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	03/16/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of one sampled resident (Resident 4) in accordance with the facility's policy and procedure titled Call Lights. This failure had the potential for Resident 4 not to receive care or receive delayed services to meet the resident's needs and could result in a fall or injury. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included paraplegia (impairment in motor or sensory function of the lower extremities) and dysphagia (difficulty in swallowing). During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/15/2025, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 4's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 2/11/2025, the FRE indicated Resident 4 was assessed as high risk for fall due to being disoriented, incontinent (involuntary loss of bladder or bowel control) and presence of predisposing disease condition. During a review of Resident 4 untitled Care Plan (CP) dated 2/11/2025, the CP indicated Resident 4 needed assistance for activities of daily living (ADL). The CP interventions indicated for nursing staff to have Resident 4's call light within reach and answer promptly. During a concurrent observation in Resident 4's room and interview on 3/14/2025 at 6:27 pm, Resident 4 was awake, lying in bed . Resident 4's call light was hanging on the top of the head of the bed. Resident 4 stated, I could not reach my call button. (continued on next page)

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 - Few	During a concurrent observation in Resident 4's room and interview on 3/14/2025 at 6:29 pm, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 4's call light was hanging on the top of the bed board and Resident 4 was unable to reach the call light. The LVN 2 stated Resident 4 could not lift her arm to get the call light on the top of the bed. LVN 2 stated Resident 4's call light needed to be within reach at all times for Resident 4 to use to call for assistance or help from the staff. During an interview on 3/16/2025 at 9:33 am with the facility's Director of Nursing (DON), the DON stated resident's call light needed to be within reach at all times for residents to activate to call for assistance from staff to prevent fall and to maintain resident's safety. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights, dated 1/2017, the P&P indicated when the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident.

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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** 40438 Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) on Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) for two of two sampled residents (Residents 42 and 49) by failing to: a. Complete the AD Acknowledgement Form on admission for Resident 49, b. Accurately fill out the information regarding AD for Resident 42. These failures had the potential for the facility staff to provide treatment and services against the will of the residents. Findings: a. During a review of Resident 49's Admission Record (AR), the AR indicated Resident 49 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), anxiety (intense, excessive, and persistent worry and fear), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 49.s Minimum Data Sheet (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated Resident 49 had intact cognition (ability to understand and process information). The MDS indicated Resident 49 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene and personal hygiene and partial/moderate assistance (helper did less than half the effort) with toileting, shower, upper and lower body dressing. During a concurrent interview and record review on 3/15/2025 at 11:31 am with the Social Services Director (SSD), Resident 49's Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life), dated 2/10/2025 was reviewed. The SSD stated, Resident 49's POLST indicated Resident 49 did not have an AD and AD acknowledgement form was not completed upon admission. The SSD stated, the AD acknowledgment form should be done on admission to indicate that the resident was given information on his rights to refuse or accept treatment and how to formulate an AD. During an interview on 3/16/2025 at 9:22 am with the facility's Director of Nursing (DON), the DON stated, all residents should have an AD Acknowledgement Form completed upon admission to help the facility staff identify the resident's preferences for care while in the facility. During a review of the facility's P&P titled, Advance Directives, revised 4/2017, the P&P indicated, Prior to, or upon admission, resident's will be provided with written information concerning the resident's right under State law to accept or refuse medical or surgical treatment and the resident's right to prepare an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42781 b. During a review of Resident 42's AR, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames the lung) and type 2 DM. During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had severely impaired cognition for daily decision making. The MDS indicated Resident 42 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 42's AD Acknowledgement Form dated 12/6/2024, Resident 42's AD Acknowledgment Form was not filled out completely. During an interview with the Social Worker (SW), and concurrent record review of Resident 42's AD Acknowledgement Form on 3/15/2025 at 4:25 pm, the SW stated, the AD Acknowledgement Form was not filled out completely. The SW stated, the AD Form needed to be filled out completely if Resident 42 had an existing AD or RP wanted to execute AD or not. The SW stated, the AD Acknowledgement Form needed to be filled out accurately because it indicated the resident's medical wants and wishes. During an interview on 3/16/2025 at 9:08 am with the facility's Director of Nursing (DON), the DON stated, the AD Acknowledgement Form needed to be discussed by the SW with the RP and/or resident and completely filled out upon admission. The DON stated, the AD Acknowledgement Form needed to be filled out accurately and completely because in cases of emergency, it was the residents right for the facility staff to follow the resident's medical preference, wants and wishes. During a review of the facility's P&P titled Advance Directives dated 4/2017, the P&P indicated prior to, or upon admission, resident's will be provided with written information concerning the resident's right under State law to accept or refuse medical or surgical treatment and the resident's right to prepare an advance directive. The P&P indicated the resident or their responsible party will be asked if the resident has completed an advance directive and to provide a copy of the documents for the residents clinical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to ensure the resident's Minimum Data Sheet (MDS, a resident assessment tool) was accurately coded to reflect the resident's discharge destination for one of one sampled resident (Resident 51). This failure resulted to inaccurate reporting to the Centers for Medicare & Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential for Resident 51 not to receive interventions to address specific care concerns. Findings: During a review of Resident 51's Admission Records (AR), the AR indicated Resident 51 was admitted to the facility on [DATE] with diagnoses that included cellulitis (skin infection) of right lower limb, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 51's Physician Order (PO) dated 2/24/2025, the PO indicated Resident 51 had an order to discharge home with home health care (refers to medical and supportive services provided to individuals in their homes to manage their health conditions) services. During a review of Resident 51's Post Discharge Plan of Care (PDPOC) dated 2/25/2025, the PDPOC indicated Resident 51 was discharged to home. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 was discharged to short-term general hospital (acute hospital). During a concurrent interview and record review on 3/15/2025 at 3:22 pm with the MDS Coordinator (MDS C), Resident 51's MDS was reviewed. The MDS C stated, Resident 51 was discharged to home on 2/25/2025. MDS C stated Resident 51 was not discharged to the acute hospital. The MDS C stated, Resident 51's MDS should be coded accurately for the resident to receive continuity of care at home. During an interview on 3/16/2025 at 9:22 am with the Director of Nursing (DON), the DON stated accurate assessment and coding were important for accurate reporting to CMS. The DON stated accurate assessment reflected the overall condition of the resident and the kind of care the resident needed upon discharge. During the review of the facility's Policy and Procedure (P&P) titled, Resident Assessment Instrument (RAI) Process, revised 4/2017, the P&P indicated, The facility will utilize the RAI process for the accurate assessment of each resident's functional capacity and health status. Each Care Area Assessment (CAA) will be completed by the responsible individual as designated.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure medications were administered before medications were documented as given in the Electronic Medication Administration Record (EMAR, a digital system used to track and document medication administration) consistent with the facility's Policy and Procedure (P&P) on medication administration for one of one sampled resident (Resident 38). This failure had the potential for missed medication or medication error for Resident 38. Findings: During a review of Resident 38's Admission Record (AR), the AR indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), dysphagia (difficulty swallowing), and acute respiratory failure (inability of the lungs to adequately exchange gases in the blood). During a review of Resident 38's Minimum Data Sheet (MDS, a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 38 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 38 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral and personal hygiene, shower, upper and lower body dressing and personal hygiene. During a concurrent medication pass observation and record review on 3/15/2025 at 8:38 am with Registered Nurse Supervisor 1 (RN 1), Resident 38's EMAR dated 3/15/2025 was reviewed. RN 1 could not unclog Resident 38's gastrostomy tube and could not administer Resident 38's medications for 9:00 am. Resident 38's EMAR indicated RN 1 marked ten medications for 9:00 am as given and administered. During an interview on 3/15/2025 at 8:54 am with RN 1, RN 1 stated medications should be signed out (documented) in the EMAR after its administration and not before they were administered, to prevent missing doses and medication errors. During an interview on 3/16/2025 at 9:22 am with the facility's Director of Nursing (DON), the DON stated all medications should be signed out as given in EMAR only after its administration for the safety of the resident to ensure right medications were given to the right resident. During a review of the facility's P&P titled, Medication Administration, revised 5/2019, the P&P indicated, It is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed. The licensed nurse administering the medication must initial the MAR for the resident on the appropriate line after giving the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility licensed staff failed to perform a thorough assessment and to immediately notify the physician of a resident's sudden change of condition (COC) for one of one sampled resident (Resident 53). This failure had the potential to result in delayed treatments and services for the resident resulting in a decline of health condition. Findings: During a closed medical record review of Resident 53's Admission Record (AR), the AR indicated Resident 53 was readmitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that cause airflow obstruction and breathing problems) and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 53's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 53 was admitted to the facility from an acute care hospital on [DATE]. During a review of the facility's Comprehensive Resident Assessment (CRA) dated [DATE], the CRA indicated Resident 53 had clear speech and was alert and oriented to time, place and person. Resident 53 required one person assistance for transfer, ambulation and was able to bear full body weight. During an interview on [DATE] at 5:18 pm, with Registered Nurse Supervisor 1 (RN 1), and a concurrent review of the facility's Nurses Notes (NN) dated [DATE], the NN indicated Resident 53 experienced heavy breathing, and the face color turned purple on [DATE] at 11:10 am. RN 1 provided breathing treatment at 11:10 am and Resident 53 was found unresponsive at 11:30 am in Resident 53's room. Cardiopulmonary Resuscitation (CPR, an emergency treatment that is done when someone's breathing or heartbeat has stopped) was performed and 911(emergency service) was called at 11:30 am. Paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) arrived at the facility at 11:35 am and Resident 53 was pronounced dead by paramedics at 11:50 am. The NN indicated there was no vital signs (VS, measurable physiological parameters that indicate the body's essential functions including blood pressure, heartrate, breathing rate and blood oxygen level) documented for Resident 53. RN 1 stated, RN 1 did not check Resident 53's VS at the time RN 1 found Resident 53 had a COC at 11:10 am and RN1 did not notify the physician immediately. RN 1 stated, RN 1 should have taken Resident 53's VS when Resident 53's was found with a COC to establish a baseline health condition of the resident. RN 1 stated, RN 1 should have called Resident 53's physician as soon as possible when Resident 53 had a sudden COC to provide immediate treatment to Resident 53 and to prevent further decline of Resident 53's health condition. During an interview on [DATE] at 10:43 am with the facility's Director of Nursing (DON), the DON stated RN 1 should have checked the resident's VS right away when Resident 53 had a COC on [DATE] at 11:10 am to determine Resident 53's health condition. The DON stated RN 1 should have reported to the physician Resident 53's COC which included difficulty breathing and change of face color to purple so that the physician could decide proper treatment to Resident 53. The DON stated, early treatment and care could have prevented Resident 53's decline of health condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure titled Change of Condition, dated ,d+[DATE], the P&P indicated It is the policy of this facility that any changes in a resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management .the licensed nurse is to thoroughly assess the change in the resident's condition and notify the resident's attending physician. A thorough assessment will include all important information related to the resident such as onset of current symptoms, vital signs, oxygen saturation (blood oxygen level) if there is a respiratory problem .

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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** 42781 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 4) who had gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition directly to the stomach) received necessary treatment and services as indicated in the facility's policy and procedure (P&P) titled Enteral Feedings. This deficient practice had the potential to result in weight loss for Resident 4 and altered nutritional status that could lead to complications. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included paraplegia (impairment in motor or sensory function of the lower extremities) and dysphagia (difficulty in swallowing) During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/15/2025, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 4's Order Summary Report (OSR) dated 2/5/2025, the OSR indicated for licensed staff to administer Glucerna 1.2 (formula) to run via enteral pump machine (EPM) at 90 millimeter (ml, unit of measurement) per hour (cc/hr) for 20 hours, to provide 1,800 ml per 2,160 kilo calories (kcal, unit of energy) to start at 12 noon and until 8am or until dose limit was reached. During a concurrent observation and interview on 3/14/2025 at 6:27 pm, Resident 4 was awake, lying in bed. The GT feeding bottle was unlabeled and the EPM was turned off. Licensed Vocational Nurse 2 (LVN 2) stated, Resident 4's GT feeding bottle was unlabeled and should have been labeled with Resident 4's name, date and time the feeding was started and the rate of the feeding. LVN 2 stated, the EPM was not turned on. During an interview on 3/14/2025 at 7:55 pm, LVN 2 stated, I hanged the feeding and did not turn on the machine until 5 pm. LVN 2 stated, the feeding for Resident 4 needed to be continuously administered at 5pm to prevent dehydration and electrolyte imbalance. During an interview on 3/16/2025 at 9:30 am with the facility's Director of Nursing (DON), the DON stated, the GT bottle formula needed to be labeled with residents name, date and time when the feeding formula was hanged and the licensed nurse's signature to determine when to change the feeding and if the feeding formula was the correct feeding that was ordered for the resident, as ordered by the physician. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated P&P titled, Enteral Feedings, the P&P indicated to prevent errors in administration, on the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order.

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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** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents on oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with professional standards of practice for four of four sampled residents (Residents 17, 30, 42 and 24) by failing to: a. Ensure Resident 17 received continuous oxygen therapy as ordered by the physician. Resident 17's nasal cannula (NC, tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) was left hanging on top of the oxygen concentrator. Resident 17 did not have a care plan developed on the use of oxygen therapy. b. Ensure to label the NC tubing for Resident 30. c. Ensure Resident 42's oxygen tubing was not touching the floor and the nasal cannula prongs were inside the resident's nostrils. d. Obtain a physician's order before providing oxygen treatment for Resident 24. These failures placed Residents 17, 30, 42, and 24 at risk for complications related to use of oxygen, shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and the risk of infections which could lead to respiratory complications. Findings: a. During a review of Resident 17's Admission Record (AR), the AR indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included myocardial infarction (heart attack), respiratory failure (inability of the lungs to adequately exchange gases in the blood) and heart failure (a chronic condition in which the heart doesn't pump enough blood for the body). During a review of Resident 17's Order Summary Report (OSR) dated 12/16/2024, the OSR indicated Resident 17 had an order for continuous oxygen at 2 liters (L) per minute via nasal cannula (NC). During a review of Resident 17's Minimum Data Sheet (MDS, a resident assessment tool) dated 1/24/2025, the MDS indicated Resident 17 had an intact cognition (ability to understand and process information). The MDS indicated Resident 17 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, partial/moderate assistance (helper did less than half the effort) with oral hygiene, substantial/maximal assistance (helper did more than half the effort to complete the activity) with shower, upper body dressing, and personal hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting and lower body dressing. (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 3/14/2025 at 6:28 pm with Certified Nurse Assistant 1 (CNA 1) inside Resident 17's room, Resident 17 was sitting in a wheelchair. CNA 1 stated Resident 17 was not on oxygen. CNA 1 stated Resident 17's oxygen tubing was hanging on top of the oxygen concentrator machine. During a concurrent interview and record review on 3/15/2025 at 10:57 am with Licensed Vocational Nurse 1 (LVN 1), Resident 17's medical records (chart) and PointClickCare (PCC, a cloud-based software) were reviewed. LVN 1 stated, Resident 17 had an order for continuous oxygen. LVN 1 stated there was no care plan developed for Resident 17 for the use of oxygen. LVN 1 stated oxygen tubing when not in use should be placed inside a transparent bag to prevent contamination and transmission of infection. LVN 1 stated Resident 17 should always be on oxygen as ordered to prevent desaturation (decrease in blood oxygen levels). LVN 1 stated Resident 17's use of oxygen should have a care plan developed with interventions specific for the resident. During an interview on 3/16/2025 at 9:22 am with the facility's Director of Nursing (DON), the DON stated, residents with order for continuous oxygen should be on oxygen all the time to prevent shortness of breath and desaturation. The DON stated oxygen tubing should be placed in a transparent bag with the resident's name to prevent falling on the floor and getting exchanged with the roommate's medical supply. The DON stated oxygen usage needed a care plan developed for the staff to provide consistent care, treatment and services specific for the resident. During a review of the facility's Policy & Procedure (P&P) titled, Oxygen Administration, revised 3/2017, the P&P indicated, Verify that there is a physician's order for oxygen administration. Review the resident's care plan for any special needs of the resident. b. During a review of Resident 30's AR, the AR indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a condition in which there was a decrease in the oxygen supply to the tissue), asthma (a condition in which a person's airways become inflamed, narrow, and swell) and chronic pulmonary edema (a condition characterized by a gradual buildup of fluid in the lungs). During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 had moderately impaired cognition. The MDS indicated Resident 30 required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene and substantial/maximal assistance with toileting hygiene. During a review of Resident 30's untitled Care Plan (CP) dated 3/11/2025, the CP indicated Resident 30 had the potential for alteration in breathing process secondary to acute respiratory failure and asthma. The CP interventions included to provide oxygen therapy as ordered. During a review of Resident 30's OSR dated 3/13/2025, the OSR indicated Resident 30 had an order for continuous oxygen at 2 liters (L) per minute via NC may titrate (adjust) up to 5 L/min to keep oxygen saturation (is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) above 92 percent (%) every shift for Asthma. (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 3/14/2025 at 6:34 pm with Certified Nurse Assistant 1 (CNA1) inside Resident 30's room, Resident was in bed with oxygen at 3 liters (L, unit of capacity)/min via NC. CNA 1 stated Resident 30's oxygen tubing was not labeled with the date when it was changed. During an interview on 3/15/2025 at 11:00 am with LVN 1, LVN 1 stated oxygen tubing were changed every Monday of the week. LVN 1 stated the oxygen tubing should be labeled with the date for the staff to determine when the last time the oxygen tubing was changed. During an interview on 3/16/2025 at 9:27 am with the facility's Director of Nursing (DON), the DON stated all oxygen tubing were changed weekly and as needed and labeled with the resident's name and date for infection control. During a review of the facility's P&P titled, Oxygen Concentrators, revised 6/2017, the P&P indicated, The facility will use disposable pre-filled humidifiers, tubing and cannulas, as applicable, for residents receiving oxygen. Cannulas should be replaced weekly. 42781 c. During a review of Resident 42's AR, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames the lung) and type 2 diabetes mellitus (elevated levels of glucose/sugar in the blood). During a review of Resident 42's OSR dated 2/11/2025, the OSR indicated for licensed staff to administer oxygen at 3L/min may titrate up to 5L/min via NC continuously to keep oxygen saturation above 92 % every shift for shortness of breath (SOB). During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had severely impaired cognition for daily decision making. The MDS indicated, Resident 42 was dependent to staff for toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 3/14/2025 at 6:33 pm, Resident 42 was awake lying in bed with nasal cannula tubing touching the floor. During a concurrent observation and interview on 3/14/2025 at 7:25 pm with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 42's nasal cannula should not be touching the floor because the floor was dirty and to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an observation on 3/15/2025 at 3:34 pm, Resident 42 was asleep, lying in bed, with both nasal prongs on Resident 42's left side of the face. During a concurrent observation and interview on 3/15/2025 at 3:41 pm with Registered Nurse 1 (RN 1), RN 1 stated nasal prongs needed to be inside both nostrils for the resident to receive adequate oxygen therapy as ordered by the physician. RN 1 stated if the oxygen cannula prongs were not inside both nostrils, Resident 42 would get less oxygen and could result in SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/16/2025 at 9:27 am, with the facility's Director of Nursing (DON), the DON stated oxygen tubing should not be touching the floor for infection control. The DON stated, the resident's nasal cannula prongs needed to be inside the nostrils for the resident to get adequate amount of oxygen as ordered by the physician. The DON stated, if the nasal prongs were not placed inside both nostrils, it could result in respiratory distress or SOB for Resident 42. During a review of the facility's P&P titled, Oxygen Administration, revised 3/2017, P&P indicated, oxygen therapy is administered by way of an oxygen mask, nasal cannula or non re-breather mask. The P&P indicated nasal cannula is a tube that is place approximately one-half inch into the resident's nose with an elastic band that is placed around the resident's head. 40037 d. During a review of Resident 24's AR, the AR indicated Resident 24 was readmitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that cause airflow obstruction and breathing problems) and dysphagia (difficulty swallowing). During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had unclear speech, rarely/never understood others and made self-understood. The MDS indicated Resident 24 was dependent for personal hygiene and rolling left and right. During an observation on 3/14/2025 at 7:09 pm, Resident 24 was lying in bed with eyes open. Resident 24 was receiving oxygen via NC at 2 liters per minute. During a concurrent interview and record review of Resident 24's physician order (PO), there was no order for oxygen therapy for Resident 24. Licensed Vocational Nurse 3 (LVN 3) stated there was no physician's order for oxygen therapy for Resident 24. LVN 3 stated, staff should obtain a physician's order before administering oxygen to residents. During an interview on 3/15/2025 at 4:18 pm with the facility's Director of Nursing (DON), the DON stated, the facility should obtain an order for administration of oxygen to the resident to ensure providing oxygen was appropriate to meet the resident's need. The DON stated procedure was a professional standard and the facility's policy to check the physician's order before giving oxygen to the resident. During a review of the facility's P&P titled Oxygen Administration dated 3/2017, the P&P indicated verify that there is a physician's order for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to ensure the physician's order for fluid restriction was implemented from 3/1/2025 to 3/15/2025 for one of two sampled residents (Resident 37) reviewed for dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so) care. This failure had the potential for fluid imbalance for Resident 37 affecting the resident's nutrition, hydration, and general condition. Findings: During a review of Resident 37's Admission Record (AR), the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control), hypertension (high blood pressure) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis). During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 12/25/2024, the MDS indicated Resident 37 had clear speech, had ability to understand others and made self-understood. The MDS indicated Resident 37 was independent (resident completes the activity by themselves with no assistance from a helper) for personal hygiene and chair/bed-to chair transfer. During a review of Resident 37's Order Summary Report (OSR) dated 9/23/2024, the OSR indicated Resident 37 had an order for fluid restriction 1000 ml(milliliter) every 24 hours. During a review of Resident 37's Medication Administration Record (MAR, used to document medications taken by each individual) for 3/2025, the MAR did not have monitoring for fluid restriction for Resident 37 from 3/1/2025 to 3/15/2025. During an interview on 3/15/2025 at 11:36 am with the Director of Staff Development (DSD), the DSD stated Resident 37 was on dialysis with fluid restriction per physician's order. The DSD stated Resident 37's MAR fluid restriction section was left blank and stated Resident 37's fluid restriction was not monitored from 3/1/2025 to 3/15/2025. The DSD stated, staff should monitor the resident's fluid restriction to prevent possible fluid overload which may affect kidney function and the resident's health condition. During an interview on 3/15/2025 at 4:20 pm with the facility's Director of Nursing (DON), the DON stated facility staff should monitor fluid intake for residents on fluid restriction to determine the resident's compliance with the fluid restriction. The DON stated failure to monitor could cause fluid overload and other complications for Resident 37. During a review of the facility's Policy and Procedure (P&P) titled Dialysis Care, dated 2/2018, the P&P indicated the dialysis unit physician is to be notified of any resident noncompliance with the diet ordered or fluid restriction.

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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** 40438 Based on observation, interview, and record review, the facility failed to ensure medications were administered and disposed consistent with the facility's policy and procedure (P&P) on medication administration and disposal of medications and medication-related supplies by failing to: a. Administer Losartan (medication to treat high blood pressure) as ordered during medication pass observation for one of one sampled resident (Resident 45). This failure had the potential to increase the risk of adverse drug reactions and cause harm to the resident. b. Ensure medication destruction occurs in the presence of two licensed nurses for 72 of 72 destructed medications. This failure had the potential to result in medication misappropriation. Findings: a. During a review of Resident 45's Admission Record (AR), the AR indicated Resident 45 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) and hypertension (HTN, high blood pressure). During a review of Resident 45's Minimum Data Sheet (MDS, a resident assessment tool) dated 2/13/2025, the MDS indicated Resident 45 had intact cognition (ability to understand and process information). The MDS indicated Resident 45 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene, and substantial/maximal assistance (helper did more than half the effort) with toileting, shower, upper and body dressing. During a review of Resident 45's Order Summary Report (OSR) dated 2/13/2025, the OSR indicated Resident 45 had an order for Losartan Potassium 25 milligrams (mg) by mouth daily for hypertension and to hold if systolic blood pressure (SBP, the top number in a blood pressure reading) was less than 110 millimeters of mercury (mmHg- unit of measurement for Blood Pressure [BP] reading). During a concurrent medication pass observation on 3/15/2025 at 9:00 am with Registered Nurse 1 (RN 1) and record review, Resident 45's OSR, Electronic Medication Administration Record (EMAR) and blood pressure summary (BPS) were reviewed. RN 1 administered Losartan 25 mg to Resident 45. RN 1 did not check Resident 45's blood pressure before administration of Losartan. The BPS dated 3/14/2025 at 5:57 pm indicated Resident 45 had a BP of 105/67 mmHg. The EMAR dated 3/15/2025 indicated RN 1 marked the medication (Losartan) as given and administered with the resident's BP of 105/67 mmHg. During an interview on 3/15/2025 at 9:13 am with RN 1, RN 1 stated Resident 45's BP was taken on 3/14/2025 at 5:57 pm. RN 1 stated she should have checked Resident 45's BP before the administration of BP medication (Losartan) to ensure the resident's BP was within the parameters ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/16/2025 at 9:22 am with the facility's Director of Nursing (DON), the DON stated all medications should be administered as prescribed by the doctor for the safety of the residents. During a review of the facility's P&P titled, Medication Administration, revised 5/2019, the P&P indicated, Medications must be administered in accordance with the physician orders, including any required time frame. The licensed nurse should also check prior to administration: allergies to medications and vital signs, if necessary. 40037 b. During an interview on 3/15/2025 at 3:45 pm, with the facility's Director of Staff Development (DSD) and a concurrent record review of two medication destruction forms (MDF, form documenting medications that had been destructed) dated 3/11/2025 and 3/14/2025, the MDFs indicated one licensed nurse signed off the two MDFs. The MDFs indicated a total of 72 prescribed medications, each medication with different quantity, were destructed. The DSD stated, medication destruction should be counted and signed off by two licensed nurses for medication safety. During an interview on 3/15/2025 at 4:07 pm with the facility's Director of Nursing (DON), the DON stated all medication destruction should be performed in the presence of two licensed nurses. The DON stated, the MDFs should include name of the medication, quantity destructed and signatures of two licensed nurses. The DON stated, this was the facility's policy to ensure medication safety and to avoid medication misappropriation. During a review of the facility's P&P titled Disposal of Medications and Medication-Related Supplies dated 4/2008, the P&P indicated Medication destruction occurs in the presence of two licensed nurses. The nurses and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form: 6. Signatures of witnesses.

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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. 42781 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) on preparing and serving food in accordance with professional standards for food service safety, proper sanitation and food handling practices by failing to ensure Kitchen Aide 1 (KA 1) wore a hair net (hair cover) while preparing food in the preparation area for one of one facility kitchen. This deficient practice had the potential for food borne illnesses (infection caused by ingesting contaminated food) to residents who received food from the facility's kitchen. Findings: During an initial tour of the kitchen on 3/14/2025 at 6:07 pm, KA 1 was observed not wearing a hairnet or hair cover while pushing the food cart with meal tray at the food preparation area. KA 1 stated, KA 1 forgot to wear a hairnet while in the kitchen. KA 1 stated it was important to wear a hairnet to prevent hair from falling into the food in the food preparation area. During an interview on 3/15/2025 at 9:21 am with the Dietary Supervisor (DS), the DS stated hair covering such as hairnet was needed to be worn by staff while inside the kitchen. The DS stated, the staff's hair could fall or drop into the food or kitchen utensils and contaminate the food. During a review of the facility's undated P&P titled, Dietary Policy and Procedure Manual, the P&P indicated all dietary employees shall follow good personal hygiene practices. The P&P indicated, head covering: hairnets or caps shall be worn while on duty.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, for two of two sampled residents (Residents 37 and 42), the facility failed to: a. Ensure Hydralazine (medication for high blood pressure) was documented in the facility's Medication Administration Record (MAR, used to document medications taken by each individual) on 3/13/2025 at 6am as given and the physician's order for Blood Glucose (BG, blood sugar level) monitoring was documented in the facility's MAR on 3/13/2025 at 6:30 am as given for Resident 37. b. Ensure Resident 42's blood glucose level was checked or monitored on 3/13/2025 as ordered and documented in the MAR. These failures had the potential for missing medication dose or overdose and had the potential risk for medication error for Residents 37 and 42. Findings: a. During a review of Resident 37's Admission Record (AR), the AR indicated Resident 37 was admitted on [DATE], with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control) and hypertension (high blood pressure). During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 12/25/2024, the MDS indicated Resident 37 had clear speech, had ability to understand others and made self-understood. The MDS indicated Resident 37 was independent (resident completes the activity by themselves with no assistance from a helper) for personal hygiene and chair/bed-to chair transfer. During a review of Resident 37's MAR for 3/2025, the MAR indicated BG monitoring on 3/13/2025 at 6:30 am was not signed off as performed, and Hydralazine at 6 am was not signed off as given. During a review of Resident 37's Order Summary Report (OSR) dated 3/15/2025, the OSR indicated Resident 37 was prescribed Blood Glucose Monitoring three times a day (ordered 9/23/2024) and Hydralazine 50 mg (milligram) by mouth every eight hours for hypertension (ordered 11/29/2024). During an interview on 3/15/2025 at 11:36 am with the Director of Staff Development (DSD), the DSD stated, licensed staff should sign on the MAR immediately after performing BG monitoring and administering medications. The DSD stated, medication administration professional standard was to check the physician's order, dispense medication and sign. The DSD stated this was to prevent resident missing dose or overdose and for resident safety. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/15/2025 at 4:23 pm with the Director of Nursing (DON), the DON stated, licensed nurses should sign off the MAR right after completing BG check or medication administration and should not leave the MAR unsigned. The DON stated, if for any reason the licensed nurse was not able to complete the physician's order, the nurse should document the reason in the resident's MAR or medical record. The DON stated this was to prevent miss any dose, overdose and medication error and for resident's safety. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration-General Guidelines, dated10/2024, the P&P indicated the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. 42781 b. During a review of Resident 42's AR, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames the lung) and type 2 DM. During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 42 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 42's OSR dated 3/8/2025, the OSR indicated an order for licensed staff to perform Accu-Chek (blood glucose[sugar] monitoring system) one time a day for DM. During a review of Resident 42's MAR for the month of March 2025, the MAR indicated Resident 42's blood glucose level was not checked or monitored on 3/13/2025 as ordered. There was no licensed nurse's initial on the MAR to indicate the blood glucose monitoring was performed for Resident 42 on 3/13/2025. During an observation on 3/14/2025 at 6:33 pm in Resident 42's room, Resident 42 was awake lying in bed. During a concurrent observation and interview on 3/15/2025 at 5:04 pm with Registered Nurse 2 (RN 2), RN 2 stated Resident 42's MAR on 3/13/2025 was not signed for blood glucose monitoring. RN 2 stated, RN2 did not know why the MAR was not signed by the licensed nurse on 3/13/2025. RN 2 stated, Resident 42's MAR needed to be signed by a licensed nurse after checking the resident's the blood glucose level or the reason why the resident was not checked for blood glucose level.

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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. 40037 Based on observation, interview, and record review, the facility failed to ensure six of 23 resident rooms (Rooms 2, 8, 10, 11, 15 and 16) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice has the potential to cause the residents in these rooms not to have enough room for activities of daily living and hinder staff from providing care to the residents. Findings: During observation of the facility on 3/16/2025 from 9:46 am to 10:52 am, Rooms 2, 8, 10, 11, 15 and 16 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate freely and/or maneuver in their wheelchairs freely. Nursing staff had enough space to provide care to these residents with dignity and privacy. There was space for beds, side tables, dressers and other medical equipment. During an interview with the Administrator on 3/16/2025 at 11:29 am regarding the six resident rooms that did not meet the minimum requirement of 80 sq. ft. per resident, the ADM stated the facility submitted a room waiver request for Rooms 2, 8, 10, 11, 15 and 16. During a review of the facility's room waiver request letter dated 3/15/2025, the room waiver letter indicated there was enough space for nursing care and the health and safety of the residents occupying these rooms are not in jeopardy (harm). The room waiver letter indicated these rooms were in accordance with the needs of the residents and would not have an adverse effect on the resident's health and safety or impede the ability of any resident to attain his or her highest practicable well-being. The room waiver letter indicated the following measurements: 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 The minimum square footage for a 2-bed room is 160 sq. ft. The minimum square footage for a 4-bed room is 320 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During interviews with the residents both individually and collectively during the recertification survey (3/14/2025 - 3/16/2025), the residents did not express any concerns regarding the size of their rooms.