STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555903	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of El Monte	5044 Buffington Rd El Monte, CA 91732

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of need for two of three sampled residents (Resident 1 and Resident 38) by failing to: a. Ensure Resident 1's call light was within reach. b. Ensure Resident 38's clock was adjusted after Daylight Saving Time (DST, the practice of turning the clock ahead as warmer weather approaches and back as it becomes colder again). The DST was on 3/10/2024. These deficient practices had the potential for Resident 1 not to receive the necessary care and services that could result in fall/accident and Resident 38 not able to know the correct time. Findings: a. During a review of Resident 1's Admission Record, the admission record indicated the facility admitted Resident 1 on 12/4/2023 with diagnoses that included need for assistance with personal care and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 1's Care Plan titled, Potential for Fall, dated 12/15/2023, the Care Plan indicated Resident 1 had a poor safety awareness. The Care Plan interventions indicated the nursing staff to place Resident 1's call light within reach and to assist Resident 1 with all needs. The CP indicated nursing staff to anticipate and meet all Resident 1's needs timely. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/18/2023, the MDS indicated, Resident 1's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 1 required moderate assistance with toileting hygiene, shower, upper and lower body dressing. During a concurrent observation on 3/12/2024 at 9:39 am, Resident 1 was asleep, lying in bed with call light below the bed of Resident 1's roommate. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/12/2024 at 9:42 am, with the Infection Preventionist Nurse (IPN), the IPN stated Resident 1's call light was under the bed of Resident 1's room mate. The IPN stated Resident 1's call light was not in reach. The IPN stated Resident 1 was unable to reach the call light. The IPN stated, the call light was needed to be within reach to for Resident 1 to use if Resident 1 needed assistance and to maintain Resident 1's safety. During an interview on 3/14/2024 at 9:55 am, with Director of Nursing (DON), the DON stated, call light was needed to be in reach for the staff to attend Resident 1's needs in a timely manner. The DON stated, call light should be within reach for Resident 1 to easily activate to call for help and to maintain Resident 1's safety. During a record review of the facility's policy and procedure (P&P) titled, Call Light, revised on 1/2017, the P&P indicated, when a resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light was within easy reach of the resident. 40037 b. During a review of Resident 38's Admission Record, the admission record indicated Resident 38 was readmitted on [DATE], with diagnoses that included dysphagia (difficult swallowing) and ascites (a condition in which fluid collects in spaces within abdomen which can affect lungs, kidneys, and other organs, causing abdominal pain, swelling, nausea and vomiting). During a review of Resident 38's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 1/15/2024, the MDS indicated Resident 38 had clear speech, was able to understand others and made self-understood. The MDS indicated Resident 38 had intact cognition. Resident 38 had no impairment for upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). During a review of Resident 38's History and Physical (H&P) dated 9/17/2023, indicated Resident 38 had the capacity to understand and make decisions. During an observation and concurrent interview on 3/12/2024 at 10:01 am, in Resident 38's room, there was a clock hanging on the wall facing Resident 38's head of bed. The clock indicated 9 am. Resident 38 stated, the DST was on last Saturday 3/9/2024 night. Resident 38 stated, Resident 38 asked staffs twice to change the time on that clock, but it did not happen. Resident 38 stated, the clock indicated an hour earlier than the actual time and it was confusing when planning daily activities. During an interview on 3/12/2024 at 10:21 am, Licensed Vocational Nurse 1 (LVN 1) stated, Resident 38's clock did not indicate the correct time, it indicated the time before the DST. LVN 1 stated, the facility should adjust the clock to reflect the actual time so residents would not confuse about the time for better care planning. During a review of the facility's policy and procedure titled, Nursing, General Rules, revised 8/2017, indicated It is the policy of the facility to provide a safe, clean, comfortable environment for residents and their families in an effort for the facility to be homelike .

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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** 40037 Based on interview and record review, the facility failed to follow its policy and procedure titled, Advance Directive for two of three sample residents by failing to: a. Provide information regarding Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.) for Resident 38. b. Ensure the AD copy was readily retrievable in Resident 18's medical records (chart). These failure had the potential to result in facility staffs provided medical care and treatment against the Resident 38 and 18's wishes. Findings: a. During a review of Resident 38's Admission Record (AR) the AR indicated Resident 38 was readmitted on [DATE], with diagnoses that included dysphagia (difficult swallowing) and ascites (a condition in which fluid collects in spaces within abdomen which can affect lungs, kidneys and other organs, causing abdominal pain, swelling, nausea and vomiting). During a review of Resident 38's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 1/15/2024, the MDS indicated Resident 38 had clear speech, able to understood others and made self-understood. Resident 38 had intact cognition (able to think and process information). The MDS indicated Resident 38 had no impairment for upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). During a review of Resident 38's History and Physical (H&P) dated 9/17/2023, the H&P indicated Resident 38 had the capacity to understand and make decisions. During a review of Resident 38's Social Service Advance Directive Assessment Note dated 7/17/2023, indicated, there was no AD assessment performed. During an interview on 3/13/2024 at 9:25 am, the Social Service Director (SSD) stated, The SSD did not have documentation indicated Resident 38's AD information was offered to Resident 38. The SSD stated, it was important to have the AD information documented in Resident 38's medical record so staffs would know the resident's treatment preferences and would not provide the treatment against Resident 38's wishes. The SSD stated, it was resident's right. 42781 b. During a review of Resident 18's AR, the AR indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 required total dependence (totally dependent with staff for assistance of activities of daily living) with toileting hygiene, shower, and lower body dressing. During a review of the Social Services Advance Directive Assessment Note dated 1/9/2024, the note indicated Resident 18 had an Advance Directive upon admission. During an interview on 3/13/2024 at 9:10 am, the Social Service Director (SSD) stated, he was unable to find Resident 18's AD in the resident's medical record. The SSD stated, the AD needed to be in Resident 18's medical records to access immediately in case of emergency. During an interview on 3/14/2024 at 9:52 pm, with the facility's Director of Nursing (DON), the DON stated the AD should be in the medical record to retrieve easily and staff to have easy access. During an interview on 3/4/2024 at 11:52 am, with Resident 18, Resident 18 stated he was unable to recall where was the AD and did not know what it was. During an interview on 3/4/2024 at 11:38 am, with the Responsible Party 1 (RP 1), RP 1 stated, she was not aware of any AD and it was never offered to her. During a review of the facility's policy and procedure titled, Advance Directives, revised 4/2017, indicated, Prior to, or upon admission, resident's will be provided with written information concerning the resident's right to prepare an advance directive. The resident or their responsible party will be asked if the resident has completed an advance directive, and to provide a copy of the document for the resident's clinical record. Social service staff will assist residents in completing an advance directive .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 14330 Based on interview and record review, the notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) did not have an informed decision from the resident's representative to pay for non-covered services after Resident 17 was discharged from Medicare Part A and Resident 17 continued to reside in the facility for one of two sampled residents (Resident 17). This deficient practice placed Resident 17 at risk for payment of out-of-pocket costs for non-coverage services while in the facility. Findings: During a review of Resident 17's Admission Record (AR), the AR indicated the facility admitted Resident 17 on 6/4/23, with diagnoses that included dementia (a general term for loss of memory) and hypertensive heart disease (problems with the heart that can develop due to high blood pressure). During a review of Resident 17's notice of NOMNC and SNF ABN dated 8/30/23, indicated these notices were issued before the last covered day of Medicare Part A Services on 9/1/23. There was no documented evidence that Resident 17's representative was given the option to make an informed decision for payment of non-covered services while Resident 17 continue to reside in the facility. During a concurrent interview and record review on 3/14/24 at 9:52 a.m., the Business Office Manager (BOM) stated she left a voicemail message to Resident 17's representative (unknown date and time) but no follow up call was made to get an informed decision from Resident 17's representative. The BOM stated the BOM mistakenly checked off the box, option 3 (I can't appeal to see if Medicare would pay). The BOM stated it was important for the resident or the resident's representative to be well informed of financial responsibility for of out-of-pocket payment of non-covered services by Medicare during the long term stay in the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to ensure its alternating pressure pad (also known as APP mattress, widely used by both hospital facilities and home care users to provide complete relief from or maximum prevention and treatment of bedsores and pressure ulcers[PU, localized damage to the skin and/or underlying tissue, usually over a bony prominence, or related to a medical or other device, resulting from sustained pressure including pressure associated with shear) was in good working condition, the dial knob for weight adjustment was missing for one of one sampled residents (Resident 38). This failure had the potential to result in the reopen of Resident 38's healed/resolved pressure ulcers. Findings: During a review of Resident 38's Admission Record (AR), the AR indicated Resident 38 was readmitted on [DATE], with diagnoses that included dysphagia (difficult swallowing) and ascites (a condition in which fluid collects in spaces within abdomen which can affect lungs, kidneys, and other organs, causing abdominal pain, swelling, nausea and vomiting). During a review of Resident 38's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 1/15/2024, the MDS indicated Resident 38 had clear speech, able to understand others and made self-understood. The MDS indicated Resident 38 had intact cognition (ability to think and process information). Resident 38 had no impairment for upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). During an observation and concurrent interview on 3/12/2024 at 10:01 am, in Resident 38's room, Resident 38 was lying in bed on an APP mattress. There was a controller connected to the mattress and the dial knob on the controller was missing. The Treatment Nurse (TX) stated, Resident 38 was on APP for skin management to prevent developing PU. The TX stated the dial knob should point at the weight of Resident 38 to provide a comfortable and therapeutic bed surface for PU management. The TX stated Resident 38 had a resolved PU. The TX stated APP was considered as a medical device and the TX was responsible for checking APP making sure APP in good condition with no missing parts. The TX stated the TX should report the issue to the maintenance staff. During a review of the facility's policy and procedure titled, Nursing, General Maintenance, revised 1/2017, indicated, it is the policy of the facility to provide general maintenance and house keeping services daily. Maintenance will ensure that inspection and services are provided to repair and maintain all functional equipment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 14330 Based on observation, interview, and record review, the facility failed to provide safety and protection for Resident 24 who had injuries from unknown source for one of one sampled resident by failing to ensure: 1. Staff immediately reported Resident 24's injuries of unknown source no later than two hours to the DPH (Department of Public Health), Ombudsman, and local law enforcement. 2. Staff investigated Resident 24's injuries of unknown source in accordance with facility's policy and procedures (P&P) for resident abuse prevention in the facility. 3. Staff notified the physician and responsible party of Resident 24's injuries of unknown source. These deficient practices compromised Resident 24's safety and protection from abuse in the facility. Findings: During a review of Resident 24's Admission Record (AR), the AR indicated the facility admitted Resident 24 on 12/10/23, with diagnoses that included dementia (a general term for loss of memory) and chronic kidney disease (a gradual loss of kidney function). During an observation on 3/12/24 at 8:45 a.m., Resident 24 was sitting in a wheelchair while in Resident 24's room. Resident 24's right side of the forehead (top part of the face, just below the hairline and above the eyebrows) had dark red purple skin discoloration with a head bump approximately the size of a quarter coin. Resident 24 also had dark purple skin discoloration below both eyes on the eye bag area (puffiness under the eyes) approximately four inches in size on each side. Resident 24 was non-communicative (unable to communicate). During an interview on 3/12/24 at 8:48 a.m., Resident 24's roommate stated it had been several days (unknown date) that Resident 24 had bruises below both eyes and bruises with a bump on the forehead. Resident 24's roommate stated she did not witness a fall incident for Resident 24 while Resident 24 was in the room. Resident 24's roommate stated she had no idea how Resident 24 got the bruises and bump on the forehead. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/24 at 12:23 p.m., Resident 24's Family member (FM) 1 stated it was during FM 2 and FM3's visit to Resident 24 on 1/25/24 at around 10:30 a.m., that the bruises below both eyes and big bump on the head were observed by the family members. FM 1 stated he was not aware of Resident 24's bruises and bump on the head until FM 1 was informed by FM 2 and FM 3 during a face time video call with Resident 24 when the family visited on 1/25/24 (as per phone history of the video call). FM 1 stated FM 1 did not know for how long Resident 24 had the injuries while in the facility. FM 1 stated staff (unknown) only said, Fall to FM 2 and FM 3 when they asked what happened to Resident 24. FM 1 stated he spoke to the Director of Nursing (DON) on the phone in the morning of 1/25/24 (unknown time), after FM 1 made the face time video call to Resident 24, and FM 1 asked the DON about Resident 24's injuries. FM 1 stated the DON did not give specific information if Resident 24 had an actual fall or any incident that might have caused the bruises below both eyes and bump on the head. During an interview on 3/12/24 at 2:50 p.m., Certified Nursing Assistant (CNA) 2 stated CNA 2 was assigned to Resident 24 today (3/12/24) and yesterday (3/11/24). CNA 2 stated CNA 2 was aware of Resident 24's bruises below both eyes and the bump with bruises on the right forehead area about more than a month ago (unknown date). CNA 2 stated CNA 2 did not know how Resident 24 got the injuries. CNA 2 stated CNA 2 reported to the morning shift (7 AM-3 PM) female charge nurse (unknown name) about the bruises and the bump on Resident 24's head. CNA 2 stated CNA 2 did not remember the name or face of the female charge nurse. CNA 2 stated CNA 2 did not know if the female charge nurse was still working in the facility. During a concurrent interview and record review on 3/12/24 at 3:29 p.m., the Licensed Vocational Nurse (LVN) 2 stated LVN 2 noticed Resident 24 already had bruises below both eyes and bump with bruises on the forehead when LVN 2 started to work full time at the facility approximately a month ago in February 2024. LVN 2 stated LVN 2 did not know how Resident 24 got the injuries. LVN 2 stated Resident 24's medical record did not contain information regarding an incident or a fall that resulted in bruises below both eyes and bruises with a bump on the forehead. There was no documented evidence the physician and responsible party were notified of Resident 24's injuries since 1/25/24, when FM 2 and FM 3 visited the resident. During an interview with the Administrator and DON on 3/14/24 at 3:40 p.m., the Administrator stated he started working in the facility on 3/12/24 and had no knowledge of Resident 24's injuries. The DON stated she was not aware of Resident 24's bruises and bump on the forehead because it was not reported by the staff. The DON stated Resident 24's injuries were not investigated and reported to DPH, Ombudsman, law enforcement, the physician, and responsible party since 1/25/24, when FM 2 and FM 3 informed the staff (unknown name) of Resident 24's injuries. The DON stated Resident 24's bruises and bump on the forehead were injuries of unknown source that should be reported within two hours to DPH, Ombudsman, and local law enforcement but the facility failed to do so. The DON further stated immediate reporting within two hours would ensure the residents (in general) were protected from abuse and/or further abuse in the facility. During a review of facility's policy and procedures (P&P) titled, Abuse Reporting and Prevention dated 1/2023, the P&P indicated injuries of unknown sources are to be reported within two hours to DPH, Ombudsman, and local law enforcement to ensure that resident rights are protected by providing a method of investigation and reporting of alleged violations.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42781 Based on observation, interview, and record review, the facility failed to assess and monitor for the presence of sediments (visible particles in the urine that may contain red or white blood cells, casts, bacteria, fungi, parasites in the urine that could indicate an infection or dehydration [fluid deficit]) in the urine for one of one sampled resident (Resident 11) with an indwelling catheter (foley/urinary catheter - a tube inserted in the bladder to drain urine into a drainage bag), as indicated in the facility's policy and procedure (P&P), titled, Indwelling Catheter Use - Indications and the resident's care plan for foley catheter. This deficient practice had the potential to result in Resident 11 to receive no care or delayed care and treatment for a urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system). Findings: During a review of Resident 11's Admission Record (AR), the AR indicated the facility admitted Resident 11 on 11/10/2023 with diagnoses that included neuromuscular dysfunction of the bladder (the nerves and muscles don't work together very well causing the bladder [organ that stores urine] to not fill or empty correctly. During a review of Resident 11's care plan titled Urinary Catheter Care Plan initiated on 11/2023, the care plan indicated Resident 11 had foley catheter related to neurogenic bladder (bladder does not empty or store urine properly due to the neurological condition). The care plan's approach (interventions) indicated monitoring for signs/symptoms of UTIs, such as color, odor, sediments, temperature change every shift due to the use of a foley catheter and reporting to the medical doctor (primary physician) if present. During a review of Resident 11's Order Summary Report (OSR), active physician orders as of 3/12/2024, the OSR include a physician's order dated 11/10/2023, the order indicated a urinary catheter French (a type of catheter) 16 (size of the catheter) for neurogenic bladder to Resident 11. During a review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/14/2023, the MDS indicated Resident 11 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 11 required maximum assistance with showers, upper body dressing, and putting on or taking off footwear. During an observation on 3/12/2024 at 9:32 am, Resident 11 was lying in bed. Resident 11 had foley catheter hanging on the left side of Resident 11's bed. Resident 11's foley catheter tubing contained white sediments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/12/2024 at 9:35 am, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there were white sediments in Resident 11's urinary catheter tubing. LVN 1 stated LVN 1 needed to notify the attending physician. LVN 1 stated Resident 11's foley catheter needed to be monitored, by licensed nurses every eight hours for signs and symptoms of UTI such as the presence of sediments to prevent infections. During an interview on 3/14/2024 at 9:57 am. with the Director of Nursing (DON), the DON stated licensed nurses needed to monitor the foley catheter every shift to check for the presence of blood or sediments, characteristics of the urine, and signs and symptoms of UTI. The DON stated sediments were in the tubing and this indicated sediments were formed for how [within] many hours and did not form quickly. During a review of the facility's P&P titled, Indwelling Catheter Use - Indications, revised on 10/2017, the P&P indicated, ongoing monitoring for changes in condition related to potential catheter associated urinary tract infections, as well as reporting and addressing these possible changes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure 3 of 3 sampled residents (Resident 25 and 45) receiving oxygen therapy were provided with respiratory care in accordance with the facility's policy and procedure (P&P) titled, Oxygen Administration, and Storage of Oxygen Cylinder, by failing to: a. Ensure Resident 25's nasal cannula tubing (flexible plastic tubing used to deliver oxygen to help with breathing) did not touch the floor and a cautionary sign was posted on Resident 25's door indicating oxygen in use. b. Ensure Resident 45's nasal cannula tubing was labeled and failing to ensure Resident 45's nasal cannula did not touch the floor, and a cautionary sign was posted Resident 45's door indicating oxygen in use. This deficient practice placed Resident's 25 and 45 at risk for infections and compromised the resident's safety. Findings: a.During a review of Resident 25's Admission Record (AR), the AR indicated Resident 25 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (a decline in mental ability, a group of thinking and social symptoms that interfere with daily functioning). During a review of Resident 25's MDS dated [DATE], indicated, Resident 25 had severe impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 25 was totally dependent (totally dependent with staff for assistance of activities of daily living) with eating, oral, toileting hygiene, shower, body dressing and personal hygiene. During a review of Resident 25's Order Summary Report (OSR), active physician orders as of 3/12/2024, the OSR included a physician order, dated 11/29/2023, the order indicated oxygen two liters per minute (L/min, unit of volume) by nasal cannula continuously to keep oxygen (02, a colorless, odorless gas needed for animal and plant life) saturation (amount of oxygen carried in blood) above 90% every shift for shortness of breath. During an observation on 3/12/2024 at 9:43 am, Resident 25 was asleep lying in bed with the nasal cannula tubing touching the floor. No sign was posted on Resident 25's door indicating oxygen was in used in Resident 25's room or to indicate smoking was prohibited. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/12/2024 at 2:22 pm, with Licensed Vocational 2 (LVN 2), Resident 25 was awake lying in bed. Resident 25's nasal cannula tubing was touching the floor. LVN 2 stated, the nasal cannula tubing should not be touching the floor because the floor was dirty and could cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one object to another, with harmful effect). LVN 2 stated there was no sign posted on Resident 25's door indicating oxygen was in use in the room or smoking was prohibited. LVN 2 stated there should be a smoking sign to remind visitors and residents not to smoke inside the room because oxygen could ignite and a cause fire. During an interview on 3/14/2024 at 9:56 am, with the facility's Director of Nursing (DON), the DON stated the nasal cannula should not touch the floor to prevent infections. The DON stated a smoking sign should be posted at the entrance of the resident's door for residents who received oxygen therapy to let the visitors know not to smoke, for residents' safety, and to avoid fires. 50012 b. During a review of the Resident 45's AR, the AR indicated Resident 45 was readmitted to the facility on [DATE], with diagnoses that included hip fracture, hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), and hypertension (abnormally high blood pressure). A review of the MDS, dated [DATE], indicated Resident 45's cognition is severely impaired. According to the MDS, Resident 45 is totally dependent on the staff for activities of daily living (transfer, dressing, eating, toilet use, personal hygiene, bathing), and is incontinent (inability to control) of bowel and bladder. A review of Resident 45's physician's order, dated 11/13/24, the order indicated to apply oxygen at two (2) liters per minute (L/min) via nasal cannula (device use for delivery of oxygen) PRN (as needed) to keep oxygen saturation (amount of oxygen carried in blood) above 92%. During an observation on 3/12/2024 at 9:23am, Resident 45 was observed lying in bed. Oxygen tank was observed in resident's room. There was no precautionary signage posted on Resident 45's door indicating oxygen was in used in the room or smoking was prohibited. During a concurrent observation and interview on 03/12/24 09:25 AM with LVN 1, LVN 1 confirmed that there was no precautionary signage posted on Resident 45's door indicating oxygen was in used in the room or smoking was prohibited. During an interview on 3/14/2024 at 9:56 am, with the DON, the DON stated smoking sign should be posted at the entrance door of residents receiving oxygen therapy to let the visitor know not to smoke to avoid fire and for the resident's safety. During a review of the facility's P&P titled, Oxygen Administration, revised 3/2017, P&P indicated, equipment and supplies are necessary when performing the procedure to place No smoking/Oxygen in Use signs. During a review of the facility's P&P titled, Storage of oxygen Cylinder, revised 11/2023, P&P indicated, cannulas should be replaced weekly.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 14330 Based on interview and record review, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week from 3/1/24 through 3/15/24 for 12 of 15 days. This deficient practice may affect the quality of nursing care provided to the residents. Findings: During a concurrent interview and record review on 3/15/24 at 11:25 a.m. with the Director of Staff Development (DSD), the nurse staffing sign-in sheet for the month of March 2024 was reviewed. The nurse staffing sign-in sheet dated 3/1/24 through 3/15/24 indicated no RN was on duty for twelve days. The DSD stated the facility had no full time RN that worked eight hours per day, seven days a week since February 2024. The DSD stated a full time RN was important to oversee residents' assessment and care in the facility every day. During a review of the facility's policy and procedures (P&P) titled, Staffing dated 3/2020, the P&P indicated the facility goal was to provide adequate staffing to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Licensed. the P&P indicated, RN staff should be available to provide and monitor the delivery of resident care services.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 14330 Based on observation, interview, and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff, for one of one day (Recertification Survey Day 1) who were directly responsible for resident care per shift daily and the information was not posted in a prominent location readily accessible to residents and visitors for viewing. This deficient practice of posting inaccurate nurse staffing information could mislead the residents and visitors that may affect the quality of nursing care provided to the residents. Findings: During an observation on 3/12/23 at 10:15 a.m., the facility's staffing information was posted inside nurse's station 1 and the information was not easily accessible for viewing by the residents and visitors. The staffing information posted indicated eight actual worked hours by one Registered Nurse (RN) during the morning shift (7AM-3PM) on 3/12/24. The staffing information was not posted in nurse's station 2. During a concurrent interview and record review on 3/12/24 at 10:20 a.m., the Director of Staff Development (DSD) stated staffing information posted indicated projected worked hours for licensed and unlicensed nursing staff. The DSD stated the nurse staffing sign -in sheet dated 3/12/24 indicated the Director of Nursing (DON) was the RN on duty for the morning shift. The DSD stated the DON did not provide direct resident care for a total of eight hours because the DON only gave antibiotics (drug that can destroy harmful bacteria in the body) through intravenous (IV, delivered into a vein by injection or through a catheter) to two residents in the facility. The DSD stated the DSD was not aware staffing information should be posted outside of both nursing stations (stations 1 and 2) in an area easily accessible for viewing by the residents and visitors. The DSD stated accurate staffing information is important for the residents and visitors to know the facility had enough staff to provide the necessary care to residents. During a review of facility's policy and procedures (P&P) titled, Staffing Nurse Information dated 1/2017, the P&P indicated staffing information should include the actual worked hours by the licensed and unlicensed nursing staff and to be posted in a prominent place readily accessible to residents and visitors.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to act upon the pharmacist's recommendations for medication regimen review (MRR) for one of five sampled residents (Resident 6). This failure had the potential to result in undesirable or non-therapeutic effect of the medication related to medication therapy for Resident 6. Findings: During a review of Resident 6's Admission Record (AR), the AR indicated Resident 6 was admitted on [DATE], with diagnoses that included bacteremia (the presence of bacteria in the blood) and hypertension (increased blood pressure). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 2/21/2024, the MDS indicated Resident 6 had clear speech, able to understand others and made self-understood. The MDS indicated Resident 38 had intact cognition (able to think and process information). Resident 38 had no impairment for upper extremities (shoulder, elbow, wrist, hand) and impairment on one side of lower extremity (hip, knee, ankle, foot). During a review of Resident 6' Consultant Pharmacist' Medication Regimen Review (CPMRR), dated 3/8/2024, The CPMRR indicated, Resident 6 took Miralax (a medication used to treat occasional constipation). The CPMRR indicated Miralax can decrease the absorption of many medications, Miralax must be administered two hours before or after the administration of other medications. The CPMRR indicated to administer Miralax with 8 ounces of water. During a review of Resident 6's Order Summary Report (OSR), dated 3/14/2024, the OSR indicated Resident 6 was prescribed Polyethylene Glycol (Miralax) powder one pack by mouth one times a day for stool softener, hold for loose stool. During an interview on 3/14/2024 at 2:19 pm, the Director of Nursing (DON) stated, the facility had 72 hours to respond to the pharmacist's MRR. The DON stated the DON was responsible for acting upon the MRR. The DON stated Resident 6's MRR dated 3/8/2024 should be carried out before 3/11/2024 and reflected as physician's order. The DON stated the facility's staff did not respond to Resident 6's MRR for Miralax in a timely manner. The DON stated it was important to follow up Resident 6's MRR to avoid medication to medication interaction based on the recommendation and promote the effectiveness of the resident's medication. The DON stated it was for the resident health and safety. During a review of the facility's policy and procedure titled, Drug Regimen Review, revised 10/2017, indicated, When the Director of Nurses receives the Pharmacy Consultant's recommendations, a copy of the recommendation will be faxed to the resident's attending physician and the physician will respond within 72 hours or the licensed nurse will call the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 14330 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 24) on a psychotropic drug (any drug capable of affecting the mood, emotions, and behavior) was free from unnecessary medication by failing to ensure: 1. Resident 24's target behavior symptom for anti-anxiety medication (Lorazepam) 0.5 milligram (mg, unit of measurement) was adequately indicated and monitored. Resident 24 was non-communicative, and the resident could not express feelings of anxiety through verbalization or in writing. This deficient practice placed Resident 24 at risk for adverse drug reactions (a harmful and unintended response to a medicine). Findings: During a review of Resident 24's Admission Record (AR), the AR indicated the facility admitted Resident 24 on 12/10/23, with diagnoses that included dementia (a general term for loss of memory) and chronic kidney disease (a gradual loss of kidney function). During an observation on 3/12/24 at 8:45 a.m., Resident 24 was sitting in the wheelchair while in Resident 24's room. Resident 24 was non-communicative (unable to communicate). During a review of Resident 24's Order Summary Report (OSR), active orders as of 3/1/24, the OSR included a physician's order, dated 12/10/23, Lorazepam 0.5 mg one tablet by mouth two times a day, for anxiety as manifested by verbalization of feeling anxious. During a review of Resident 24's Medication Administration Record (MAR) dated 3/1/24 through 3/31/24, the MAR indicated Resident 24 received Lorazepam 0.5 mg one tablet by mouth at 9 a.m., and 5 p.m. everyday. During a concurrent interview and record review on 3/14/24 at 3:10 p.m., Licensed Vocational Nurse (LVN) 2 stated Resident 24 was non-communicative, and the resident's primary language was Chinese. LVN 2 stated when Resident 24 was a making a sound with voice, Umm she counted the sound as Resident 24's verbalization of feeling anxious. LVN 2 stated whenever a resident uttered words (making a sound with voice), it could be due to feelings of discomfort/pain or trying to communicate resident (in general) needs. LVN 2 stated Resident 24's anti-anxiety medication (Lorazepam) [prescribed] for the target behavior symptom of verbalization of feeling anxious was inadequately indicated and the symptom was inadequately monitored because Resident 24 was non-communicative and could not express feelings of anxiety in writing. LVN 2 stated it was important to accurately monitor the target symptom of Resident 24 to evaluate if the medication was effective or not, and if Resident 24 benefited from a [medication] gradual dose reduction. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure, revised 9/2017, titled, Psychotropic Drug Treatment. The policy's purpose indicated to provide psychotropic drug treatment for a resident with a specific condition as diagnosed and documented in the clinical record. The policy indicated; the resident has the right to be free from unnecessary drugs/medications. The procedure indicated Psychotropic drugs include antianxiety agents. The policy indicated unnecessary drugs are any drugs when used, without adequate indications for its use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40037 Based on observation, interview and record review, the facility failed to ensure sanitizing solution used for cleaning food prepare area had the correct concentration that met industrial standard to prevent possible contamination for one of three sanitizing red buckets. The recommended concentration for cleaning solution was 200 parts per million (ppm), the sanitizing solution the facility used was 100 ppm. This failure had the potential to result in food prepare areas were not sanitized enough causing contamination and food borne illness to the residents. Findings: During a tour to the facility's kitchen on 3/12/2024 at 8:28 am with the Dietary Assistant (DA), the facility kitchen had three round red buckets with sanitizing solution and towels soaked in the solution. The DA tested each bucket's solution for quaternary (a type of chemical that is used to kill bacteria, viruses and mold) concentration with a test strip dipping in the solution and comparing color change against the color indicator on the test strip container. The color indicator had colors from light purple to dark purple indicating concentration ppm that correlated for each shade of purple. The test result for one of the buckets was 100 ppm. During a concurrent interview, the DA stated, the kitchen used the red bucket solution to clean food prepare surfaces and the concentration should reach 200 ppm to kill the bacteria and viruses. The DA stated, if the concentration not reached 200 ppm, the countertop would not been fully sanitized, and there was a potential for contamination and causing possible food borne illness to the residents. During an interview on 3/13/2024 at 9:01 am, the Dietary Supervisor (DS) stated, the facility used Multi-Quat Sanitizer from Ecolab (company) for sanitizing solution in red bucket. The DS stated the bucket solution should be changed every two hours or as needed. The DS stated, the red bucket solution should reach 200 ppm in order to kill bacteria to prevent contamination and food borne illness. The DS stated, it was for the resident's health and safety. During a review of the facility's undated Policy and Procedure (P&P) titled, Dietary Policy & Procedure Manual, the P&P indicated the facility will follow manual or alternate sanitizing procedures for food service equipment. Manual sanitizing shall be accomplished in the final sanitizing rinse by one of the following: contact with a solution of 200 ppm quaternary ammonium for one minute.

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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** 50016 Based on observation, interview and record review, the facility failed to ensure for one of one sampled resident (Resident 254), the resident's intravenous catheter (IV, a thin plastic tube inserted into a vein using a needle allowing for the administration of medications, fluids and/or blood products) site was labeled with the date and time the IV was inserted. This failure had the potential to result in Resident 254 acquiring an infection that could worsen the resident's health condition. Findings: During a review of Resident 254's Admission Record (AR), the AR indicated Resident 254 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction), cellulitis (an inflammation of the skin and deep underlying tissues), and urinary tract infection (an infection in the kidney, ureter, or bladder). During a concurrent observation and interview on 03/12/24 at 9:28 am, Resident 254 was observed awake and lying in bed with an IV on the left antecubital (the anterior surface of the elbow joint or elbow pit) area. The IV catheter site was observed dry and intact and secured with paper tape. The IV site had no label indicating date and time of insertion. Resident 254 stated that he was recently hospitalized for and infection and spent about 3 days in the hospital. Resident 254 stated the IV was placed at the facility 4 days ago when he was admitted but cannot recall the name of the nurse who inserted the IV. During an interview on 03/12/24 at 4:07 pm, with the Director of Nursing (DON), the DON stated Resident 254's IV should be labeled with the date and time of insertion and initialed with the licensed nurse who inserted the IV. The DON stated labeling the IV site would track how long the IV has been in the patient to avoid infection. During a review of the facility's policy & procedures titled, Peripheral Venous Catheter Insertion, dated 6/2018, the P&P indicated, all dressings will be labeled with (date, time, and initials) and documented in medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for six of twenty-three resident rooms (Rooms 2, 8, 10, 11, 15 and 16). This deficient practice had the potential to impact the ability to provide safe nursing care and to provide privacy to the residents residing in the Rooms 2, 8, 10, 11, 15 and 16. Findings: During an interview with the facility Administrator (ADM) on 3/14/2023 at 11:03 am, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) for this year. During review of the facility's room waiver request letter dated 3/13/2023. The letter indicated there was ample room to accommodate wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), and other medical equipment as well as space for mobility and movement of ambulatory residents. The letter indicated, there was an adequate space for nursing care and health and safety of the residents occupying these rooms and the residents were not in jeopardy. The letter indicated the rooms were in accordance with the special needs of the residents and the request for a waiver did not have an adverse effect on the resident's health and safety or impeded the ability of residents in the rooms to attain his or her highest practicable well-being. During a review of the Client Accommodations Analysis dated 3/13/2024, the analysis indicated the following: Room Sq. Ft. Beds 2 286.92 4 8 151.40 2 10 152.24 2 11 151.92 2 15 147.50 2 16 147.50 2 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation on 3/14/2024 at 11:12 am, Rooms 2, 8, 10, 11, 15 and 16 had adequate space, nursing was able to provide care, comfort, and privacy was provided to the residents. The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was adequate room for the operation and use of the wheelchairs, walkers (is a device that gives additional support to maintain balance or stability while walking,), and canes. The room size did not affect the care and services provided to the residents. During an interview on 3/14/2024 at 11:14 am with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, there was enough space in the rooms and CNA 1 was able to provide care to the residents. CNA 1 stated CNA 1 was able to move wheelchairs and walkers inside the rooms with no issues. During an interview on 3/14/2024 at 11:18 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the rooms had enough room to give care and treatment to the residents. During a concurrent observation and interview on 3/14/2024 at 11:29 am with Resident 17, Resident 17 was inside room [ROOM NUMBER] standing next to a bed. Resident 17 stated the room space was great and was right for Resident 17.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to ensure that the call light was within reach for two of two sampled residents (Resident 204,). This deficient practice had the potential to result in the residents being unable to summon health care worker for assistance for care and services as needed. Findings: During a review of the admission record (AR), the AR indicated Resident 204's was readmitted to the facility on [DATE], with diagnoses that included history of abnormalities of gait and mobility, unspecified muscle wasting and atrophy (muscle shrinking), and contracture (a deformity) of left hand. A review of the Minimum Data Set [MDS- an assessment tool] dated 12/23/23, the MDS indicated Resident 204 had severe impairment of cognitive skills for daily decision making. Resident 204 required total assistance in bed mobility, transfer, dressing, and personal hygiene. During a review of Resident 204's Care Plan titled Fall Risk, dated 12/12/2023, the Care Plan indicated Resident 204 was at risk for fall related to impaired balance, gait problems and poor safety awareness. The Care Plan interventions indicated the nursing staff to place Resident 204's call light within reach and staff to answer promptly. The Care Plan indicated nursing indicated staff will make sure the resident's call light is within reach and to encourage the resident to use it for assistance as needed. During a review of Resident 204's Fall Risk Assessment (method of assessing a patient's likelihood of falling), dated 12/12/2023, indicated the score 16. At the bottom of the form showed total score above ten represents high risk. During an observation on 03/12/24 at 9:10 a.m., with Certified Nursing Attendant 1(CNA 1), Resident 204 was observed lying in bed with head of bed elevated. The call light was clipped to the pillow (not within reach of Resident 204). In a concurrent interview on 03/12/24, at 9:10 a.m., with CNA 1, CNA 1 stated the call light was not within Resident 204's reach and should have been always within reach. During an interview on 3/14/2024 at 9:56 am, with the Director of Nursing (DON), the DON stated call light needed to be within reach of Resident 204 for the staff to attend Resident 204's needs in a timely manner. The DON stated the call light should be within reach of Resident 204 to maintain the resident's safety. During a review of the facility's policy and procedure (P&P) titled, Call Light revised in 1/2017, the P&P indicated, when a resident is in bed, be sure the call light is within easy reach of the resident and answer the resident's call as soon as possible.