STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER: Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1570 North Fair Oaks Ave Pasadena, CA 91103	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47362 Based on observation, interview, and record review the facility failed to promote respect and dignity for one (1) of 1 sampled resident (Residents 40) for the dignity care area by not ensuring: 1. Resident 40's indwelling catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine) urine collection bag was inside the dignity bag (a bag used to the cover and hold the catheter drainage/collection bag, so it is not visible). 2. Resident 40's rectal bag (soft, silicone catheters with a retention balloon intended to hold the catheter within the rectum and create a seal, may be used for the temporary management of diarrhea and fecal incontinence, to protect perineal skin and wounds, and to prevent cross infection) was inside the dignity bag. Findings: A review of Resident 40's Admission Record indicated the facility admitted Resident 40 on 10/5/2023 with the diagnoses that included lack of coordination, muscle weakness, sepsis (the body's extreme response to an infection) A review of Resident 40's History and Physical Examination, indicated Resident 40 has fluctuating capacity to understand and make decisions. A review of Resident 40's Minimum Data Set (MDS, standardized care and screening tool), dated 3/1/2024, indicated Resident 40 was moderately impaired with cognitive (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 40 required substantial maximal assistance (helper does more than half of the effort) on eating, oral hygiene, toileting hygiene, shower bathe self, upper body dressing, lower body dressing putting on/taking off footwear and personal hygiene. During concurrent observation and interview on 4/3/2024 at 3:29 PM with the Registered Nurse Supervisor (RNS 1), the RNS 1 stated the foley catheter and rectal tube of Resident 40 were not in a dignity bag. The foley catheter tubing was observed touching the floor. The RNS1 further stated having the catheter and rectal tube in a dignity bag was important to ensure dignity and avoid Resident 40 to feel embarrassed. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/5/2024 at 9:50 AM with the Interim Director of Nursing (IDON) ,the IDON stated the foley catheter and the rectal bag should be in a dignity bag. The IDON stated, The catheter was not supposed to be touching the floor. This was not only for dignity but also for infection control. A record review of the facility's Policy and Procedure (P&P) titled Dignity, revised 2/2021 indicated each resident cared for will be in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P also indicated demeaning practices and standards of care that compromise dignity was prohibited. Staff are expected to promote dignity and assist residents; for example, helping the resident to keep the urinary catheter bags covered.

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F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48395

Based on interview and record review the facility failed to follow their policy and procedure titled Advance Directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them) for three (3) of 5 sampled residents (Residents 45, 7 and 8) for the advance directive care area by:

1. Not ensuring the Advance Directive Acknowledgement Form notifying Resident 45 of his right to execute an advance directive was fully filled out.

2. Not ensuring a copy of the Advance Directive was readily accessible in Resident 7 and 8's medical chart.

This deficient practice violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. In addition, this failure had the potential to result in nursing staff not knowing if Residents 45, 7 and 8 had specific resident wishes to follow in case of an emergency.

Findings:

1. During a review of Resident 45's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (damage or disease that affects the brain) and dementia (a loss of brain function that can affect memory, thinking, language, judgement, or behavior).

During a review of Resident 45's History and Physical Examination (H&P), dated 1/24/24, H&P indicated the resident is unable to understand his medical condition or his bill of rights (a patient's rights and responsibilities).

During a review of Resident 45's (MDS - a standardized resident assessment care screening tool), dated 2/5/2024, MDS indicated the resident had adequate hearing (no difficulty in normal conversation, social interaction, listening to TV), clear speech (distinct intelligible words), had the ability to express his ideas and wants, understood others with clear comprehension, had no evidence of a new change in mental status, did not exhibit any behaviors of inattention, disorganized thinking or altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment] and arousal [alertness]), and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with transfers (how resident moves to and from bed, chair and wheelchair), eating, toileting, dressing (how a resident puts on, fastens and takes off all items of clothing) and personal hygiene.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/4/2024 at 2:02 PM with Social Services Consultant (SSC), Resident 45's Advance Healthcare Directive (AHCD) Acknowledgement Form dated 1/23/2024 was reviewed. The AHCD Acknowledgement Form was not fully filled out and did not indicate whether the resident had executed an advance directive or not. SSC stated the form should have been completely filled out so that the resident knows and understands his rights about advance directives and also so that staff could refer to it to see if the resident had executed an advance directive or not. 2. During a review of Resident 7's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 7's H&P, dated 4/7/2023, H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], MDS indicated the resident had adequate hearing, unclear speech (slurred or mumbled words), was rarely able to express his ideas and wants, sometimes understood and responded adequately to simple, direct communication only, had a short-term and long-term memory problem, was totally dependent (helper does all of the effort) with toileting and showering and needed substantial/maximal assistance (helper does more than half the effort) with transfers, eating, dressing and personal hygiene. During a concurrent interview and record review on 4/4/24 at 3:56 PM with SSC, Resident 7's medical chart dated 7/19/2022-4/4/2024 was reviewed. No advance directive was found in Resident 7's medical chart. SSC stated, there was no advanced directive in Resident 7's medical chart and stated that it was important for the advance directive to be in the resident's medical chart so that staff could refer to it to ensure they are meeting the residents needs in case of an emergency. During a concurrent interview and record review on 4/4/24 at 4:23 PM with SSC, the facility's policy and procedure (P&P) titled, Advance Directives revised December 2016 was reviewed. The P&P indicated, Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. SSC stated that she agrees with the P&P and that the AHCD Acknowledgement Form should be filled out in its entirety and if the resident has an advance directive, it should also be present in the resident's medical chart so that staff can refer to it in case of an emergency. 46087 3. A review of Resident 8's Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and chronic obstructive pulmonary disease (COPD- disease that causes obstructed airflow from the lungs). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's Minimum Data Set (MDS - a standardized assessment and care planning tool), dated 1/11/2024, indicated Resident 8 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making. The MDS indicated Resident 8 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS also indicated that Resident 8 has no advance directive. During an interview on 4/3/2024 at 9:57 AM with Social Services Director (SSD), SSD stated Resident 8's Physician Orders for Life-Sustaining Treatment (POLST, a form designed to improve patient care by creating a portable medical order form that records patients) dated 11/18/2023 indicated that advance directive is available and reviewed. SSD stated advance directive was not available in Resident 8's hard chart (physical chart), and it is not in electronic record as well. SSD stated advance directive is important to follow Resident 8's wishes. During a concurrent record review of Resident 8's POLST dated 11/18/2023, and social service notes dated 11/21/2021 and 11/25/2021 and interview with Social Service consultant (SSC) on 4/4/2024 at 2:35 PM, SSC stated, POLST indicated that Resident 8 has advance directive, SSC stated Resident 8's advance directive was not available in Resident 8's medical records because it was never obtained from Resident 8's responsible party. SSC stated social service notes on 11/21/2021 and 11/25/2021 are the only time facility followed up with Resident 8's responsible party regarding the resident's advance directive. SSC stated that SSD should have followed up until advance directive was obtained from the Resident 8's responsible party. A review of facility's Policy and Procedure titled Advance Directives, revised in December 2016, indicated a policy that prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The policy also indicated the interdisciplinary team will review annually with the resident, his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47362

Based on observation, interview and record review, the facility failed to conduct an assessment and utilize other alternatives prior to use of physical restraints (any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement) for three(3) of four (4) sampled resident (Residents 50, 37, and 33) for restraint care area, in accordance with the facility policy.

This deficient practice had the potential to result in injury to Residents 50, 37and 33's and decline in the residents' quality of life, psychosocial and physical functioning.

Findings:

1. A review of Resident 50's Admission Record indicated the facility admitted Resident 50 on 2/20/2024 with the diagnoses that included lack of coordination, anxiety (feeling of fear, dread, and uneasiness), abnormalities of gait and mobility.

A review of Resident 50's History and Physical, indicated Resident 50 had fluctuating capacity to understand and make decisions.

A review of Resident 50's Minimum Data Set (MDS, standardized care and screening tool), dated 2/28/2024, indicated Resident 50 's cognitive (processes of thinking and reasoning) skills for daily decision making was severely impaired. The MDS indicated Resident 50 required substantial maximal assistance (helper does more than half of the effort) for eating, oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. The MDS also indicated Resident 50 was not using any mobility device like cane, walker, wheelchair, limb prosthesis). The MDS also indicated restraints and alarm was not used.

During observation on 4/2/2024 at 9:41 AM, Resident 50 was at the hallway sitting on a wheelchair with lap buddy (device that hooks to the wheelchair thereby preventing the resident from standing or falling, which could be considered as a restraint if it impairs the resident's ability to move).

During concurrent observation at the facility hallway and interview on 4/5/2024 at 3:08 PM with the Certified Nursing Assistant (CNA 3), Resident 50 was observed on the wheelchair at the hallway with lap buddy cross his lap. CNA3 stated Resident 50 had lap buddy every time he's out of bed and on his wheelchair.

During concurrent observation, record review of Resident 50's medical record, and interview on 4/5/2024 at 3:16 PM with the Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 50 does not have an order for lap buddy. The RNS 1 also stated there was no consent obtained, no care plan developed, or assessment conducted prior to use of the lap buddy. RNS1 stated they should have obtained the consent prior and assessed Resident 50.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Policies and Procedure (P&P) titled, Use of Restraint, revised 4/2017, indicated restraint shall only be used for the safety and wellbeing of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of fall. The P&P also indicated restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/ or representative. The P&P also indicated care plans for residents in restraints will reflect interventions that addresses not only the immediate medical symptoms but the underlying problems that may be causing the symptoms. 46087 2. A review of Resident 33's Admission Record indicated resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/11/2024, indicated Resident 33's cognition (ability to think and reason) was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. MDS indicated restraints was not used for Resident 33. During an observation with Resident 33 on 4/3/2024 at 10:20 AM, in the activity room, Resident 33 was in a Geri chair (Geri chair, a large, padded, and mobile reclining chair that prevented the resident from rising). During a concurrent observation and interview with Director of Staff Development assistant (DSDA) on 4/3/2024 at 10:25 AM, DSDA stated Resident 33 is on a Geri chair, and Resident 33 usually comes in the activity room in a Geri chair. DSDA stated that she had seen Resident 33 in Geri chair even before, and never seen her in a wheelchair. During a concurrent record review of Resident 33's medical records and interview with Director of Staff Development (DSD) on 4/5/2024 at 1:57 PM, DSD stated Geri chair can be a form of restraint, DSD added, the purpose of Geri chair should be indicated in the physician's order. DSD also stated, restraints need to have a consent from family or responsible party. DSD stated Resident 33 did not have an active physician's order for Resident 33's use of Geri chair. DSD stated assessment should be done prior to using Geri chair on a resident. During the same interview with DSD on 4/5/2024 at 1:57 PM, DSD stated she did not know if Resident 33 was assessed by rehabilitation department prior to use of Geri chair. DSD was not able to provide documentation of the assessment for Resident 33 and a consent form for the use of Geri chair. DSD stated that she had seen Resident 33 in a Geri chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 37's Admission Record indicated resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 37's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and epilepsy (a result of abnormal electrical brain activity, also known as a seizure, kind of like an electrical storm inside your head). A review of Resident 37's MDS, dated [DATE], indicated Resident 37's cognition was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated restraints was not used for Resident 37. During an observation of Resident 37 on 4/4/2024 at 10:30 AM, in the resident's room, Resident 37 was in a Geri chair. During a concurrent observation and interview with DSDA on 4/4/2024 at 10:35 AM, DSDA stated Resident 37 is on a Geri chair while the resident is in his room. DSDA stated she had seen Resident 37 in Geri chair even before, and never seen Resident 37 in a regular wheelchair. During a concurrent record review of Resident 37's medical records and interview with MDS Nurse (MDSN) on 4/4/2024 at 11:45 AM, MDSN stated he had seen Resident 37 in Geri Chair. MDSN stated the facility's process with Geri chair use is to have rehabilitation department assess and evaluate the use of Geri chair, outcome will be coordinated to nursing department, and Doctor (MD) will be notified and carry out MD's order (physician's order) accordingly. MDSN also stated there is no order for Resident 37 to use Geri chair, and MDSN added that it is not a good practice to use Geri chair without a MD's order because it looks like Geri chair is being used as restraints. MDSN stated Resident 37 has no Geri chair assessment on the medical records. MDSN also stated Resident 37 has no care plan for Geri chair use. A review of facility's Policy and Procedure titled Use of Restraints, revised in April 2017, it indicated examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, Geri-chairs, and lap cushions and trays that the resident cannot remove. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including placing a resident in a chair that prevents the resident from rising. The policy also indicated prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. In addition, the policy indicated, restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period for the use of the restraint.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) assessment was completed within the required time frame for one (1) of two (2) sampled residents (Resident 12), for Resident Assessment care area, as indicated on the facility Resident Assessment policy. This deficient practice had the potential to not be able to track Resident 12's status between comprehensive assessments to ensure critical indicators of gradual change in resident's status are monitored. Findings: A review of Resident 12's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 12's Admission (comprehensive) Minimum Data Set indicated an assessment reference date (ARD, observation end date) of 11/13/2023, and completion date of 12/7/2023. During a concurrent record review of Resident 12's MDS and interview with MDS Nurse (MDSN) on 4/4/2024 at 7:40 PM, MDSN stated a Resident 12 did not and should have had a quarterly MDS assessment completed on the month of February 2024. During an interview with Interim Director of Nursing (IDON) on 4/4/2024 at 7:50 PM, IDON verified that quarterly MDS was not done for Resident 12. IDON stated it was important to complete the MDS timely because MDS reflects the status of Resident 12. A review of the facility's policy and procedure titled Resident Assessments, revised in November 2019, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: - Quarterly Assessment - Conducted not less frequently than three (3) months following the most recent Omnibus Budget Reconciliation Act ([OBRA], also known as the Nursing Home Reform Act of 1987, has dramatically improved the quality of care in nursing homes over the last twenty years by setting federal standards of how care should be provided to residents) assessment of any type.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview, and record review, the facility failed to follow through with the Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) recommendation to obtain a PASARR level II (a resident-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC)) evaluation for two of four sampled residents (Residents 27 and 14), for PASARR care area, in accordance with the facility policy. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services necessary for Residents 14 and 27's wellbeing. Findings: 1. A review of the Admission Record indicated Resident 27 was readmitted to the facility on [DATE], with diagnoses that included schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), diabetes mellitus (high blood sugar), and hypertension (elevated blood pressure). A review of Resident 27's PASARR completed on 1/10/2024, indicated the need for Level II PASARR evaluation. A review of Minimum Data Set (MDS, a comprehensive assessment and screening tool), dated 1/26/2024, indicated Resident 27 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 27 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene and required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 27 was receiving antipsychotic (medication primarily used to manage psychosis [collection of symptoms that affect the mind, where there has been some loss of contact with reality] principally in schizophrenia). During an interview on 4/4/2024 at 11:58 AM, with Registered Nurse Supervisor 1 (RNS 1), she stated she was responsible for overseeing PASARR. RNS 1 stated that she did not follow through with a PASARR representative regarding the need for Resident 27's Level II evaluation. RNS 1 stated that Level II evaluation was to determine appropriate placement and/or the need for specialized services. 48395 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 14's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (damage or disease that affects the brain) and schizoaffective disorder (a type of mental illness characterized by symptoms of both schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions] and a mood disorder which includes mania [extreme highs] or severe depression [severe lows]), bipolar type (a mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration). A review of Resident 14's History and Physical Examination (H&P), dated 6/30/2023, H&P indicated the resident was able to make decisions for activities of daily living. A review of Resident 14's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 1/29/2024, MDS indicated the resident had severe impairment with cognitive decision making (difficulty with or unable to make decisions, learn, remember things). Resident 14 required partial/moderate assistance (helper does less than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position) and walking 10 feet. Resident 14 required supervision or touching assistant (helper sets up or cleans up; resident completes activity) with dressing (how a resident puts on, fastens and takes off all items of clothing) and personal hygiene and was independent with eating. During a concurrent record review of Resident 14's PASSAR 2 screening letter, dated 2/25/2024 and interview with Registered Nurse 1 (RN1) on 4/4/2024 at 2:24 PM, the PASSAR 2 screening letter indicated that it was not scheduled due to the resident being discharged from the facility. RN 1 stated that the information was incorrect, and Resident 14 was not discharged at that time, and she should have submitted another PASSAR level 1 screen to reopen the case. RN 1 further stated that it's important that residents get properly screen for PASSAR so that they can receive the proper benefits they need for their mental health. A review of the facility's Policy and Procedure titled, Admission Criteria, revised March 2019, indicated if the level I screen indicates that the individual may meet the criteria for a mental disorder (MD), intellectual disabilities (ID), or related disorders (RD), he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review, the facility failed to develop a person-centered behavioral care plan for one of 21 sampled residents (Resident 49). This failure had the potential to result in Resident 49 not receiving the proper care and interventions. Findings: A review of Resident 49's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of schizophrenia (a serious mental disorder in which people interpret reality abnormally and may result in some combination of hallucination, delusions, and extremely disordered thinking and behavior that impairs daily functioning) and dementia (a loss of brain function that affects brain functions such as memory, thinking, language, judgement, or behavior). During a review of Resident 49's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 2/19/2024, indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 49 needed substantial/maximal assistance with transfers, needed partial/moderate assistance (helper does less than half the effort) with dressing and toileting and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with rolling left to right and sitting up in bed and was independent with eating. A review of Resident 49's Order Summary Report, dated 4/1/2024, indicated Resident 49 had an order to take Risperdal (an antipsychotic medication used to treat schizophrenia) twice a day and an order to monitor behavior episodes of schizophrenia manifested by irritability, striking out during activities of daily living (ADL; activities related to personal care) care and to tally it with hashmarks for each episode on the residents medication administration record (MAR) every shift for his Risperdal usage. During a concurrent record review of Resident 49's Electronic Health Record (EHR; an electronic version of a patient's medical history), dated 2/13/2024 to 4/5/2024, and interview with the MDS Nurse on 4/5/2024 at 10:03 AM, the MDS Nurse stated, The resident did not have any care plans for his schizophrenia diagnosis, his specific behaviors, or the psychotropic medications he is on. MDS stated that there should have been a care plan established for the resident's schizophrenia diagnosis, behaviors, and psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications because it allows the staff to establish proper goals and interventions so the staff could properly monitor the resident's behaviors and to be aware if any new changes develop. During an interview on 4/5/2024 at 10:15 AM with Interim Director of Nursing (IDON), IDON stated that Resident 49 should have had a patient centered care plan regarding his specific behaviors and the medications the resident is on to address those behaviors so that staff are aware of both the resident's current issues and the interventions to address them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised December 2016, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timelines to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident, with the policy interpretation and implementation stating: - The comprehensive, person-centered care plan will: - Incorporate identified problem areas; - Incorporate risk factors associated with identified problems; - Reflect treatment goals, timetables and objectives in measurable outcomes; - Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview and record review, the facility failed to revise the activity care plan for two of 21 sampled residents (Residents 7 and 21) to reflect current needs, preference, abilities, and limitations, in accordance to the facility policy. This failure had the potential to not provide Residents 7 and 21's activities, which could affect residents' mental and emotional well-being. Findings: 1. A review of Resident 7's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 7's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 3/6/2024, MDS indicated the resident had adequate hearing (no difficulty in normal conversation, social interaction, listening to TV) and unclear speech (slurred or mumbled words). Resident 7 was rarely able to express his ideas and wants and sometimes understood and responded adequately to simple, direct communication only. Resident 7 had severe impairment (never/rarely made decision) with cognitive (ability to think, remember and reason) skills for daily decision making. Resident 7 was totally dependent (helper does all of the effort) with toileting and showering and needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair and wheelchair), eating, dressing (how a resident puts on, fastens and takes off all items of clothing), and personal hygiene. A review of the Activities Log Sheets, dated March 2024, indicated Resident 7 did not attend any activities in the activity room for the month of March 2024. During an interview on 4/4/2024 at 8:33 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that the resident was always sleeping, preferred to stay in bed, and does not like to get up or sit on the wheelchair. A review Resident 7's Activities Care Plan, dated 12/21/2023, the indicated the resident required assistance and encouragement in attending and/or participating with planned activities program, it also indicated resident preferred activities related to behavioral symptoms. The goal for the care plan was for the resident to participate in activities of ability at least three times a week with interventions that included to invite and assist resident to activities daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 7's activities care plan and interview on 4/4/2024 at 4:40 PM with Activities Director (AD), AD stated Resident 7's activities care plan indicated to encourage the resident in attending and/or participating in activities. AD stated that they do not provide any in room activities for Resident 7 because he refuses and that he doesn't like to attend any activities in the activities room. 2. A review of Resident 21's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of polyosteoarthritis (when five or more joins have arthritis [pain and stiffness] at the same time) and dementia (a loss of brain function that affects memory, thinking, language, judgement or behavior). A review of Resident 21's H&P, dated 6/3/2023, H&P indicated the resident does not have the capacity to understand and make decisions. A review of Resident 21's MDS, dated [DATE], MDS indicated the resident was severely impaired (difficulty with or unable to make decision, learn, remember things) in cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 21 needed partial/moderate assistance (helper does less than half) for rolling left to right in bed, going from a sitting to a lying down position in bed and upper body dressing (the ability to dress and undress above the waist), needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and personal hygiene. Resident 21 needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing (the ability to dress and undress below the waist). A review of the Activities Log Sheets, dated March 2024, indicated Resident 21 did not attend any activities in the activity room for the month of March 2024. A review of Resident 21's Order Summary Report , dated 4/1/2024, indicated, Activities as tolerated not in conflict with treatment plan. A review of Resident 21's Activities Care Plan, dated 11/14/2023, indicated the resident had little or no activity involvement and had a goal of the resident participating in one on one (1:1) activities 1 to two times a week with interventions including reminding the resident that she may leave activities at any time and is not required to stay for the entire activity. A review of Resident 21's Care Plan, dated 12/21/2023, indicated the resident requires assistance and encouragement in attending and/or participating with planned activities program. It indicated Resident 21 preferred activities related to behavioral symptoms with goals including for the resident to participate in activities of ability at least three times a week. It also included an intervention indicated to identify resident lifestyle, occupation and hobbies and invite and assist resident to activities daily. During an interview on 4/4/2024 at 8:37 AM with CNA 1, CNA 1 stated that Resident 21 likes to stay in bed. During an interview on 4/4/2024 at 4:40 PM with AD, AD stated that she has no documentation of providing any 1:1 activities to Resident 21. AD further stated that it's important to offer residents to participate in activities so that it can help them feel better. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 6:52 PM with Infection Preventionist (IP), IP stated that for resident activities, there should be a plan for visiting, a care plan and documentation that they were visited by activities staff as well as documentation of whether the staff had tried to encourage the resident to participate in activities and if the resident refuses. IP also stated Resident 7 and 21's care plan should have been modified because they do not participate in or refuse to participate in activities. IP stated the interventions need to be reassessed because if the current interventions are not working, then they need to be changed. IP further stated that offering activities to residents helps with the residents' emotional well-being. IP added offering activities helps the residents socialize, not feel isolated, and be able to interact with others especially with those residents who are depressed, During an interview on 4/5/2024 at 12:20 PM with Interim Director of Nursing (IDON), IDON stated that it's important for residents to participate in activities because it allows them to improve their mental health and enhance their daily life. IDON further stated that it's also important to have documentation of attempts to have the resident participate in activities or if they refuse so that they could figure out what's going on for those who are refusing. IDON stated the rest of the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) can reassess the resident's needs and update their care plan and interventions. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised December 2016, the P&P indicated: - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. - The interdisciplinary team must review and update the care plan: - When there has been a significant change in the resident's condition; - When the desired outcome is not met; - The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation and interview, the facility failed to ensure one of 21 sampled resident (Resident 45) for the Activities of Daily Living (ADLs) care area was provided a communication board (a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves) that was readily accessible with the language they're able to understand. This failure had the potential to result in Resident 45 experiencing a delay in receiving appropriate care and treatment due to the staff not being able to properly communicate with the resident. Findings: During a review of Resident 45's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (damage or disease that affects the brain) and dementia (a loss of brain function that can affect memory, thinking, language, judgement, or behavior). During a review of Resident 45's History and Physical Examination (H&P), dated 1/24/24, H&P indicated the resident is unable to understand his medical condition or his bill of rights (a patient's rights and responsibilities). During a review of Resident 45's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 2/5/2024, MDS indicated the resident had adequate hearing (no difficulty in normal conversation, social interaction, listening to TV), clear speech (distinct intelligible words), had the ability to express his ideas and wants, understood others with clear comprehension, had no evidence of a new change in mental status, did not exhibit any behaviors of inattention, disorganized thinking or altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment] and arousal [alertness]), and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with transfers (how resident moves to and from bed, chair and wheelchair), eating, toileting, dressing (how a resident puts on, fastens and takes off all items of clothing) and personal hygiene. During an observation on 4/2/2024 at 9:32 AM in Resident 45's room, no communication board was observed hanging on or near the bed or on the bedside table. During an observation on 4/3/2024 at 7:50 AM in Resident 45's room, no communication board was found near his bed or on top of his bedside table. During an interview on 4/3/2024 at 9:12 AM with Resident 45, Resident 45 stated English is not his primary language that is why there is not much communication between himself and the staff and that the staff do not use a communication board when attempting to speak with him. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 45's Communication Care Plan dated 1/30/2024, the Communication Care Plan indicated Resident 45 had a communication problem related to language barrier with a goal to improve communication function by using a communication board with interventions including monitoring the effectiveness of communication strategies and assistive devices communication board. During a concurrent observation and interview on 4/4/2024 at 8:43 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 45's room, no communication board was found around or near the resident's bed, or inside or on top of his bedside table. LVN 1 stated, that no communication board could be found. LVN 1 also stated, it is important to have a communication board at the bedside so that staff could communicate with the resident when needed. During an interview on 4/4/2024 at 8:50 AM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated, if ever she needs to communicate with Resident 45 regarding something more than basic needs, she calls a supervisor to help so they could use a non-facility provided translating application on their personal phone since CNA 2 did not know if the facility had professional translation service. CNA 2 also stated, she does not know of any other resources she could use to help translate or communicate with the resident and that it is important to speak with the resident in a language that they understand so that they can identify what the resident needs and attend to them. During an interview on 4/4/2024 at 8:55 AM with Registered Nurse 1 (RN 1), RN 1 stated the only means of communication that the facility provides for non-English speaking residents is a communication board and stated that communication boards should be readily accessible at the resident's bedside. During an interview on 4/4/2024 at 9:10 AM with Social Services Director (SSD), SSD stated, the only means of communication they use at the facility for those residents who do not speak English is by providing them with a communication board. SSD also stated communication boards should always be easily accessible at the resident's bedside to both staff and residents because it is important to speak with non-English speaking residents in a language that they understand so that they could be more comfortable and would be able to fully understand what is being spoken to them by staff. During an interview on 4/4/2024 at 9:32 AM with LVN 1, LVN 1 , a resident's communication board always needs to be accessible and at the bedside hanging by the bed or on the table. During an interview on 4/4/2024 at 2:53 PM with Infection Preventionist (IP) with the Interim Director of Nursing (IDON) present, IP stated the facility mainly uses communication boards and sometimes personal cell phones for translation application for residents who do not speak English. IP also stated, communication boards should be readily accessible so that they could meet the needs of the resident especially for any emergency, safety issue or if they are in pain since the resident will need to be able to communicate with the staff and so the staff can provide them with the resident's needs. IP further stated staff should be assessing to make sure when they check on the resident that their communication board is readily accessible and should also bring it up during shift change report. During a review of the facility's policy and procedure (P&P) titled, Translation and/or Interpretation of Facility Services, revised November 2020, the P&P indicated, It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the limited English proficiency (LEP) individual. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised March 2018, the P&P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: communication (speech, language, and any functional communication systems).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview, and record review the facility failed to provide appropriate and consistent activities for two of two sampled residents (Resident 7 and 21) for the activities care area. This failure had the potential to decrease the physical wellbeing, sense of belonging and emotional health for Resident 7 and 21. Findings: 1. During a review of Resident 7's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 7's History and Physical Examination (H&P), dated 4/7/2023, H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/6/2024, MDS indicated the resident had adequate hearing (no difficulty in normal conversation, social interaction, listening to TV), had unclear speech (slurred or mumbled words), was rarely able to express his ideas and wants, sometimes understood and responded adequately to simple, direct communication only, had a short-term and long-term memory problem, was totally dependent (helper does all of the effort) with toileting and showering and needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair and wheelchair), eating, dressing (how a resident puts on, fastens and takes off all items of clothing) and personal hygiene. During a review Resident 7's Activities Care Plan dated 12/21/2023, the Activities Care Plan indicated the resident required assistance and encouragement in attending and/or participating with planned activities program and resident preferred activities related to behavioral symptoms. The goal for the care plan was for the resident to participate in activities of ability at least three times a week with interventions that included to invite and assist resident to activities daily. During a review of Resident 7's Activities Participation Care Plan dated 3/12/2024, the Activities Participation Care Plan indicated that the resident had activity participation challenged by behavioral symptoms with goals including the resident will have activities to avoid the use of antipsychotics (medication to treat psychosis [a severe mental disorder in which a person loses the ability to recognize reality or relate to others]) and to reduce behavioral and psychological symptoms of dementia (BPSD) with interventions that stated to allow the resident to attend activities related to lifestyle and activities of daily living (ADL; activities related to personal care) and to bring to activities as indicated. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Activities Log Sheets, dated March 2024, the Activities Log Sheets indicated that Resident 7 did not attend any activities in the activity room for the month of March 2024. During a review of Resident 7's Order Summary Report dated 4/1/2024, the Order Summary Report indicated, Activities as tolerated not in conflict with treatment plan. During an observation on 4/2/2024 at 9:04 AM in Resident 7's room, Resident 7 was observed sleeping in bed. During an observation on 4/2/2024 at 10:01 AM in Resident 7's room, Resident 7 was observed sleeping in bed. During an observation on 4/2/2024 at 12:30 PM in Resident 7's room, Resident 7 was observed lying down and asleep in bed. During an interview on 4/4/2024 at 8:33 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the Resident 7 is always sleeping, prefers to stay in bed and does not like to get up or sit in his wheelchair. During an interview on 4/4/2024 at 4:40 PM with Activities Director (AD), AD stated that they did not offer and provide any in room activities for Resident 7 since the resident does not like to attend any activities in the activities room. 2. During a review of Resident 21's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of polyosteoarthritis (when five or more joins have arthritis [pain and stiffness] at the same time) and dementia (a loss of brain function that affects memory, thinking, language, judgement or behavior). During a review of Resident 21's H&P, dated 6/3/2023, H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], MDS indicated the resident was severely impaired (difficulty with or unable to make decision, learn, remember things) in cognitive (ability to think, remember, and reason) skills for daily decision making, needed partial/moderate assistance (helper does less than half) for rolling left to right in bed, going from a sitting to a lying down position in bed and upper body dressing (the ability to dress and undress above the waist), needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and personal hygiene and needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing (the ability to dress and undress below the waist). During a review of Resident 21's Activities Care Plan, dated 11/14/2023, the Activities Care Plan indicated that the resident had little or no activity involvement and had a goal of the resident participating in one on one (1:1) activities one to two times a week with interventions that including reminding the resident that she may leave activities at any time and is not required to stay for the entire activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Care Plan dated 12/21/2023, the Care Plan indicated the resident requires assistance and encouragement in attending and/or participating with planned activities program and resident preferred activities related to behavioral symptoms with goals including the resident will participate in activities of ability at least three times a week and intervention that stated identify resident lifestyle, occupation and hobbies and invite and assist resident to activities daily. During a review of the Activities Log Sheets, dated March 2024, the Activities Log Sheets indicated that Resident 21 did not attend any activities in the activity room for the month of March 2024. During a review of Resident 21's Order Summary Report dated 4/1/2024, the Order Summary Report indicated, Activities as tolerated not in conflict with treatment plan. During an observation on 4/2/2024 at 8:53 AM in Resident 21's room, Resident 21 was observed lying in bed. During an observation on 4/2/2024 at 12:03 PM in Resident 21's room, Resident 21 was observed lying in bed. During an observation on 4/2/2024 at 2:40 PM in the hallway in front of Resident 21's room, Resident 21 was observed lying in bed. During an interview on 4/4/2024 at 8:37 AM with CNA 1, CNA 1 stated Resident 21 likes to stay in bed. During an interview on 4/4/2024 at 4:40 PM with AD, AD stated she has no documentation of providing any 1:1 activities to Resident 21 and further stated that it is important to offer residents to participate in activities so that it can help them feel better. During an interview on 4/4/2024 at 4:43 PM with AD, AD stated she has no documentation about whether there was any attempt to encourage any of the residents to participate in activities or if any of the residents refuse because she did not know she had to document those situations. During an interview on 4/4/2024 at 6:52 PM with Infection Preventionist (IP), IP stated for Resident 7 and 21'st activities, there should be a plan for visiting, a care plan and documentation that they were visited by activities staff as well as documentation of whether the staff had tried to encourage the resident to participate in activities and if the resident refuses. IP further stated offering activities to residents in accordance to the resident's preference, helps with the residents' emotional well-being and helps them socialize and interact a bit with others especially with those residents who are depressed, it is better that they not be isolated. During an interview on 4/5/2024 at 12:20 PM with Interim Director of Nursing (IDON), IDON stated it is important for residents to participate in activities because it allows them to improve their mental health and enhance their daily life. IDON further stated it is also important to have documentation of attempts to have the resident participate in activities or if they refuse so that they could figure out what's going on for those who are refusing, and they can communicate with the rest of the interdisciplinary team (IDT; a group of health care professionals with various areas of expertise who work together toward the goals of their clients) to reassess the resident's needs. (continued on next page)

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F 0679 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, Activity Programs, revised June 2018, the P&P indicated, Activity programs are designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident, with its policy interpretation and implementation stating: - The activities program is provided to support the well-being of resident and to encourage both independence and community interaction. - Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. - The activities program is ongoing and includes the facility-organized group activities, independent individual activities and assisted individual activities. - Our activities programs are designed to encourage maximum individual participation and are geared to the individual residents' needs. - All activities are documented in the resident's medical record.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview and record review, the facility failed to ensure the Low Air Loss mattress (LAL mattress, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) was set up accurately for two (3) of three (3) sampled residents (Resident 33, 6, and 29) for pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) care area. This deficient practice had the potential for Resident 33 to develop a new pressure ulcer and for Residents 6 and 29's pressure ulcer to worsen. Findings: 1. A review of the Admission Record indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), dysphagia (difficulty swallowing), and difficulty in walking. A review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/11/2024, indicated Resident 33's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. MDS indicated Resident 33 was at risk for pressure ulcer. MDS indicated Resident have one or more unhealed pressure ulcers. Resident 33's skin and ulcer treatments were the use of pressure reducing device for bed turning/repositioning program, nutrition, or hydration to manage skin problems and pressure ulcer care. A review of Resident 33's Care Plan, dated 1/24/2023, indicated Resident 33 is at risk for developing pressure ulcer, bruising, and other types of skin breakdown. Interventions were to use pressure relieving devices as needed. A review of Resident 33's Care Plan, dated 8/18/2023, indicated Resident 33 has an unstageable pressure ulcer in coccyx (commonly referred to as the tailbone) or potential for pressure ulcer development related to immobility. Staff interventions included were to follow facility policies/protocols for the prevention/treatment of skin breakdown. A review of Resident 33's Weights and Vitals Summary, dated 4/5/2024 at 4:29 PM, indicated Resident 33's weight as follows: On 4/2/2024 - 136 pounds (Lbs., unit of measurement) On 3/4/2024 - 136 Lbs. On 2/2/2024 - 136 Lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/4/2024 - 136 Lbs. During an observation in Resident 33's room on 4/3/2024 at 8:30 AM, Resident 33 was on a LAL mattress, which was set at 350 Lbs. During a concurrent observation in Resident 33's room and interview with Restorative Nurse Assistant 1 (RNA1) on 4/4/2024 at 10:15 AM, RNA verified that Resident 33's mattress was set at 350 lbs. RNA 1 stated, Resident's weight is not even close to 350 lbs. We set the LAL mattress by the resident's weight. RNA 1 also stated, the licensed nurses must do their rounds when they come in and make sure the LAL mattress is on and is set correctly according to resident's current weight. During an interview on 4/5/2024 at 1:40 PM, Licensed Vocational Nurse 2 (LVN2) stated using a LAL mattress was important for residents that have wounds especially for those who cannot reposition by themselves. LVN 2 added LAL mattress should be set based on resident's weight to provide the therapeutic purpose. A review of the facility's Policy and Procedure titled, Prevention of Pressure Injuries, revised April 2020, indicated to select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. A review of facility's Policy and Procedure titled, Support Surface Guidelines, revised in September 2013, indicated that redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation, and provide pressure relief or reduction. It also indicated that any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, static air, alternating air, gel, or air-loss device, when lying in bed. 47362 2. A review of Resident 6's Admission Record indicated the facility admitted Resident 6 on 1/15/2024. Resident 6's diagnoses included hemiplegia (refers to a severe or complete loss of strength), and hemiparesis (refers to a relatively mild loss of strength), lack of coordination, anxiety (feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat). A review of Resident 6's History and Physical (H&P) dated 2/8/2024 indicated Resident 6 does not have the capacity to understand and make decisions. A review of Resident 6's Minimum Data Set (MDS, standardized care and screening tool), dated 2/12/2024, indicated Resident 6's was severely impaired on cognition (processes of thinking and reasoning skills for daily decision making). The MDS indicated Resident 6 required partial/ moderate assistance (helper does less than half of the effort) on eating, oral hygiene, and upper body dressing. The MDS also indicated the resident was dependent (helper does all the effort) on toileting, shower bathe self, putting on, taking off footwear and personal hygiene. The MDS indicated skin and ulcer /injury treatments, turning and repositioning program, nutrition or hydration interventions, application of non-surgical dressings, applications of ointments/ medications and application of dressings to feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Braden Scale (developed to foster early identification of residents at risk for forming pressure sores), dated 12/14/2023 indicated a score of 12 (a score of 12 indicated high risk for developing pressure ulcer). A review of Resident 6's Weights and Vitals Summary dated 3/4/2024 at 8:46 AM indicated Resident 6 weight was 161 pounds (lbs. unit of measuring mass) and Resident 6 was 164 lbs. on 4/2/2024 at 10:47AM. During observation on 4/2/2024 at 9:09 AM Resident 6 was in bed with the low air loss mattress (LAL) setting was 400. During concurrent observation in Resident 6's room and record review on 4/3/2024 at 3:19 PM with RNS 1, RNS 1 stated Resident 6 LAL mattress setting was set at 240. The RNS 1 stated Resident 1's weight was 164 lbs. RNS 1 also stated if the setting of the LAL mattress was not right and accordance with the resident's weight, if will outweigh the benefits of the LAL mattress. The LAL mattress setting should be on the 160's Resident 6 weight was 164 lbs. 3. A review of Resident 29's Admission Record indicated the facility admitted Resident 29 on 1/5/2022. Resident 29's diagnoses included anxiety (feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), functional quadriplegia (a form of paralysis that affects all four limbs, plus the torso), anemia (a condition in which the body does not have enough healthy red blood cells). A review of Resident 29's H&P dated 3/13/2023 indicated Resident 29 does not have the capacity to understand and make decisions. A review of Resident 29's MDS, dated [DATE], indicated Resident 29's was severely impaired on cognition (processes of thinking and reasoning skills for daily decision making). The MDS indicated Resident 29 required substantial/maximal assistance (helper does more than half of the effort) on eating, oral hygiene, upper body dressing, lower body dressing. Dependent (helper does all the effort). On toileting, shower bathe self, putting on, taking off footwear. The MDS indicated determination of pressure ulcer/ injury risk, B. Formal assessment tool. C. Clinical assessment. The MDS also indicated Resident 29 was high risk of developing pressure ulcer/injuries (Damage to an area of the skin caused by constant pressure on the area for a long time). The MDS indicated skin and ulcer/ injury treatments, A. Pressure reducing device for chair, B. Pressure reducing device on bed, C. Turning and repositioning program. A review of Resident 29's Braden Scale, dated 2/2/2024 indicated a score of 12. A review of Resident 29's Weights and Vitals Summary dated 3/4/2024 at 8:46 AM indicated Resident 6 weight was 154 pounds (lbs. unit of measuring mass) and Resident 29 's was 150 lbs. on 4/2/2024 at 10:47AM. A review or Resident 29's Care plan, date revised 2/7/2024 indicated focus, skin integrity, at risk for skin breakdown and moderate risk for pressure injury. Interventions/ task LAL mattress for skin management and offloading pressure point areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 4/2/2024 at 9:04 AM observed Resident 29 on bed with the LAL mattress setting set at 350. During interview on 4/3/2024 at 4:02 PM with the RNS 1, the RNS 1 stated the LAL mattress setting should be set at the correct level based on resident's weight. A review of the user manual for Satin Air Low Air Loss Mattress, (undated) indicated, Intended use the Satin Air Low Air Loss Mattress System was intended to reduce the incidence of pressure ulcer while optimized patient comfort. A review of the facility Policies and Procedure (P&P) titles Support Surface Guidelines revised on 9/2013 indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for resident at risk for skin breakdown. Steps in the procedure, guidelines for selecting appropriate pressure relieving devices. 1.Any individual at risk for developing pressure ulcer should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air loss or gel when lying in bed. 2.Use of pressure risk scale such as the Braden scale to help determine need of an appropriate type of pressure relieving devices.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to check the gastrostomy tube (GT - a flexible tube surgically inserted into the abdomen to stomach for feeding and medication administration) placement before flushing a GT with water for one of two (2) sampled residents (Resident 37) in tube feeding care area. This deficient practice had high risk for Resident 37 to have complications including aspiration. Findings: A review of Resident 37's Admission Record indicated resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 37's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and epilepsy (a result of abnormal electrical brain activity, also known as a seizure, kind of like an electrical storm inside your head). A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/26/2024, indicated Resident 37's cognition (ability to think and reason) was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 37's order summary report dated 4/1/2024, indicated an order on 12/21/2023 to check GT placement before initiation of formula, medication administration and water flushing at least every eight (8) hours. The order summary report also indicated an order on 12/21/2023 to flush GT with 50 ml of water before GT feeding administration. During a medication administration observation on 4/5/2024 at 8:24 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 flushed 30 milliliters (ml, unit of measurement) of water to Resident 37's GT. LVN 1 attempted to flush another 30 ml of water while she's wearing her stethoscope (medical device used for listening to internal sounds of a human body such as lungs or abdomen) to check placement of GT. During a concurrent observation in Resident 37's room, and interview with LVN 2 on 4/5/2024 at 8:30 AM, LVN 2 stated, using water flush is not needed to check GT placement. LVN 2 stated that air should be pushed while stethoscope is placed near the GT site to check placement. During an interview on 4/5/2024 at 9:30 AM with Interim Director of Nursing (IDON), IDON stated the right practice to check GT placement is to flush small amount of air to the GT and hear a sound around GT site using stethoscope. IDON stated flushing water before verifying GT placement might cause harm to resident if GT was not actually in place. IDON stated complications like stomach perforation (a full-thickness injury of the wall of the organ) might happen that can lead to discomfort, pain and hospitalization . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Policy and Procedure titled Enteral Feedings-Safety Precautions, revised in November 2018, it indicated the facility would remain current in and follow accepted best practices in enteral nutrition. It also indicated to check enteral tube placement every 4 hours and prior to feeding or administration of medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47362 Based on observation, interview, and record review, the facility staff failed to ensure one (1) of two (2) sampled residents (Resident 10) received two 2 liters per minute (LPM) of oxygen (the odorless gas that is present in the air and necessary to maintain life) as needed according to physician's order. This deficient practice had the potential to cause complications associated with oxygen therapy (a treatment that provides you with extra oxygen to breathe in). Findings: A review of Resident 10's Admission Record indicated the facility admitted Resident 10 on 9/7/2023 with the diagnoses that included lack of coordination, abnormalities of gait and mobility, and chronic obstructive pulmonary disease (COPD is a group of lung diseases that make it hard to breathe and get worse over time). A review of Resident 10's History and Physical (H&P) indicated Resident 10 was competent to understand her medical condition and patients' bill of rights as presented by the staff. A review of Resident 10's Minimum Data Set (MDS, standardized care and screening tool), dated 3/7/2024, indicated Resident 10 was moderately impaired with cognition (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 10 was supervision or touching assistance (helper provides verbal cues and/ or touching/steadying and/ or contact guard assistance us resident completes activity. Assistance may be provided throughout the activity or intermittently) on eating, oral hygiene, shower/bath self, personal hygiene. Partial/moderate assistance (helper does less than half the effort) on toileting hygiene upper body dressing, lower body dressing, putting on/taking off socks. During observation on 4/2/2024 at 9:18AM, Resident 10 was in bed with the oxygen on via nasal canula (flexible tube that goes around your head and into your nose) at 8 LPM. During concurrent observation and interview on 4/3/2024 at 11:13 AM with Registered Nurse Supervisor (RNS 1), the RNS 1 stated Resident 10 was in bed using oxygen via nasal canula, the oxygen setting was at 10 LPM The RNS 1 also stated oxygen humidifier (filled with sterile water, used to moisten the oxygen) was dated 3/23/2024, the RNS 1 stated it was supposed to be changed last 3/30/2024. During concurrent interview and record review on 4/4/2024 at 7:34 PM with the infection preventionist (IP), the IP stated Resident 10 had COPD, 10 LPM was not acceptable for Resident 10. IP further stated Resident 10's oxygen order was 2 LPM via nasal cannula as needed date ordered on 9/18/2023. The IP also stated the nurse should be administering and monitoring the Resident 10's oxygen flowmeter (an equipment used to control oxygen flow delivery in patients undergoing oxygen therapy). A review of facility's Policies and Procedure (P&P) titled Medication and Treatment date revised 7/2016, indicated the orders for medication and treatment will be consistent with principles of safe ineffective order writing. The P&P also indicated medications shall be administered only upon written order of person duly licensed and authorized to prescribed medication in this state. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Policies and Procedure (P&P) titled Oxygen date revised 10/2010 indicated the purpose of this procedure is to provide guidelines for safe oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview and record review, the facility failed to ensure one of two sampled resident (Resident 32) for dialysis (a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane) care area, who was receiving hemodialysis (process of removing waste products and excess fluid from the body) treatment was provided dialysis care and services in accordance with the facility policy. This deficient practice had the potential for unnoticed or missed excessive bleeding and infection on Resident 32's dialysis arteriovenous (AV) fistula (vascular access in patients receiving regular hemodialysis). Findings: A review of Resident 32's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included end stage renal disease (kidneys suddenly become unable to filter waste products from your blood that can develop rapidly over a few hours or a few days), dependence on renal (kidney) dialysis, and hypertension (high blood pressure). A review of Resident 32's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/16/2024, indicated Resident 32's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated Resident 32 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 32's order summary report, dated 4/1/2024, indicated an order on 1/14/2024, that two (2) hours post dialysis, monitor pressure dressing and assess site for bleeding and skin integrity every evening shift every Monday, Wednesday, and Friday. A concurrent record review of Resident 32's Dialysis Communication Record, dated 4/3/2024, and interview with Licensed Vocational Nurse 1 (LVN 1) on 4/3/2024 at 3:35 PM, indicated the resident's dialysis communication record was not filled out completely when the resident returned from dialysis on 4/3/2024 afternoon. The post dialysis assessment, which included cognitive status, vital signs, dialysis access site, site location, cough, sore throat, shortness of breath, fever, breathing patterns/breath sounds, licensed nurse signature was not completed on 3/20/2024 and 3/27/2024. LVN 1 stated the dialysis communication record for Resident 32 should be completed by the charge nurse upon resident's return from dialysis to know the status of the resident. LVN 1 stated Resident 32's post dialysis assessment on the Dialysis Communication Record was not completed for Resident 32 on 4/3/2024 because she did not know that Resident 32 was already back from dialysis. LVN 1 stated it was important to properly assess resident, document accurately, and complete the dialysis communication record to make sure that resident will receive the proper care. LVN 1 added Charge nurses need to check vital signs (clinical measurements of pulse rate, temperature, respiration rat and blood pressure) and the resident's dialysis access needs to be observed and documented. (continued on next page)

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Pasadena Nursing Center	1570 North Fair Oaks Ave Pasadena, CA 91103

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 32's Dialysis Communication Record and interview on 4/4/2024 at 11:26 AM, with Registered Nurse Supervisor 1 (RNS1), RNS 1 stated Resident 32's Dialysis Communication Record was not filled out completely on 3/20/2024 and 3/27/2024. RNS 1 stated assessing resident after dialysis is important to make sure Resident 32's dialysis arteriovenous (AV) fistula (vascular access in patients receiving regular hemodialysis) is not bleeding, and to know if Resident 32's vital signs were within normal range after dialysis. RNS 1 stated the importance of post dialysis monitoring by stating facility want to make sure that blood pressure did not lower too much, charge nurses need to check vital signs and dialysis access needs to be observed and documented. A review of the facility's Policy and Procedure titled, Hemodialysis, Care of Residents, dated August 2017, it indicated, the facility provides residents with safe, accurate, and appropriate care, assessments, and interventions to improve resident outcomes. General care indicated a Dialysis Communication Record is initiated and sent to the dialysis center each appointment; Ensure it is received upon return and to check vital signs upon arrival post dialysis according to physician's order.

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48395

Based on observation, interview, and record review, the facility failed to assess risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about) and attempt alternatives prior to the use of side rails (adjustable metal or rigid plastic bars that attach to the bed) for one of 21 sampled Residents (Resident 7) as indicated on the facility policy.

This failure had the potential to result in the inappropriate use of side rails for Resident 7, which could pose a safety risk and result in injury or harm.

Findings:

A review of Resident 7's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

A review of Resident 7's History and Physical Examination (H&P), dated 4/7/2023, indicated the resident does not have the capacity to understand and make decisions.

A review of Resident 7's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 3/6/2024, indicated the resident was severely impaired (never/rarely made decisions) with cognitive (ability to think, remember and reason) skills for daily decision making. Resident 7 was totally dependent (helper does all of the effort) with toileting and showering and needed substantial/maximal assistance (helper does more than half the effort) with transfers (how resident moves to and from bed, chair and wheelchair), eating, dressing (how a resident puts on, fastens and takes off all items of clothing) and personal hygiene.

During an observation on 4/2/2024 at 9:04 AM in Resident 7's room, Resident 7 was observed sleeping in bed with both his side rails up which were each one long rail per side that was the length of the bed.

During an observation on 4/2/2024 at 10:01 AM in Resident 7's room, Resident 7 was observed lying down in bed with both of his side rails up which were each one rail as long as the length of the bed.

During an observation on 4/3/2024 at 3:08 PM in Resident 7's room, Resident 7 was observed asleep in bed with both of his side rails up which were each one rail as long as the length of the bed.

During an interview on 4/4/2024 at 10:12 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that there are times where they have both of Resident 7's side rails up to prevent the resident from falling.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/4/2024 at 3:08 PM with Licensed Vocational Nurse 1 (LVN 1) inside Resident 7's room, Resident 7 was observed lying in bed with his left side rail up. LVN 1 stated that they like to keep one side rail up for the resident to help support him in turning since the resident can turn on his own in bed. LVN 1 further stated that there should never be a time where the resident has both side rails up since that could be considered a restraint (a device that limits a patient's movement). During a concurrent record review of Resident 7's Electronic Health Record (EHR; an electronic version of a resident's medical history), dated 7/19/2022 to 4/4/2024 and interview with the MDS Nurse on 4/4/2024 at 3:39 PM, MDS Nurse stated Resident 7's. EHR did not have an order for the use of side rails. MDS Nurse stated that Resident 7 should have an order for side rails if he has a need for it so that staff could refer to it for the resident's safety. A concurrent record review of Resident 7's Electronic Health Record, dated 7/19/2022 to 4/4/2024 and interview with Infection Preventionist (IP) on 4/4/2024 at 7:21 PM, IP stated that there was no documentation found in the EHR indicating that Resident 7 was assessed for the use of side rails. IP also stated that unless the resident themselves requests for the resident to have both their side rails up, they should never be up because it could be considered a restraint and it could also put the resident at risk for getting hurt. During an interview on 4/5/2024 at 12:16 PM with Interim Director of Nursing (IDON), IDON stated the use of side rails must first be evaluated and assessed for the resident to ensure that it is needed since it could be considered as a restraint. IDON further stated that after side rails are assessed, a physician order is obtained and a care plan is developed. A review of the facility's policy and procedure (P&P) titled, Proper Use of Side Rails, revised December 2016, the P&P indicated: - Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). - Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. - An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 46087 Based on observation, interview and record review, the facility failed to ensure staffing information was posted and placed in a visible and prominent place on 4/2/2024. As a result, the total number of staff and the actual hours worked by the staff was not readily accessible to residents and visitors. Findings: During an observation, on 4/2/2024 at 7:41 AM, no visible daily staffing information posting was found at the Subacute and North Nursing Station. During an interview, on 4/5/2024 at 1:05 PM, Director of Staff Development Assistant (DSDA) stated they never posted the number of licensed nurses (Registered Nurse [RN] and Licensed Vocational Nurse [LVN]) and the number of unlicensed nursing personnel (Certified Nurse Assistants [CNA]) directly responsible for resident care since DSDA started to work at the facility (cannot recall date). DSDA stated she did not know why the facility never practice posting the number of Directly responsible for resident care (means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living [ADLs], giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition). During an interview, on 4/5/2024 at 1:10 PM with Director of Staff Development (DSD), She stated that they never posted the shift staffing information that consist of the census, the total number of RN, LVN and CNA's working each shift. DSD added this posting should be easily seen and read by residents, visitors, and staff. She said that it should be posted on both floors of the building. A review of the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers, revised July 2016, policy indicated facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Cross reference F759 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of residents as indicated on the facility policy by: 1. Failing to ensure the narcotic (drug that produces analgesia [pain relief], narcosis [state of stupor or sleep], and addiction [physical dependence on the drug]) count sheet contained two Licensed Nurses' signatures for one of two medication cart 1 (MC 1). This deficient practice had the potential for inaccurate record of narcotic medication use and loss of accountability, which could result to drug loss, diversion, and could potentially harm the resident if ingested. 2. Licensed Vocational Nurse (LVN 2) failed to administer Metoprolol (a medication that lowers your blood pressure and heart rate) twice daily for Resident 38 as indicated in the Physician's order. 3. LVN 2 failed to administer Resident 157's medications within one hour of scheduled time of 9 AM. 4. LVN 2 failed to administer Resident 40's medications within one hour of scheduled time of 9 AM. These deficient practices had the potential to result in Residents 38, 157, and 40 to suffer an adverse effect and cause deterioration in residents' health. Findings: 1. A review of the narcotic count sheet indicated the following: a. On 3/6/2024, the night shift (11 PM to 7 AM shift) licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. b. On 3/8/2024, the day shift (7AM to 3 PM shift) licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. c. On 3/14/2024, the evening shift (3PM to 11PM) licensed nurse did not sign off the NCS for the end of the shift narcotic count. d. On 3/22/2024, the evening shift licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. e. On 3/29/2024, the evening shift licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. The night shift licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 3/30/2024, the evening shift licensed nurse did not sign off the NCS for the start of the shift narcotic count and end of shift narcotic count. g. On 4/3/2024, the evening shift licensed nurse did not sign off the NCS for the end of the shift narcotic count. During a concurrent record review of the NCS and an interview with Licensed Vocational Nurse 2 (LVN 2) on 4/4/2024 at 3:15 PM, LVN 2 stated the NCS had missing licensed nurse's signature from either one or both licensed nurses on 3/6/2024, 3/8/2024, 3/14/2024, 3/22/2024, 3/29/2024, 3/30/2024 and 4/3/2024 for both the start of the shift count and/or end of the shift narcotic count. During an interview with Interim Director of Nursing (IDON) on 4/5/2024 at 2:35 PM, IDON stated narcotic medications must be counted at every shift change by two licensed nurses and then compared against the controlled substance administration records. IDON stated after completing the count, both licensed nurses are also required to sign the NCS. IDON stated that doing the narcotic count, and signing the NCS is important for accountability. A review of the facility's undated form titled, Narcotic count sheet, instructions indicated that by signing below, you acknowledge that you have counted the controlled drugs on hand a have found the quantity of each medication counted is in agreement with the quantity on the Controlled Drug Record. 2. A review of Resident 38's Admission Record indicated Resident 38 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included sepsis (infection of the blood) of unspecified organism, type 2 diabetes mellitus (a disease that occurs when your blood sugar is too high), and hypertension (high blood pressure). A review of Resident 38's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/12/2024, indicated Resident 38 had moderately impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making and required partial/moderate assistance (helper does less than half the effort) with shower/bathing, lower body dressing and putting on/taking off footwear. It also indicated that Resident 38 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, upper/lower body dressing and personal hygiene. During an observation of the medication administration for Resident 38 on 4/4/2024, at 8:58 AM, LVN 2 administered Metoprolol Succinate Oral Capsule extended relief (ER) 24 hour sprinkle 25 mg by mouth. During a concurrent record review of Resident 38's medication orders, and interview with LVN 2 on 4/4/2024 at 10:11 AM, LVN 2 stated that Resident 38 has an order of metoprolol succinate oral capsule for hypertension, to give every day with meals, ordered since 12/30/2023. LVN 2 stated did not and should have administered Metoprolol with meals. 3. A review of Resident 157's Admission Record indicated resident was admitted to the facility on [DATE]. Resident 's diagnoses included anxiety (a feeling of fear, dread, and uneasiness), suicidal ideations, and major depressive disorder (depression, causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 157's Order Summary, dated 4/5/2024, indicated an order for Zoloft (medication used to treat certain mental/mood disorders) oral tablet 50 mg to give 1 tablet by mouth one time a day for depression on 3/31/2024. During an observation of the medication administration on 4/5/2024, at 10:08 AM, LVN 2 administered Zoloft oral tablet 50 mg by mouth to Resident 157. 4. A review of Resident 40's Admission Record indicated the facility admitted Resident 40 on 10/5/2023 with diagnoses that included lack of coordination, muscle weakness, and sepsis (the body's extreme response to an infection). A review of Resident 40's MDS, dated [DATE], indicated Resident 40's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 40 required substantial maximal assistance (helper does more than half of the effort) with eating, oral hygiene, toileting hygiene, shower bathe self, upper body dressing, lower body dressing putting on/taking off footwear and personal hygiene. A review of Resident 40's Order Summary, dated 4/5/2024, indicated the following: o Ascorbic Acid (vitamins) oral tablet, give 500 mg by mouth two times a day for supplement, ordered on 3/26/2024. o Aspirin (beneficial in reducing the risks of heart disease) oral tablet Chewable 81 mg, give 1 tablet by mouth one time a day for cerebral vascular accident (CVA or a brain attack, is an interruption in the flow of blood to cells in the brain) prophylaxis, ordered on 3/26/2024. o Baclofen (used to help relax certain muscles in your body) oral tablet 10 mg, give 1 tablet by mouth three times a day related to muscle spasm of back, ordered on 3/26/2024. o Ferrous Sulfate (a medication used to treat anemia [a lack of red blood cells caused by having too little iron in the body) oral tablet 325 mg, give 1 tablet by mouth one time a day for anemia, ordered on 3/26/2024. o Metoprolol oral tablet 25 mg, give 1 tablet by mouth every 12 hours related to essential hypertension, hold if systolic blood pressure is less than 110 or heart rate less than 60, ordered on 3/26/2024. o Pro-Stat Oral Liquid (ready-to-drink medical food), give 30 ml by mouth two times a day for supplement, ordered 4/3/2024. During an observation of the medication administration for Resident 40 on 4/5/2024, at 10:15 AM, LVN 2 administered the following medications by mouth: o Ascorbic Acid oral tablet 500 mg o Aspirin oral tablet chewable 81 mg 1 tablet o Baclofen oral tablet 10 mg 1 tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Ferrous Sulfate oral tablet 325 mg 1 tablet o Metoprolol Tartrate oral tablet 25 mg 1 tablet o Pro-Stat oral liquid 30 ml by mouth During an interview with LVN 2 at 4/5/2024 at 10:36 AM, LVN 2 confirmed the medications administered for Residents 60 and 40 were medications scheduled for 9 AM. LVN 2 stated, It is important for residents to get their medications on time for their health. LVN 2 added that residents can have a change in condition if medications were not given on time. During an interview with LVN 1 at 4/5/2024 at 10:44 AM, LVN 1 stated that medications can be administered one hour before or after the scheduled time. LVN 1 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. A review of facility's Policy and Procedure titled, Administering Medications, revised in April 2019, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Cross reference: F759 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Eight (8) medication errors out of 27 total opportunities contributed to an overall medication error rate of 29.63 % for three (3) ouf six (6) sampled residents (Residents 38, 157 and 40) observed during medication administration (med pass). 1. Licensed Vocational Nurse (LVN 2) failed to administer Metoprolol (a medication that lowers your blood pressure and heart rate) twice daily for Resident 38 as indicated in the Physician's order. 2. LVN 2 failed to administer Resident 157's medications within one hour of scheduled time of 9 AM. 3. LVN 2 failed to administer Resident 40's medications within one hour of scheduled time of 9 AM. These deficient practices had the potential to result in harm to Residents 38, 157 and 40 by not administering medications as prescribed by the physician to meet their individual medication needs. Findings: 1. A review of Resident 38's Admission Record indicated Resident 38 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included sepsis (infection of the blood) of unspecified organism, type 2 diabetes mellitus (a disease that occurs when your blood sugar is too high), and hypertension (high blood pressure). A review of Resident 38's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/12/2024, indicated Resident 38 had moderately impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making and required partial/moderate assistance (helper does less than half the effort) with shower/bathing, lower body dressing and putting on/taking off footwear. It also indicated that Resident 38 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, upper/lower body dressing and personal hygiene. During an observation of the medication administration for Resident 38 on 4/4/2024, at 8:58 AM, LVN 2 administered Metoprolol Succinate Oral Capsule extended relief (ER) 24 hour sprinkle 25 mg by mouth. During a concurrent record review of Resident 38's medication orders, and interview with LVN 2 on 4/4/2024 at 10:11 AM, LVN 2 stated that Resident 38 has an order of metoprolol succinate oral capsule for hypertension, to give every day with meals, ordered since 12/30/2023. LVN 2 stated did not and should have administered Metoprolol with meals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 157's Admission Record indicated resident was admitted to the facility on [DATE]. Resident 's diagnoses included anxiety (a feeling of fear, dread, and uneasiness), suicidal ideations, and major depressive disorder (depression, causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy). A review of Resident 157's Order Summary, dated 4/5/2024, indicated an order for Zoloft (medication used to treat certain mental/mood disorders) oral tablet 50 mg to give 1 tablet by mouth one time a day for depression on 3/31/2024. During an observation of the medication administration on 4/5/2024, at 10:08 AM, LVN 2 administered Zoloft oral tablet 50 mg by mouth to Resident 157. 4. A review of Resident 40's Admission Record indicated the facility admitted Resident 40 on 10/5/2023 with diagnoses that included lack of coordination, muscle weakness, and sepsis (the body's extreme response to an infection). A review of Resident 40's MDS, dated [DATE], indicated Resident 40's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 40 required substantial maximal assistance (helper does more than half of the effort) with eating, oral hygiene, toileting hygiene, shower bathe self, upper body dressing, lower body dressing putting on/taking off footwear and personal hygiene. A review of Resident 40's Order Summary, dated 4/5/2024, indicated the following: o Ascorbic Acid (vitamins) oral tablet, give 500 mg by mouth two times a day for supplement, ordered on 3/26/2024. o Aspirin (beneficial in reducing the risks of heart disease) oral tablet Chewable 81 mg, give 1 tablet by mouth one time a day for cerebral vascular accident (CVA or a brain attack, is an interruption in the flow of blood to cells in the brain) prophylaxis, ordered on 3/26/2024. o Baclofen (used to help relax certain muscles in your body) oral tablet 10 mg, give 1 tablet by mouth three times a day related to muscle spasm of back, ordered on 3/26/2024. o Ferrous Sulfate (a medication used to treat anemia [a lack of red blood cells caused by having too little iron in the body) oral tablet 325 mg, give 1 tablet by mouth one time a day for anemia, ordered on 3/26/2024. o Metoprolol oral tablet 25 mg, give 1 tablet by mouth every 12 hours related to essential hypertension, hold if systolic blood pressure is less than 110 or heart rate less than 60, ordered on 3/26/2024. o Pro-Stat Oral Liquid (ready-to-drink medical food), give 30 ml by mouth two times a day for supplement, ordered 4/3/2024. During an observation of the medication administration for Resident 40 on 4/5/2024, at 10:15 AM, LVN 2 administered the following medications by mouth: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pasadena Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1570 North Fair Oaks Ave Pasadena, CA 91103	

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Ascorbic Acid oral tablet 500 mg o Aspirin oral tablet chewable 81 mg 1 tablet o Baclofen oral tablet 10 mg 1 tablet o Ferrous Sulfate oral tablet 325 mg 1 tablet o Metoprolol Tartrate oral tablet 25 mg 1 tablet o Pro-Stat oral liquid 30 ml by mouth During an interview with LVN 2 at 4/5/2024 at 10:36 AM, LVN 2 confirmed the medications administered for Residents 60 and 40 were medications scheduled for 9 AM. LVN 2 stated, It is important for residents to get their medications on time for their health. LVN 2 added that residents can have a change in condition if medications were not given on time. During an interview with LVN 1 at 4/5/2024 at 10:44 AM, LVN 1 stated that medications can be administered one hour before or after the scheduled time. LVN 1 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. A review of facility's Policy and Procedure titled, Administering Medications, revised in April 2019, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure on storage of controlled medication (a prescription medicine that is subject to strict legal controls) when a bottle of liquid lorazepam (medication used to treat anxiety) was not stored inside a permanently affixed locked box/compartment inside the refrigerator. This deficient practice had the potential for improper use of controlled medication due to easier access which can lead to medication error and to cause residents to be exposed to adverse side effects of the medication. Findings: During a concurrent observation of medication cart 1 (MC 1) and interview with Licensed Vocational Nurse 2 (LVN 2) on 4/4/2024 at 2:55 PM, a bottle of lorazepam liquid with open date of 4/2/2024 was inside the narcotic drawer. LVN 2 stated that lorazepam liquid does not need refrigeration so it was stored in MC1. During a concurrent observation of medication room [ROOM NUMBER] (MR 1) and interview with LVN 1 on 4/4/2024 at 3:08 PM, medication refrigerator was observed with three (3) shelves. LVN 1 stated that the plastic bin on the third shelf was removable and it is where refrigerated narcotics are stored. LVN 1 stated that liquid lorazepam was a controlled medication and needed to be refrigerated. During a concurrent MR 1 observation, record review of liquid lorazepam's manufacturer storage direction, and interview with Interim Director of Nursing (IDON) on 4/5/2024 at 3:30 PM, IDON stated that refrigerated narcotic medications, including liquid lorazepam, should be kept on a separate locked box which should be permanently affixed inside the refrigerator. IDON stated that the manufacturer's recommendation for liquid lorazepam indicated to store at cold temperature, refrigerate at two (2) to eight (8) degrees Celsius. A review of the facility's Policy and Procedure titled Storage of Medications, revised November 2020, indicated medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. It also indicated controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility failed to ensure that the kitchen utensils and equipment's were kept clean and maintained in good condition, and to discard expired foods and not stored in the kitchen. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization . Findings: During observation in the facility's kitchen with Dietary Supervisor (DS) on [DATE] at 7:40 AM, the following were observed: 1. One (1) can opener base was dirty with gunk (material that is dirty, sticky, or greasy) and has amber color rust on the metal sharp part. DS stated the kitchen staff uses the can opener to open the canned food. 2. A jar of parsley flakes spice container was dirty. The DS stated there were black spots around the lid. 3. A jar of ground Cumin, a jar of paprika, and a jar of cayenne, container was not properly sealed. 4. Bread toaster was not clean with burnt food debris inside. 5. Nine (9) pouches of vanilla instant pudding labeled with date delivered on ,d+[DATE] (did not indicate year) and was not labeled with expiration date. labeled with date open on [DATE] and expiration date on [DATE]. 6. Three (3) knives with white handle and one (1) knife with wooden handle were dirty, with black specks (black spots) discoloration on the handles and blades. 7. Refrigerator door dirty, with brown color (mud like substance) on the door hinge on the bottom right. In addition, rust noted from the inside of the freezer on the bottom left front corner. 8. Spatula handle peeling off with black speck on the handle. 9. Yellow lemon squeezer has chipped paint, with blackish gray discoloration. 10. Strainer for food was dirty, with dry blackish to yellowish particles on the fine mesh (material made of a network of wire or thread). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation in the facility kitchen and interview on [DATE] at 7:33 AM with the Dietary Aid (DA), the DA stated all the can opener needs to be clean all the time after used, it should have no food particles or no gunk on the sharp part and at base. DA stated all containers of powdered seasonings (ground cumin, paprika, and cayenne) are supposed to be sealed properly so that the insects cannot get inside the container, it will contaminate the food. The DA also stated the inside of the bread toaster was dirty, DA further stated it was hard to clean the inside of the toaster. DA also stated everything in the kitchen needs to be cleaned properly and in good working condition such as no peeling/ chipped parts, no black specks, no rust, and discoloration to prevent food contaminations. During observation interview and record review on [DATE] at 7:40 AM with the Dietary Supervisor (DS), the DS stated the facility Policy and Procedure (P&P) titled Sanitation date revised ,d+[DATE] indicated policy statement the food services area shall be maintained in a clean and sanitary manner. Policy interpretation and implementation: 1. All the utensils, counters, shelves, and equipment's should be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair. 2. All equipment's, food contact surface and utensils shall be washed to remove or completely loosened soils by using the manual or mechanical means necessary and sanitize using hot water and/ or chemical sanitizing solutions. A review of facility's P&P title Food Receiving and Storage revised date ,d+[DATE] indicated food shall be received and store in a manner that complies with safe food handling practices. Dry foods that are stored in bins will be removed from original packaging, label and dated.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review the facility failed to implement its policy and procedure on infection control for two (2) of 21 sampled residents (Resident 33 and 106) when: 1. Hospice staff (HS) did not use personal protective equipment (PPE, used to prevent or minimize exposure and to protect from potential transmission of biological agents that can be transferred from person to person by direct and indirect contact) while rendering care to Resident 33 who has an order for enhanced standard precaution (ESP, use of PPE beyond anticipated blood and body fluid exposures). 2. Resident 106's nasal canula (medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) was not changed per Doctor's (MD) order. These deficient practices have the potential to result in a widespread infection in the facility that could compromise the health of the residents, visitors, and staff. Findings: 1. A review of Resident 33's Admission Record indicated resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 33's History and Physical, dated 7/22/2023, indicated a diagnosis of gastrostomy tube (GT - a flexible tube surgically inserted into the abdomen to stomach for feeding and medication administration). It also indicated that Resident 33 does not have the capacity to understand and make decisions. A review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/11/2024, indicated Resident 33's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 33 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 33's Order Summary report, dated 4/1/2024, indicated an order, dated 2/7/2024, for ESP, monitor GT, and wound sites for signs of possible infection and vital signs. It also indicated to notify MD if suspected infection, every shift for ESP monitoring. During an observation on 4/2/2024 at 8 AM, Resident 33's room was observed with ESP signage outside the door. During an observation on 4/4/2024 at 10 AM, HS entered Resident 33's room carrying a bag with wound dressing supplies. HS did not don (put one) PPE prior to entering Resident 33's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/4/2024 at 10:10 AM in Resident 33's room, HS was observed standing close to Resident 33's bed with gloves on both hands but was not wearing an isolation gown. During an interview on 4/4/2024 at 10:12 AM with Certified Nurse Assistant 4 (CNA 4), CNA 4 verified that HS is not wearing the complete PPE needed for ESP residents. CNA 4 stated that HS should wear proper PPE which included isolation gown, gloves and mask when taking care of Resident 33. CNA 4 added that wearing PPE in an ESP room is important to protect resident, Resident 33 has a GT and wound, staff giving care to her should wear the proper PPE for infection control. During an interview on 4/4/2024 at 3:22 PM with Director of Staff Development (DSD), she stated that Resident 33's room is an ESP room wherein everybody including staff, visitors, and contracted staff who goes to the room to render direct care to residents needs to follow the ESP isolation directions that's on the signage that is posted outside Resident 33's room A. DSD stated that ESP is to protect residents from infections and viruses. DSD stated an inservice on ESP was provided to staff on 3/25/2024, but not all staff received the inservice. DSD stated there was no follow inservice given to the staff who missed the inservice on 3/25/2024. DSD added, Infection control inservice should be for all staff. A review of facility's Policy and Procedure titled, Enhanced Standard Precautions, dated 6/20/2023, indicated ESP is defined as to the use of PPE beyond anticipated blood and body fluid exposures. PPE are to be used during high contact resident care activities that have demonstrated to result in transfer of multidrug resistant organisms (MDROs, bacteria that resist treatment with more than one antibiotic) to the hands and/ or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. It indicated the residents at high risk for MDRO colonization and transmission: Presence of indwelling devices: urinary catheter, feeding tube, tracheostomy tube, vascular catheters Wounds or presence of pressure ulcer (unhealed). It also indicated to don PPE outside the resident's room or upon entry before beginning activity. 2. A review of Resident 106's Admission Record indicated resident was admitted to the facility on [DATE]. Resident 106's diagnoses included psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). A review of Resident 106's order summary dated 4/1/2024, indicated an order on 3/19/2024, to change oxygen nasal cannula every week on Monday and as needed (PRN) and to label with the resident's name and date it when it was changed. During an observation on 4/2/2024 at 9:59 AM in Resident 106's room, an oxygen concentrator was observed on the right side of the resident's bed. A nasal cannula tubing was attached to it and was labeled, 3/19/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 106's room and interview with Director of Staff Development Assistant (DSDA) on 4/4/2024 at 11:20 AM, DSDA verified that the nasal cannula tubing attached to the oxygen concentrator which was placed on the right side of the resident's bed was dated 3/19/2024. DSDA stated that it should have been changed and labeled with the date on Monday, 4/1/2024 DSDA stated it was important to change the nasal cannula weekly for infection control. During a concurrent record review of Resident 106's Order Summary report, dated 4/1/2024, and interview with Licensed Vocational Nurse 2 (LVN 2) on 4/4/2024 at 2:28 PM, LVN 2 stated that Doctor's order indicated to change resident's nasal cannula every Monday and as needed, and to label it with the date when it was changed. LVN 2 stated that it is important to change nasal cannula weekly to avoid collection of bacteria. A review of facility's Policy and Procedure (P&P) titled, Standard Precautions, revised December 2007, indicated that standard precautions (used for all resident care) will be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. A review of facility's P&P titled, Oxygen Administration, revised October 2010, it indicated to review the physician's orders or facility protocol for oxygen administration.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48395 Based on observation, interview, and record review, the facility failed to provide the minimum 80 square feet (sq. ft.) per resident in multiple resident bedrooms for one (1) of 21 Resident rooms (Room C) in the facility. This failure had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care. Findings: A review of the facility's, Client Accommodation Analysis Form, dated 4/2/2024, indicated Resident Room C, measured 158.2 sq. ft , which did not meet the 80 square footage requirement per resident. During an observation and initial tour of the facility on 4/2/2024 at 9:30 AM, Room C did not meet the minimum requirement of 80 sq. ft. per resident. A review of the room waiver, dated 4/2/2024, indicated the following: Room #Beds Sq.Ft. Sq.Ft. per Bed 2 (Room C) 2 158.2 79.1 A review of the facility's Room Waiver Request, dated 4/2/2024, indicated the facility's request for a waiver for Room C that measures less than 80 sq. ft. per resident. The Room Waiver Request also indicated that, There is enough space to provide for each resident's care, dignity and privacy, and, Are in accordance with the special needs of the residents and do not have any adverse effect on the residents' health and safety or impede the ability of any residents and the room to attain his/her highest practicable well-being. During a concurrent record review of the Client Accommodations Analysis form, dated 4/2/2024, and interview with the Administrator (ADM) on 4/5/2024 at 3:54 PM, the Client Accommodations Analysis form indicated the square footage of all the rooms in the facility. ADM verified that all the residents' rooms aside from Room C met the required square footage per resident. ADM further stated that there have been no complaints about Room C being too small to accommodate the needs of the residents who reside in that room. During the recertification survey from 4/2/2024 to 4/5/2024, Room C was observed with adequate ventilation and lighting. The residents in the rooms have bathroom and toilet facilities. The residents have privacy curtains around their beds, which assured privacy. There was adequate space for getting in and out of the wheelchairs and residents were afforded sufficient freedom of movement in the rooms. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The residents did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. Residents that are wheelchair bound were able to move in the room without difficulty. The Department, therefore, would be recommending the waiver request for Room C

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review the facility failed to maintain safe, clean, comfortable sanitary and home like environment for one (1) of four (4) sampled residents (Resident 10) by not ensuring that Resident 10's bathroom trash can was not overflowing with trash, and bathroom toilet was free of fecal matter. These deficient practices caused an unsanitary and had a potential for residents to be placed at risk for injury. Findings: A review of Resident 10's Admission Record indicated the facility admitted Resident 10 on 9/7/2023 with the diagnoses that included lack of coordination, abnormalities of gait and mobility, chronic obstructive pulmonary disease (COPD is a group of lung diseases that make it hard to breathe and get worse over time). A review of Resident 10's History and Physical indicated Resident 10 was competent to understand her medical condition and patients' bill of rights as presented by the staff. A review of Resident 10's Minimum Data Set (MDS, standardized care and screening tool), dated 3/7/2024, indicated Resident 10 was moderately impaired with cognition (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 10 was independent (resident completes the activity by themselves with no assistance from helper). During observation on 4/2/2024 at 9:28 AM in Room B, observed room [ROOM NUMBER]'s bathroom trashcan was overflowing with used toilet paper and soiled diaper. In addition, fecal matter (bodily waste matter derived from ingested food and the secretions of the intestines and discharged through the anus) brownish in color specks outside the toilet bowl, and on the bottom part of the bathroom wall near the toilet. During an interview on 4/5/2024 at 9:41 AM with the Assistant Director of Staff and development (ADSD), the ADSD stated the rooms and bathrooms are supposed to be clean, trash cans were not supposed to be overflowing for infection control. ADSD also stated, there should be no clutters on the floor to prevent accidents like falling, it was for the safety of everybody. The facility needs to be clean, safe, and sanitary environment to prevent infection. During an interview on 4/5/2024 at 9:50 AM with the Interim Director of Nursing (IDON) described the picture of Room B's bathroom taken on 4/2/2024 at 9:26 AM, the IDON stated the trashcan was overflowing with soiled diaper and used toilet paper and these were infection control issue. The IDON stated with the type of residents that the facility has, the residents might get the habits of picking up the trash. IDON also described the toilet bowl with fecal matter, brown colored specks outside the toilet bowl, IDON further stated it is infection control. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Policies and Procedure (P&P) titled Homelike Environment date revised 2/2021, indicated residents are provided with safe, clean, comfortable, and homelike environment and encourage to use their personal belongings. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflects a personalized home like setting. These characteristics include clean sanitary in orderly environment. A review of facility's P&P titled Standard Precautions revised date 10/2007 indicated under environmental control to ensure that the environmental surfaces, bed, bedrails, bedside equipment, and other frequently touched surfaces are appropriately clean.