the frozen meat from the freezer and thawed it in the refrigerator. The CDM stated the potentially hazardous zone for meat product were at 40-degree Fahrenheit to 135-degree Fahrenheit. During an interview on 11/25/24 at 10:24 a.m. with the Registered Dietitian (RD) the RD stated DC 1 should have thawed the frozen meat in the refrigerator, in the microwave or by cooking. The RD stated it was the practice to put frozen meat in a container in running cold water. The RD stated it was important kitchen staff knew the policy and procedure for safety food practice. The RD stated DC 1 did not follow the policy and procedure for the facility food safety. The RD state all the kitchen staff should have known the food safety practice. During a review of the facility's dietary cook job description titled, Dietary [NAME] dated 2023, the job description indicated, .Major Duties and Responsibilities .Ensures that food procedures are followed in accordance with established policies .must be knowledgeable of food services practices and procedures . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Food Safety Requirements dated 10/2022, the P&P indicated, .It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will be stored, prepared, distributed and served in accordance with professional standards for food services safety .Food service safety refers to handling, preparing, and storing food in ways that prevent foodborne illness .4. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards. a. Thawing -approved methods for thawing frozen food including thawing in the refrigerator, submerging under cold running water, thawing in the microwave oven, or as part of a continuous cooking process .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview and record review, the facility failed to store, prepare, and serve food in accordance with professional standards of practice for food service safety when: 1 One opened box of pancake batter mix was not labeled with an open on date. 2. Residents snacks were not labeled with prepared on date an in refrigerator for residents to eat. 3. A hornet and wasp pesticide (bug spray) bottle was found below kitchen sink cabinet. 4. Six bags of muffins in the freezer were not labeled with the received-on date. 5. Resident refrigerator contained unlabeled foods with no received on date, resident name and content. 6. Uncooked frozen meat were found inside the resident refrigerator. These failures had the potential to transmit food-borne illnesses (caused by eating or drinking something that is contaminated with germs such as bacteria, viruses, or parasites or chemicals such as toxins or metals that can make people sick) and cross-contamination(transfer of harmful bacteria, parasites, or viruses from one food to another, or from surfaces to food) to 29 of 29 sampled residents. Findings: 1. During an observation and interview on [DATE] at 8:05 a.m. in the kitchen with the Certified Dietary Manager (CDM) an open pancake mixed carton had no open on date. The CDM stated pancake box mix should have an open on date when kitchen staff opened it. During an interview on [DATE] at 4: 38 p.m. with the CDM, the CDM stated the pancake box mixed should be labeled when it was opened. The CDM stated it was important to date the pancake box, so kitchen staff knew how old the pancake mix was. The CDM stated residents could get sick if they consumed food beyond the expiration date. The CDM stated the kitchen staff did not follow the policy for labeling food. During an interview on [DATE] at 10:24 a.m. with the Registered Dietitian (RD), the RD stated, Every time they [kitchen staff] open something there should be an open date. The RD stated, it was important to date open items, so kitchen staff knew when to use the items. The RD stated the kitchen staff should have checked the items daily. The RD stated the CDM was responsible to make sure kitchen staff knew about food label requirements. The RD stated residents could get food borne illnesses if they consumed food that was beyond the used by date. The RD stated the facility failed to follow the policy when staff did not label the pancake mix with an open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Date Marking for Food Safety dated , d+[DATE], the P&P indicated, .The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food .the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared . 2. During a concurrent observation and interview on [DATE] at 8:10 a.m. in the kitchen with the Certified Dietary Manager (CDM), the residents' snacks located in a bin in the refrigerator was not labeled with prepared on date. The CDM stated resident snacks were made last night ([DATE]) and the snacks should have a prepared on date. The CDM stated the night cook should prepare the snacks and label with a date before placing in refrigerator for the residents to eat. The CDM stated it was important to date the snacks in the bin so residents would not consume snacks beyond the expiration date. The CMD stated, consuming snacks beyond the used by date could get residents sick and cause food borne illness. During an interview on [DATE] at 10:24 p.m. with the Registered Dietitian (RD), the RD stated the kitchen staff should be making resident snacks daily. The RD stated there should be a made by date on the bin when resident snacks are stored in the refrigerator. The RD stated residents could get sick if they consumed snacks past the expiration date. The RD stated, the kitchen staff did not follow facility policy when there was no date on the residents' snacks. During a review of the facility's policy and procedure (P&P) titled, Date Marking for Food Safety dated , d+[DATE], the P&P indicated, .The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food .the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared . 3. During a concurrent observation and interview on [DATE] at 8:15 a.m. in the kitchen a bottle of hornet and wasp pesticide (bug spray) was found under the sink. The Certified Dietary Manager (CDM) stated it should not be in the kitchen and was not sure who brought the bug spray bottle in the kitchen. During an interview on [DATE] at 4:38 p.m. with CDM stated the hornet and wasp bug spray bottle should not have been stored in the kitchen. The CDM stated using the bug spray in the kitchen could have cross-contaminated resident food and residents could get sick. During an interview on [DATE]at 10:24 a.m. with the Registered Dietitian (RD), the RD stated, storing chemicals in the kitchen was not acceptable and it might cross-contaminate resident food. The RD stated cross-contamination could cause food borne illness. The RD stated, the kitchen staff did not follow their policy and procedure. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage dated revised , d+[DATE], the P&P indicated, .8. Pesticides and other toxic substances and drugs will not be stored in the kitchen area or in storerooms for food or food preparation equipment and utensils . 4. During a concurrent observation and interview on [DATE] at 8:20 a.m. in the kitchen with the Certified Dietary Manager (CDM), six bags of muffins were not labeled with a received on date. The CDM stated the muffins were ordered sometime this month. The CDM stated the muffins should be labeled with the received on date before putting them in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 4:38 p.m. with the CDM, the CDM stated the bags of muffins should have a label with received on date and an expiration date. The CDM read the facility policy and procedure and stated the kitchen staff did not follow the policy and procedure. The CDM stated it was important to label the muffins with a received on date to prevent serving it to residents past the expiration date. The CDM stated residents could have gotten food borne illness if served muffins past the expiration date. The CDM stated the muffins could have tasted bad and residents would not eat it. The CDM stated labeling the muffins with received on date would have ensured kitchen staff to use the old ones first. During an interview on [DATE] at 10: 24 a.m. with the Registered Dietitian (RD) the RD stated, It should have been labeled when they received it. The RD stated it was important to date the muffins with a received on date. The RD stated, We want to make sure we don't want to be serve expired items. The RD stated, consuming expired items could cause residents to become ill. The RD stated the best practice is to label every item with a received on date. The RD stated, kitchen staff did not follow their policy and procedure. During a review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezer dated revised , d+[DATE], the P&P indicated, .7. All food is appropriately dated to ensure proper rotation by expiration dates. 'Received' dates (date of delivery) are marked on cases and on individual items removed from cases for storage. 5. During a concurrent observation and interview on [DATE] at 9:20 a.m. with the Certified Dietary Manager (CDM) one raisin carrot salad container, one beef and potatoes container, three cups of yogurt, a single frozen hot pocket, one opened bag of mozzarella were found in inside of the residents' freezer and refrigerator. The CDM stated all resident food items should have been labeled with the resident name and received date. During an interview on [DATE] at 4:38 p.m. with the CDM, the CDM stated it was important to label resident food item to ensure resident were getting their food. The CDM stated it was important to labeled resident food to prevent serving food to wrong resident and to prevent cross contamination. The CDM stated the Certified Nursing Assistance (CNA) were responsible for labeling resident food items. The CDM stated resident food items should have been thrown away past the expiration date. During a review of the facility's policy and procedure (P&P) titled, dated no date the P&P indicated, .2. All food items that are already prepared by family or visitors bought in must be labeled with content and dated . 6. During a concurrent observation and interview on [DATE] at 9:20 a.m. with the Certified Dietary Manager (CDM) 16 ounces of mild Italian ground sausage, 16 ounces of frozen ground beef and one roll of frozen chorizo were in the resident freezer/refrigerator. The CDM stated the resident freezer/refrigerator should not contain uncooked frozen meat. The CDM stated kitchen staff were not able to cook meat brought into the facility. During an interview on [DATE] at 4:38 p.m. with the CDM the CDM stated uncooked frozen meats should not have been in the resident refrigerator. The CDM stated the dietary staff were responsible for maintaining the temperature and housekeeping were responsible for cleaning the resident refrigerator. The CDM read the resident policy and stated the facility did not follow their policy and procedure. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Resident Refrigerators dated ,d+[DATE], the P&P indicated, .Dietary and housekeeping staff shall clean the refrigerator weekly and discard any food that are out of compliance .Raw meat or eggs are not allowed in a resident's refrigerator .

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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** 49949 Based on observation, interview and record review, the facility failed to be established and maintained an infection control program to provide safe, sanitary, and comfortable environment to help prevent infections for two of 12 sampled residents (Resident 30 and Resident 23) when: 1. Resident 30's continuous positive airway pressure (CPAP- is a machine that uses mild air pressure to keep breathing airways open while you sleep) mask was observed not stored in a bag and on the ground. 2. Resident 23's oxygen tubing (a tube that delivers oxygen to people who have low oxygen levels) was observed wrapped around Resident 23's bed rail, not stored in a bag, and Resident 23's nebulizer (a device that changes medication from a liquid to a mist so it can be inhaled into the lungs) was observed on the ground, not covered in a bag. These failures placed Resident 30 and Resident 23 at risk to develop respiratory and healthcare associate infections. Findings: 1. During a concurrent observation and interview on 11/19/24 at 1:00 p.m. in Resident 30's room a continuous positive airway pressure (CPAP- is a machine that uses mild air pressure to keep breathing airways open while you sleep) mask was observed on the ground next to the bed. Resident 30 stated he had been in the facility for three weeks. Resident 30 stated he used the CPAP mask nightly to help with his sleep and had been using the machine to help with his breathing since he was in his early 40's. Resident 30 stated, the bag used to store the was torn , and the CPAP mask was on the ground. Resident 30 stated he did not like the CPAP mask on the ground. During a concurrent observation and interview on 11/20/24 at 8:31 a.m. in Resident 30's room with Certified Nursing Assistant (CNA) 5, CNA 5 confirmed the CPAP mask was on the ground next to Resident 30's bed. CNA 5 stated the CPAP mask should not be on the ground and should be in a bag on stored away. CNA 5 stated, We should have it in a bag to prevent cross-contamination [unintentional transfer of harmful bacteria from one object to another, such as from raw meat to cooked food]. CNA 5 stated, I need to take it to Infection Preventionist (IP) to sanitized it CNA 5 stated, It can get resident sick and cause infection. CNA 5 stated, We don't want resident to have an infection especially in lungs. CNA 5 stated it is everyone's responsibility to make sure the CPAP mask was not on the ground. CNA 5 stated all CNAs and nursing were responsible to make sure the CPAP mask was stored properly. CNA 5 stated she should have notified the charge nurses the CPAP was on the ground so the charge nurse could have taken care of the issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24 at12:06 p.m. with the Director of Staff Services (DSD), the DSD stated, the CPAP mask should have been in a bag and stored in a designated area. The DSD stated once the CPAP mask was found on the ground, it should have been disinfected. The DSD stated Resident 30 was at risk for respiratory infections. The DSD stated everyone was responsible in making sure the CPAP mask was not on the ground. The DSD stated when the CPAP mask was not being used the charge nurses should have stored in a bag off the floor. The DSD stated the CPAP mask and machine should be inspected daily to ensure it was cleaned and to prevent infections. During an interview on 11/25/24 at 12:25 p.m. with the Director of Nursing (DON), the DON stated the CPAP should have been in a bag. The DON stated she expected the nurses and CNAs to clean and wipe the CPAP mask and put it in a bag until next use. The DON stated the CPAP mask on the ground was putting Resident 30 at risk for a respiratory infection. The DON stated, the Infection Prevention (IP) should have been checking and made sure the CPAP mask was not on the ground. The DON stated she was not sure if the IP went to check Resident 30's CPAP mask. During an interview on 11/25/24 at 5:00 p.m. with the IP, the IP stated Resident 30 CPAP's mask was on the ground placed him at risk for a respiratory infection. The IP stated the CPAP mask should have been stored in a bag and stored away. The IP stated the CNA should have wiped it down with sanitizer cloth and stored it away. The IP stated it was the CNA's and charge nurse's responsibility to make sure the CPAP masks was not on the ground. The IP stated she was not sure when the last infection control in services was done. During a review of Resident 30 s Admission Record (document containing resident demographic information and medical diagnosis) dated 10/25/24, the admission record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnosis included type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), shortness of breath, asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe), hypertension(HTN-high blood pressure) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 30 s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/7/24, the MDS, indicated Resident 30's had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 30 was cognitively intact. During a review of Resident's 30 care plan titled, Untitled dated undated, the care plan indicated, .[box] Focus: The resident has asthma .[box]Goal: the resident will remain free from complications of asthma through the review date .[box]Interventions: Resident may use CPAP at bed time . During a review of the facility's policy and procedure (P&P) titled, CPAP/BiPAP Cleaning dated 10/2022, the P&P indicated, .6. Clean mask frame daily after use with CPAP cleaning wipes or soap and water, dry well. Cover with plastic bag or completely enclosed in machine storage when not in use . (continued on next page)

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	555892	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Care Center	2108 Stillman Selma, CA 93662

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a professional references review, retrieved https://www.sleepfoundation.org/cpap/cpap-side-effects, titled, Common Side Effects of CPAP dated 2/27/24 the reference indicated, .People who use CPAP machines may develop upper respiratory infections or sinus infections. Bacteria and viruses in the mouth, throat, and lungs can enter the CPAP mask or hose while a person breathes during sleep. Allergens such as mold and dust can also enter the mask or hose. If a CPAP machine is not cleaned properly, germs and allergens can build up within the device and may lead to illness . 48739 2. During a concurrent observation and interview on 11/19/24 at 10:34 a.m. with Resident 23 in Resident 23's room, Resident 23 was observed dressed sitting up in bed watching television (TV), with his oxygen machine turned on and his oxygen tubing wrapped around Resident 23's bed rail. Resident 23 stated he would put on his oxygen tubing when he needed it. During a review of Resident 23's AR dated 11/25/24, the AR indicated Resident 23 was admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a condition of the lungs where the air sacs are damaged and enlarged, causing breathlessness [difficulty breathing]), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 23's MDS, dated [DATE], the MDS section C indicated Resident 23 had a BIMS score of 15, which indicated Resident 23 was cognitively intact. During a concurrent observation and interview on 11/19/24 at 12:30 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 23's room, Resident 23's nebulizer was observed on the ground. CNA 1 stated Resident 23's nebulizer should not have been on the ground. CNA 1 stated Resident 23's nebulizer placed on the ground was an infection control problem. CNA 1 stated Resident 23 could get sick. CNA 1 stated Resident 23's nebulizer needed to be cleaned. During an interview on 11/22/24 at 4:20 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated it was not acceptable for Resident 23's nebulizer to be on the ground and for Resident 23's oxygen tubing to be wrapped around the bed rail. The MDSN stated the tubing needed to be changed right away. The MDSN stated there was a risk of infection to Resident 23 because the tubing was on the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24 at 11:16 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 23's nebulizer and oxygen tubing that was on the ground should have been disinfected immediately for infection control. The DSD stated using a dirty nebulizer or tubing would put Resident 23 at risk for infection. The DSD stated CNAs and nurses are all responsible to make sure Resident 23's nebulizer and oxygen tubing were not on the ground. The DSD stated Resident 23's nebulizer and oxygen tubing should have been in a bag when stored and not in use. The DSD stated if the nebulizer and tubing were on the ground they would have needed to be sanitized, the CNA should have notified the nurse, and the items should have been taken away to be cleaned. The DSD stated staff should have educated the resident on why the items should not have been on the ground. The DSD stated the nebulizer and oxygen tubing should have had a designated place to be stored. The DSD stated if there was another nebulizer available, Resident 23's nebulizer should have been replaced. The DSD stated the nurse was responsible for storing the nebulizer and oxygen tubing in a zip lock bag and put away with the date labeled on the bag when not in use. During a review of the facility's P&P titled, Oxygen Administration, dated 10/2022, indicated . infection control measures include . change oxygen tubing . as needed if it becomes soiled or contaminated . change nebulizer tubing and delivery devices . as needed if they become soiled or contaminated . keep delivery devices covered in plastic bag when not in use . During a review of the facility's P&P titled, Safe and Homelike Environment, dated 10/2022, indicated . sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living .

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation and interview during the survey period of 11/19/24 to 11/25/24, the facility failed to provide the minimum of at least 80 square feet (sq. ft- unit of measurement) per resident in multiple resident bedrooms, and at least 100 sq. ft in single residents rooms for 11 of 20 rooms (Rooms 1, 5, 6, 8, 9, 10, 11, 12, 18, 19, and 20), when the amount of usable living space was not adequate for residents. This failure had the potential for residents in Rooms 1, 5, 6, 8, 9, 10, 11, 12, 18, 19, and 20 to not have reasonable privacy or adequate space. Findings: During an environment tour with the Maintenance Director on 11/25/24 03:05 PM, the inspection indicated the following rooms did not meet the minimum square footage as required by regulation. These rooms were as follows: Room Number Square Feet # of Residents 1 120 2 2 120 1 3 118 1 4 118 1 5 92 1 6 174 3 7 102 1 8 118 2 9 117 2 10 117 2 11 117 2 12 111 2 13 114 1 (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	14 110 1 15 113 1 16 118 1 17 111 1 18 117 2 19 92 1 20 95 1 However, variations were in accordance with the needs of the residents except for Residents in room [ROOM NUMBER]. The residents had a reasonable amount of privacy except for room [ROOM NUMBER]. Closets and storage space were adequate except for room [ROOM NUMBER]. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate except for room [ROOM NUMBER]. Wheelchairs and toilet facilities were accessible except for in room [ROOM NUMBER]. The waiver will not adversely affect the health and safety of residents except for Residents in room [ROOM NUMBER]. Recommend waiver to be continue in effect except for room [ROOM NUMBER]. _____ _____ Health Facilities Evaluator Sup Signature Date

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49949 Based on observation, interview and record review, the facility failed to keep the environment free from insects in accordance with the facility's policy and procedure (P&P) Pest Control Program when ants were observed in the kitchen floor and cabinet. This failure led to insects being observed in the kitchen facility and had the potential to cross contaminate food being prepared in the kitchen for 29 residents. Findings: During a concurrent observation and interview on 11/19/24 at 8:15 a.m. in the kitchen with the Certified Dietary Manager (CDM), multiple live and dead ants were on the ground and under the sink of a cabinet. The CDM stated ants should not be in the kitchen. The CDM confirmed multiple ants were in the kitchen floor and under the sink cabinet. During an interview on 11/21/24 on 4:38 p.m. with the CDM, the CDM stated, ants should not be in the kitchen. The CDM stated, ants could have cross contamination (the transfer of harmful bacteria, parasites, or viruses from one food to another, or from surfaces to food) food and items in the kitchen. The CDM stated residents could have gotten sick from cross contamination. The CDM stated the kitchen staff should have cleaned up the dead ants. The CDM stated kitchen staff were responsible for keeping the kitchen cleaned. The CDM stated kitchen staff notified Maintenance Supervisor (MS) and the MS should have called pest control. The CDM stated she was not sure when the pest control came. During a concurrent interview and record review on 11/25/24 at 12:38 p.m. with the Administrator (ADM), the ADM stated the facility does not have pest control contract with a pest control company. The ADM stated, the MS was notified on 11/19/24 of ants in the kitchen and should have called pest control the same day. The ADM stated, ants can cause cross contamination in the kitchen. The ADM stated, If ants continue to be an issue in the kitchen, then the pest control should come out more than monthly. The ADM stated current pest control is not effective. During a concurrent interview and record review on 11/25/24 at 3:14 p.m. with the spell out MS, the MS stated, the kitchen staff notified him about ants on 11/17/24. The MS stated the pest control should have been contact on 11/17/24. The MS stated he contact the pest control company on 11/19/24. The MS stated the pest control company came out on 11/19/24. The MS stated current pest control program was not effective. The MS stated the kitchen could have used more pest control services due to pest. During a review of the facility's invoice titled, [Company Name] Pest Control dated 11/19/24, the invoice indicated, .[box checked] Ants .Notes: Kitchen baited for ants . During a review of the facility's policy and procedure (P&P) titled, Pest Control Program dated 10/2022, the P&P indicated, .It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodent .