STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555919	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Manor	100 East 2nd Street Imperial, CA 92251

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care that promoted dignity and respect for one of 12 residents (Resident 5) reviewed for resident rights, when Resident 5's urinary catheter bag (tube inserted to drain urine) was not covered. As a result, Resident 5's urinary bag was visible to anybody passing by. Findings: Resident 5 was admitted to the facility on [DATE] with diagnose that included benign prostate hyperplasia with lower urinary symptoms (BPH -noncancer causing prostate enlargement) according to undated the facility admission record. A review of Resident 5's Minimum Data Set (MDS- a standardized, federally mandated assessment tool used in nursing homes) Section C, dated 1/31/25, was conducted. The document indicated Resident 5 had a Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify cognitive [thinking process] impairment of resident) score of 00 which indicated severe mental impairment. On 4/7/25 at 8:49 A.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered, while other residents were present in the dining room. On 4/7/25 at 12:29 P.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered, while other residents were present in the dining room. On 4/8/25 at 7:30 A.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered, while other residents were present in the dining room. On 4/8/25 at 8:42 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she did not know she had to cover Resident 5's urinary bag. CNA 1 acknowledged that leaving the resident's urinary bag uncovered did not promote the resident's dignity and could result in the resident feeling embarrassed. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 10:20 A.M, an interview was conducted with CNA 2. CNA 2 stated Resident 5's urinary bag should be covered to promote the resident's dignity. On 4/9/25 at 2:45 P.M. an interview and record review were conducted with the Director of Nursing (DON). The DON stated Resident 5's urinary bag should be covered with to promote Resident 5's dignity. A review of the facility's policy and procedure titled Resident Rights, dated February 2021, was conducted. The policy indicated, .Employees shall treat all residents with kindness, respect and dignity .1 These rights include the resident's rights to: a. a dignified existence . A review of the facility's policy and procedure titled Dignity, revised in February 2021, was conducted. The policy indicated, .1. Residents are treated with dignity and respect at all times .

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 2 was admitted to the facility was readmitted on [DATE] with diagnoses to include paranoid schizophrenia (subtype of schizophrenia, a mental illness with persistent paranoid delusions), muscle spasm and dementia (memory loss) per the undated facility admission Record. A review of Resident 2's swallow evaluation dated 9/14/23 indicated Resident 2 had history of dysphagia (difficulty in swallowing) and examination performed was modified swallow impression positive laryngeal penetration. A review of Resident 2's weight records was conducted. The weight record indicated monthly weights from August 2024 to March 2025: 7/14/24 114.1 pounds (lbs.) 8/15/24 110.9 lbs. 9/12/24 108.3 lbs. 10/11/24 108 lbs. 11/12/24 105.8 lbs. 12/16/24 108 lbs. 2/14/25 108 lbs. 3/14/25 108 lbs. On 4/8/25 at 8:20 A.M., an interview was conducted with CNA 1. CNA 1 stated Resident 2's meal intake had been 75 to 100% lately. CNA 1 stated sometimes Resident 2's intake was 50%. On 4/8/25 at 10:26 A.M., an interview was conducted with CNA 2. CNA 2 stated Resident 2 was losing weight. CNA 2 stated when she started working in the facility, Resident 2 could eat by himself but now he needed assistance with eating. On 4/8/25 at 2:27 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 2 needed assistance with eating since 2023. LN 1 stated he was not aware that Resident 2 had poor meal intake. LN 1 stated CNAs were responsible of letting LNs know when residents had poor meal intake. On 4/9/25 at 3 P.M, an interview and joint record review were conducted with the Director of Nursing (DON). The DON stated Resident 2's weight loss was not significant. The DON acknowledged Resident 2 experienced weight loss from July through November 2024. The DON reviewed Resident 2's medical record. The DON stated she could not find documentation to show that Resident 2's weight loss was identified, discuss and addressed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/9/25 at 5:16 P.M., an interview and record review were conducted with the DON and the Registered Dietician (RD). The RD stated Resident 2 should have been placed on weekly weights. The DON acknowledged Resident 2's weight loss should have been identified and discussed in the IDT (Interdisciplinary team - group of professionals from different fields who collaborate to achieve a common goal) meeting to address the resident's weight loss. The DON stated the Resident 2's physician should have been notified. A review of the facility policy title Weight Assessment and Intervention, revised March 2022 was conducted. The policy indicated .Resident weights are monitored for undesirable or unintended weight loss or gain . Evaluation .2. The physician and the multidisciplinary team identify conditions . that may be causing weight loss . Based on observations, interview, and record reviews, the facility failed to implement a comprehensive systemic approach, to ensure nutritional status were maintained for two of two sampled residents (Resident 12 and Resident 2) when: 1. Resident 12's unplanned significant weight loss (loss of body weight greater than 5% in a month) was not identified and addressed. 2. Resident 2's unplanned weight loss was not identified and addressed. As a result, the facility's system was not effective at identifying and addressing progressive weight loss. The staff were not consistent in identifying unplanned weight loss and significant weight loss. The interdisciplinary team (IDT - a group of professionals from different disciplines who collaborate to treat a patient's needs) did not developed a plan to monitor and address the residents' weight loss. The above cited systems failures had the potential to negatively impact and compromise the medical status of the residents. Unintentional weight loss in people older than 65 years is associated with increased morbidity and mortality. (American Family Physician, July 2021/Volume 104, Number 1) Findings: 1. According to the admission Record, Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic disorder (occurs when abnormal chemical reactions in your body disrupt this process), iron deficiency (a condition in which blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues), paraplegia (loss of motor and/or sensory function in the lower part of the body, including the legs and lower abdomen), and gastrostomy status (an opening (gastrostomy) into the stomach, typically for feeding or draining purposes). During a review of the Minimum Data Set (MDS-an assessment tool), the MDS indicated, Resident 12 had a BIMS (Brief Interview for Mental Status - a tool to test cognition) score of 9 which meant a score between 8 and 12 indicated moderate to mild mental impairment. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/7/25 at 12:23 P.M., an observation was conducted during lunch. Resident 12 was observed in the dining room. Certified Nursing Assistant (CNA) 1 was feeding Resident 12. CNA 1 was observed holding a spoon of pureed food up to Resident 12's mouth. Resident 12 had her lips tightly closed shut, and she tilted her chin away from the spoon. On 4/8/25 at 7:13 A.M., a concurrent observation and interview was conducted in the dining room during breakfast with Licensed Vocational Nurse Student (LVNS) 1. Residents were observed walking out of the dining room. Resident 12 was sitting in a wheelchair, at a dining room table during breakfast, without a breakfast tray. LVNS 1 stated Resident 12 refused to eat breakfast, and her tray was taken away. LVNS 1 stated, .they're looking for something else to give her for breakfast . LVNS 1 stated Resident 12 has been refusing to eat meals and, .we give her [a supplemental drink] as alternative . On 4/09/25 at 3:00 P.M., an interview was conducted with CNA 2. CNA 2 stated Resident 12 had been refusing to eat during meals. CNA 2 stated she noticed Resident 12 was losing weight. CNA 2 stated, . Before when I would change her [briefs], it would be more difficult to put [the brief] around her .I think she uses the green [brief] which is size 2x. Now, the brief fits looser, we don't struggle as much to put it on her. That's how I could tell that she lost weight . During a review of Resident 12's Electronic Health Record, titled, the Weight Summary for August 2024 through March 2025 indicated: 8/15/24-190.4 pounds 9/12/24-182 pounds 10/11/24-173 pounds 11/22/24-171.7 pounds 12/12/24- 168 pounds 1/15/25- refused to be weighed 2/12/25-164 pounds 3/14/25-157 pounds Resident 12 experienced a 25-pound weight loss (13.7%) in six months, from 9/24 to 3/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with the Registered Dietitian (RD) on 04/08/25 02:19 P.M., the RD stated she was aware that Resident 12 had lost 7 pounds from 2/25 to 3/25. The RD stated the weight loss was unplanned and considered a significant weight loss. The RD stated in her opinion Resident 12's weight loss was not concerning because staff had reported that Resident 12 .had been eating good . and because Resident 12 was still in the obese category based on her height and weight. The RD stated, I feel like I'm more concerned [about weight loss] with someone who is not eating . The RD stated on 3/26/25 she wrote a progress note on 3/26/25, but did not do a comprehensive nutritional assessment for Resident 12. The RD stated comprehensive nutritional assessments were only done annually for all residents, regardless of any significant weight changes. During a review of Resident 12's Progress Notes, a note titled Weight Change Note dated 3/26/25 indicated, Weight loss of 7 lbs (pounds) in the past 1 month reported to RD. Resident 12 was reported to be eating well. Good appetite and good p.o. (oral) intake. BMI (Body Mass Index - a widely used measure that estimates body fat based on height and weight) of 30. No diet changes recommended at this time. Continue monitoring daily p.o. intake and monthly weights. Notify RD of significant changes . During a review of Resident 12's Weight Summary dated, 4/10/25 at 8:58 A.M., Resident 12's weight was recorded as 147.4 pounds, which indicated a weight loss of 10 pounds (6%, which is a significant weight loss) since 3/14/25. On 4/10/25 at 11:09 A.M., a follow up interview was conducted with the RD. The RD stated she wrote a progress note on 4/9/25 with interventions to address Resident 12's weight loss. The RD stated, .the interventions listed in the progress note was what I should have done to prevent even more weight loss from happening . On 4/10/25 at 8:20 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that a comprehensive nutritional assessment was done when a resident has significant weight loss. The DON stated, A comprehensive assessment should have been done, with interventions . The DON stated the resident was, .at risk of losing body mass, muscle mass, and losing function . During a review of the facility policy titled Nutrition revised 10/17 indicated, . 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission .and as indicated by a change in condition that places the resident at risk for impaired nutrition . During a review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol revised 9/2012, the document indicated, The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview, and record review, the facility failed to ensure a registered nurse (RN) was on duty for 8 consecutive hours per day, for three months, October 1 to December 31, 2024. This failure had the potential for advanced care activities, that needed an RN, to not be provided to the residents due to the unavailable RN. Findings: During the initial tour of the facility on 4/07/2025 at 9 A.M., the only RN at the facility was the Director of Nursing (DON). A review of the facility's PBJ (payroll-based journal) Staffing Data Report, [NAME] Report 1705D (a report that can help Skilled Nursing Facilities identify areas for improvement in care and operations) of fiscal year 2025 Quarter 1, indicated the facility was triggered for no RN hours, which meant four or more days within the quarter with no RN hours. The Report indicated the following dates with no RN hours: - 10/1,10/2,10/3, 10/4,10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/24. - 11/1, 11/2, 11/3 (SU), 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/12, 11/13, 11/14, 11/15, 11/16, 11/17, 11/18, 11/19, 11/20, 11/21, 11/22, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/29, and 11/30/24. - 12/1, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, and 12/31/24. On 4/7/24 at 9:07 A.M., an interview was conducted with the Facility Assistant (FA). The FA stated the Director of Nursing (DON) was the only RN in the building. The FA stated the DON was not included in the schedule because the DON came to the facility on an as needed basis only. On 4/8/25 at 2:27 P.M., an interview was conducted with licensed nurse (LN) 1. LN 1 stated the DON was the only RN working in the facility. LN 1 stated the DON came to facility approximately twice times a week. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/25 at 11:17 A.M., an interview was conducted with the DON. The DON stated she was the only RN working in the facility. The DON stated she came to the facility to fill in for call offs or last-minute call in sick. The DON acknowledged there should be an RN for 8 consecutive hours in a 24-hour shift. On 4/10/25 at 8:17 A.M., an interview and joint record review of the facility's Direct Care Service Hours Per Patient Day (DHPPD- staffing requirement reporting) was conducted with the FA. The FA stated from January of 2025 to current, there was no RN scheduled to work at the facility. According to the DHPPD report for March 17 to 31, 2025, there were no RNs projected to work, and there were no RNs who actually worked on March 17 to 31, 2025. The FA stated the DON was the only RN in the facility. Th FA acknow;edged there was no consistent RN for eight (8) consecutive hours per day for seven (7) days. A review of the facility's policy titled Staffing, Sufficient and Competent Nursing, revised in August 2022, was conducted. The policy indicated .3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than five percent when two out of 31 medications were administered incorrectly. The facility's error rate was 6.45%. These failures had the potential to negatively affect the residents' health and safety. Findings: 1. On 4/9/25 at 8 A.M., a medication administration observation was conducted with licensed nurse (LN) 1. LN 1 prepared and administered three medications to Resident 27. One of the medication LN 1 administered to Resident 27 was Benztropine mesylate (a medication for [Parkinson's disease] a progressive disease of the nervous system affecting movement) 1 milligram (mg). A review of Resident 27's physician order was conducted. The physician order, dated 8/15/23, indicated an order to give Resident 27 .Benztropine Mesylate Oral Tablet 2 MG (Beztropine Mesylate) Give 1 mg by mouth one time a day . On 4/9/25 at 10:31 A.M., an interview and joint record review of Resident 27's physician order were conducted with LN 1. LN 1 stated the physician order was written as Benztropine mesylate 2 mg and give 1mg by mouth one time a day. LN 1 stated the pharmacy dispensed a blister pack of Benztropine mesylate in 20 mg tablet. LN 1 acknowledged that the order for Benztropine was unclear and should have been clarified with Resident 27's physician. On 4/9/25 at 4:54 P.M., an interview and joint record review were conducted with the Director of Nursing (DON). The DON stated Resident 27's Benztropine order should have been clarified with the resident's physician. 2. On 4/9/25 at 8:44 A.M., a medication administration observation was conducted with licensed nurse (LN) 1. LN 1 prepared and administered six medications to Resident 26. One of the medication LN 1 administered to Resident 26 was Olanzapine (a medication for [schizophrenia] mental illness characterized by disturbance in thought) 20 milligrams (mg). A review of Resident 26's physician order was conducted. The physician order, dated 8/20/24, indicated an order to give Resident 26 .OLANzapine Oral Tablet 10 MG (Olanzapine) .Give 10 mg by mouth one time a day . and .OLANzapine Oral Tablet 20 MG (Olanzapine) . Give 20 mg by mouth at bedtime . A review of Resident 26's Olanzapine blister pack label indicated . Olanzapine 20 mg TAB . TAKE 1 TABLET BY MOUTH IN THE MORNING & BEDTIME . On 4/9/25 at 4:55 P.M., an interview and joint record review were conducted with the Director of Nursing (DON). The DON stated according to the physician order, Resident 26 should have been given Olanzapine 10 mg in the morning. The DON stated Resident 26's physician order for Olanzapine was 10 mg for morning but pharmacy dispensed 20 mg for both morning and bedtime. The DON stated the medication was not administered in accordance with the physician order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled Administering Medications, revised in April 2019, was conducted. The policy indicated, .4. Medications are administered in accordance with prescriber orders .10. The individual administering the medication checks the label THREE (3) times to verify the .right dosage . before giving the medication .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure pureed food was prepared in a consistency that met the needs for two of two sampled residents sampled residents (12, 13). This failure placed the residents at risk for choking and/or aspiration (inhaling food into the lungs). Findings: 1. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic disorder (occurs when abnormal chemical reactions in your body disrupt this process), iron deficiency (a condition in which blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues), paraplegia (loss of motor and/or sensory function in the lower part of the body, including the legs and lower abdomen), and gastrostomy status (an opening (gastrostomy) into the stomach, typically for feeding or draining purposes). A review of the of the facility document titled, Nutrition Quarterly Review assessment written by the dietary services supervisor (DDS) indicated, the Resident 12 was on a puree diet due to chewing problems. 2. Resident 13 was admitted to the facility on [DATE] with diagnoses which included underweight. During an observation of pureed foods preparation with [NAME] 1 and [NAME] 2 on 4/7/25 at 11:16 A.M., [NAME] 1 was preparing brussel sprouts in a pureed form. [NAME] 1 placed 2 4-ounce scoops of cooked brussel sprouts into a blender, with 1 ½ 4-ounce scoops of broth into the blender. After blending the brussel sprouts and the broth, [NAME] 1 placed a scoop of the blended brussel sprouts onto two plates, covered the plates, and then placed them on two trays. The blended brussel sprouts had pea sized chunks and was not smooth in appearance. On 4/7/25 at 11:25 A.M., an interview was conducted with [NAME] 2. [NAME] 2 stated the blended brussel sprouts, .needs more broth and more time in the blender . [NAME] 2 stated it was important to make the food smooth per recipe, .if they have a problem chewing the meat, it needs to not have chunks, we need to follow the recipe . During a record review, the recipe for Brussel Sprouts indicated, .PUREE DIET: Process each serving, gradually adding 2-4 tbsp [tablespoons] of vegetable or chicken stock until smooth and mixture meets the Spoon Tilt Test standard. Food should be smooth with no lumps .Pureed vegetables should have a smooth texture, no lumps, and hold shape on a spoon . During a record review of the policy titled, Pureed dated July 2019, the document indicated, PUREED .This modification is designed for people who have severe chewing and/or swallowing problems. Properly pureed foods elimitate the chewing phase .Puree all foods to a smooth, lump-free .consistency .Always refer to the recipe and spreadsheet for directions .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to identify weight loss trends in their Quality Assurance Performance Improvement (QAPI- a plan developed by the facility with the goal of improving conditions in the facility) as an area of improvement that required an action plan. As a result, the facility did not provide a systemic approach in adressing Resident 12 and Resident 2's weight loss. (Refer to F-692) Findings: During a interview and record review with the Director of Nursing (DON) on 4/10/25 at 2:05 P.M., the DON stated the issues that were discussed during the monthly QAPI meetings were elopement prevention and resident to resident altercations. The DON stated the weight losses should have been identified by the facility, and discussed in the monthly QAPI meetings. The DON stated, Yes, the weight losses should have been identified before [the recertification suvey] .it's part of patient care. Monitoring weight was part of patient care and should have been part of QAPI because it would sound an alarm . During a review of the facility's undated policy titled, QAPI Policy and Procedure, the policy indicated, the purpose of QAPI was, to monitor, evaluate, and improve the quality of resident care and services provided at [Facility's Name] . In addition, the policy indicated the objective of QAPI included to, .Engage staff at all levels in identifying and solving quality concerns .

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	555919	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Manor	100 East 2nd Street Imperial, CA 92251

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their own infection prevention and control program for two of two sampled residents (5, 12) when: 1. Resident 5's uncovered urinary bag touched the floor on multiple occasions for one of 12 residents (Resident 5). 2. The Centers for Disease Control and Prevention (CDC) guidelines for Enhanced Barrier Precautions (EBPs, an infection control intervention using protective gown and gloves) was not implemented for Resident 12. These failures could potentially contribute to Resident 5 acquiring a urinary tract infection. Also, failure to implement the CDC guidelines had the potential to result in the spread of Multiple Drug Resistant Organisms (MDROs, microorganisms, mainly bacteria, that are highly resistant to many types of antibiotics) throughout the facility. Findings: 1. Resident 5 was admitted to the facility on [DATE] with diagnose that included benign prostate hyperplasia with lower urinary symptoms (BPH -noncancer causing prostate enlargement) according to the undated facility admission record. A review of Resident 5's Minimum Data Set (MDS- a standardized, federally mandated assessment tool used in nursing homes) Section C, dated 1/31/25, was conducted. The document indicated Resident 5 had a Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify cognitive [thinking process] impairment of resident) score of 00 which indicated severe mental impairment. On 4/7/25 at 8:49 A.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered and was touching the floor. On 4/7/25 at 12:29 P.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered and was touching the floor. On 4/8/25 at 7:30 A.M., an observation was conducted of Resident 5. Resident 5 sat in a wheelchair in the dining room with his urinary bag uncovered and was touching the floor. On 4/8/25 at 8:37 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 5's urinary bag and tubing should not be touching the floor. On 4/8/25 at 10:16 A.M, an interview was conducted with CNA 2. CNA 2 stated Resident 5's urinary bag and tubing was not supposed to be on the floor. CNA 2 stated the floor was contaminated and infection might go to Resident 5's urinary bag. CNA 2 stated Resident 5's urinary bag and tubing should be above the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/25 at 2:50 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 5's urinary bag and tubing should not touch the floor because of possibility of reintroducing the bacteria back to the urinary tract causing infection. A review of the facility's policy titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, revised September 2017 was conducted. The policy indicated .Steps in procedure . 6 .c .Do not place the drainage bag on the floor . 2. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic disorder (occurs when abnormal chemical reactions in your body disrupt this process), iron deficiency (a condition in which blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues), paraplegia (loss of motor and/or sensory function in the lower part of the body, including the legs and lower abdomen), and gastrostomy status (an opening (gastrostomy) into the stomach, typically for feeding or draining purposes). On 4/7/25 at 7:30 A.M., observations were conducted of the nursing unit. Residents 12 was identified with indwelling medical devices (a medical device inserted into the body and left in place for a period of time, either for treatment or to allow access for various procedures). There was no signage posted for EBP, or PPE available for staff use observed outside the residents' bedrooms. During an interview on 4/8/25 at 7:45 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated the residents with indwelling medical devices were not placed on EBP. The IP stated he did not know what Enhanced Barrier Precautions were or what the precaution entailed. On 4/9/25 at 11:03 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated she did not know what Enhanced Barrier Precautions were, and that the facility had not implemented EBP for any residents with indwelling medical devices. During a review of the All Facilities Letter (AFL- a memorandum issued by the California Department of Public Health), dated 6/13/2024, the memo indicated skilled nursing facilities should implement EBP per Centers for Disease Control (CDC) guidance, as part of infection control for skilled nursing facilities. A review of the facility's policy titled Infection Prevention and Control Program, revised October 2018, indicated, The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures .outbreak management, prevention of infection .policies and procedures reflect the current infection prevention and control standards of practice . During a review of the Quality, Safety and Oversight (QSO- a memorandum issued by the Centers for Medicare & Medicaid Services) 24-08-NH the memorandum indicated, EBP are indicated for residents with any of the following .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Indwelling medical device examples include .urinary catheters, feeding tubes .EBP should be used for any residents who meet .the criteria, wherever they reside in the facility .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist Nurse (IP) completed required annual specialized training related to infection control. This deficient practice had the potential to affect the facility's ability to maintain a safe environment and to prevent and manage transmission of diseases and infections. Findings: During an interview with the IP on 4//25 at 7:45 A.M., the IP stated he had been the IP at the facility, for about a year . The IP further stated he is scheduled to pass medications for 36 hours a week and dedicated approximately 2-4 hours weekly as an IP. A review of the IP's training certificates indicated, the IP completed a course titled, Infection Control and Prevention on 12/13/24 for 4 credit hours. In addition, the IP completed a course titled Hand Hygiene For Healthcare Online Course on 1/2/24 and a Personal Protective Equipment Online Course on 1/2/24. The courses had no listed CEU's (Continuing Education Units- a measure in ongoing education programs) or credit hours. During a concurrent interview and record review with the Director of Nursing (DON) on 4/10/25 at 10:38 AM., the Job Description for the facility's Infection Preventionist indicated, Specific Requirements .Must possess a current, unencumbered, active license to practice as a Registered Nurse in this state. The DON acknowledged the IP was a Licensed Vocational Nurse and not a Registered Nurse. During a record review of the Job Description for the facility's Infection Preventionist dated 2001, the Job Description indicated, Working Conditions .Attends and participates in continuing education programs .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to ensure scales were calibrated per manufacturer's instructions. This failure had the potential for inaccurate weights to be obtained. Findings: During an observation and interview on 4/9/25 at 9:22 A.M., the Maintenance Worker (MW) stated the maintenance department was responsible for calibrating (the process of checking a measuring instrument to see if it is accurate) scales used to weigh residents. The MW stated the facility used two different scales: a standing scale for residents who were able to stand, and a scale to weigh residents while they are sitting in the wheelchair. The MW stated to calibrate the standing scale, he will press the tare button to zero out the scale. The MW stated once the scale reads 0.0, the scale is calibrated. The MW stated he did not use any handheld weights, .I put a person on the scale, not weights . to ensure the machine was calibrated. On 4/9/25 at 10:02 A.M., an interview was conducted with the Maintenance Supervisor (MS). The MS stated to calibrate the standing scale and the wheelchair scale, he uses two five-pound hand weights. The MS stated to calibrate the wheelchair machine, he will zero it out . then place a five-pound weight on the machine. The MS stated if the machine reads five pounds, then it is calibrated. A review of the manufacturer's instructions for the standing scale titled, Medical Scale-Calibration Manual, indicated, .Calibration of the scale is performed using certified weights. 50/100/200/400 lbs [pounds] are employed as the calibration standards . A review of the manufacturer's instructions for the wheelchair scale titled, Weighing Indicator User Manual indicated, .The indicator is calibrated by the following procedures .The minimum test weight that can be used is 1% of the full-scale capacity . On 4/10/25 at 8:20 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for maintenance to calibrate the scales according to the manufacturer's instructions. The DON stated, We should know how to calibrate the scales. The scales should be accurate because we want to obtain the residents' accurate weight. It can deter, or give false impressions of the [resident's] weight and therefore affect the patient's plan of care . During a review of the facility's policy titled Scale Use Policy, the policy indicated, .all residents will be weighted .using calibrated and facility-approved scales, following standard procedures to ensure accuracy, safety, and dignity .

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure that 1 of 9 resident rooms (room [ROOM NUMBER]) accommodated 4 or less residents. Findings: During the initial facility tour on 4/7/25 at 9 A.M., room [ROOM NUMBER] was observed to have 6 resident beds in the room. During a review of the facility's Analysis of Accommodations (document with measurements of the square footage of the useable living space of individual resident rooms and approved capacities), the document indicated room [ROOM NUMBER] had 6 residents housed in the room. There were no quality of care or quality of life issues identified during the survey for the six residents that resided in room [ROOM NUMBER]. A contuinance of a waiver allowing the six-bed room was therefore recommended.

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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** Based on observation and record review, the facility did not meet the minimum requirement of 80 square feet per resident in rooms 1, 2, 3, 6, 7 and 8. Findings: An observation of resident rooms was conducted from 4/7/25 through 4/10/25 during the annual recertification survey. A review of the facility's Analysis of Accommodations indicated there were 6 of 9 resident rooms that did not meet the minimum room size requirement, as follows: 1. room [ROOM NUMBER], with 3-resident occupancy, 72 square feet per resident totaling 216 square feet. 2. room [ROOM NUMBER], with 3-resident occupancy, 74 square feet per resident totaling 222 feet. 3. room [ROOM NUMBER], with 3-resident occupancy, 72 square feet per resident totaling 216 square feet. 4. room [ROOM NUMBER] with 3-resident occupancy, 70 square feet per resident totaling 210 square feet. 5. room [ROOM NUMBER] with 3-resident occupancy, 73.66 square feet per resident totaling 221 square feet. 6. room [ROOM NUMBER], 4-resident occupancy, 70.75 square feet per resident totaling 283 square feet. The variations in room size requirements did not adversely affect the resident's health, safety, quality of care, or quality of life during the survey. A continuance of the room size waiver for all affected rooms were recommended.