STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555922	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards Skilled Nursing	1 Amistad Drive Ladera Ranch, CA 92694

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45064 Based on interview, medical record review, and facility P&P review, the facility failed to ensure a copy of the advance directive was maintained in the medical record for one of three final sampled residents (Resident 5) reviewed for advance directives. This failure had the potential for Resident 5's decisions regarding his healthcare and treatment options to not be honored. Findings: Review of the facility's P&P titled Advance Directive reviewed 1/2/25, showed prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or his or her legal representative about the existence of any written Advance Directives. Further review of the P&P showed information about whether or not the resident has executed an advance directive shall be display prominently in the medical record. Medical record review for Resident 5 was initiated on 4/14/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE], and 1/16/25. Review of Resident 5's POLST dated 1/16/25, showed Resident 5's advance directive was not available. Review of Resident 5's H&P examination dated 1/17/25, showed Resident 5 had fluctuating capacity and could make needs known. Review of Resident 5's Interdisciplinary Care Conference notes dated 1/21/25, showed Resident 5's Family Member 1 stated the resident had an advance directive and would bring in a copy of the advance directive. Review of Resident 5's medical record failed to show a copy of the advance directive was maintained in Resident 5's medical record. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 1024 hours, an interview and concurrent medical record review for Resident 5 was conducted with the SSD. The SSD verified there was no copy of Resident 5's advance directive in the medical record, nor was it uploaded in Resident 5's EMR. The SSD stated Resident 5 had an advance directive and should have followed up and obtained a copy of the resident's advance directive. The SSD further stated a copy of the advance directive should have been maintained in Resident 5's medical record and should have been readily retrievable by the facility staff. On 4/16/25 at 0853 hours, the DON was informed and acknowledged the above findings.

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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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 45064 Based on observation, interview, and facility P&P review, the facility failed to ensure the residents' medical records were safeguarded to protect the confidential health information of the residents in the facility. This failure had the potential for the residents' personal and health information to be accessed from the unauthorized users. Findings: Review of the facility's P&P titled Privacy, Electronic Data Security dated 11/2017 showed the protection of all the resident's data is the responsibility of the facility and shall be protected from accidental or malicious destruction, disclosure, or modification. The facility's workstation security must place the display screens and keyboards devices in a way access is limited/restricted and not in public view. Log-off when leaving the terminal. On 4/14/25 at 1211 hours, during the initial tour of the facility, Nurses' Station A was observed with a laptop on top of the medication cart turned on with the residents' information available to be viewed and read. The medication cart was placed in the hallway unattended and there was no licensed nurse present near the medication cart. The other facility staff, residents, and residents' visitors were observed passing by the medication cart in the hallway with the computer screen left turned on, opened, and unattended. On 4/14/25 at 1219 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 was observed attending to the medication cart located in Nurses' Station A and noticed the laptop on top of the medication cart was opened. LVN 5 stated, Why was the computer opened and who opened it? LVN 5 verified the laptop was opened and stated the computer screen should have been closed for privacy. LVN 5 acknowledged she should have been very careful not to leave the medication cart computer screen open for privacy issue. On 4/16/25 at 1129 hours, an interview and concurrent facility P&P review was conducted with the DON. The DON was informed of the observation of the electronic medical record on the medication cart left opened and unattended. The DON verified and acknowledged the above findings

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, medical record review, and P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for one nonsampled resident (Resident 41). * The facility failed to ensure a physician's order was obtained, a care plan was formulated, the assessment was completed, and the appropriate instructions were obtained to maintain the appropriate care of a heart monitoring machine for Resident 41. These failures had the potential for the residents to not receive the necessary care and services to maintain their highest physical well-being. Findings: Review of the facility's P&P titled General Equipment Use Guidelines dated 3/4/25, showed the residents admitted with equipment to follow the manufacturer guidelines for use and management. On 4/14/25 at 0913 hours, an observation and concurrent interview was conducted with Resident 41 in her room. Resident 41 was observed with a machine on top of her bed plugged in to the electrical wall outlet and with a pillowcase on top. Resident 41 stated she had a heart condition and needed a machine to monitor her heart which automatically transmitted the data to the contracted company. Resident 41 stated she would lay down on top of the machine placed on her bed, turned on the machine, and the machine monitored her heart. Medical record review for Resident 41 was initiated on 4/15/25. Resident 41 was admitted to the facility on [DATE], with a clinical diagnosis of heart failure. Review of Resident 41 's Order Summary Report dated 4/15/25, Admission Evaluation dated 3/26/25, and Care Plan Report failed to show a documented evidence a physician's order was obtained for the use, care and maintenance of the heart monitor machine, a care plan was formulated, and the presence of Resident 41 's heart monitor machine was documented when the resident was admitted to the facility. On 4/15/25 at 0914 hours, a follow-up interview was conducted with Resident 41. Resident 41 stated she brought her heart monitor machine from home to monitor her heart and was using it every day. Resident 41 was asked if the facility staff assisted her on taking care and checking the functionality of the machine. Resident 41 stated no. On 4/15/25 at 1436 hours, an interview and concurrent medical record review for Resident 41 was conducted with LVN 3. LVN 3 was asked about Resident 41 's condition. LVN 3 verified Resident 41 had a heart problem and was receiving medication. LVN 3 was asked about Resident 41's heart monitor machine at bedside. LVN 3 acknowledged and verified she was not aware about Resident 41 's heart monitor machine at bedside. LVN 3 verified there was no physician's order, no care plan, and no documentation of the heart monitor machine were documented. LVN 3 acknowledged there should have been a physician's order obtained, care plan formulated, and documentation of the heart monitor machine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/ 16/25 at 1122 hours, an interview and concurrent medical record review for Resident 41 was conducted with the DON. The DON was asked about the facility's process of the residents' own machine brought from home. The DON stated per facility's P&P, they would follow the recommendation from the manufacturer's guidelines in care and management of the machine. The DON was asked what should have been documented about the resident's machine use. The DON stated there should have been a physician's order, a formulated care plan, and an assessment for the functionality of the machine use of the resident. The DON was informed of Resident 41 's heart monitor machine at the resident's bedside with no physician's order, care plan, and assessment for the functionality of the machine documented. The DON verified the findings and stated there should have been a physician's order obtained, a care plan formulated, and an assessment for the functionality of the machine documented when Resident 41 was admitted to the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care for one of 14 final sampled residents (Resident 2). * The facility failed to administer the oxygen therapy treatment as ordered by the physician for Resident 2. This failure had the potential for the resident to not receive oxygen as ordered and adequate respiratory care. Findings: Review of the facility's P&P titled Oxygen Management revised 10/28/19, showed oxygen therapy is administered to the resident only upon the written order of a licensed physician or in the event of an emergency until a physician order can be received. The licensed nurse is to check for physician's order for oxygen and liters/minute to be administered. On 4/14/25 at 0949 hours, during the initial tour observation, Resident 2 was observed lying in bed with oxygen via nasal cannula which was attached to the oxygen machine concentrator with setting noted at 1 liter per minute. During the observation, the oxygen tubing was labeled and dated; however, the nasal cannula was not placed on the resident's nares. Medical record review for Resident 2 was initiated on 4/14/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 2/8/25, showed Resident 2 had no capacity to make health care/ medical decisions; however, the resident could make simple needs known. Review of Resident 2's Order Summary Report dated 4/14/25, showed a physician's order dated 2/7/25, for oxygen at 2 liters per minute via nasal cannula every shift to keep oxygen saturation level greater than 92%. Review of Resident 2's care plan report dated 2/10/25, showed a care plan problem for altered respiratory status and the intervention included to administer oxygen at 2 liters per minute via nasal cannula. On 4/14/25 at 0949 hours, an observation and concurrent interview for Resident 2 was conducted with IP 2. IP 2 verified the oxygen setting was at 1 liter per minute and the nasal cannula was not on the resident's nares. IP 2 acknowledged the findings and placed the nasal cannula to Resident 2's nares. On 4/14/25 at 1049 hours, an interview for Resident 2 was conducted the IP 2 who stated the oxygen concentrator was replaced due to malfunction issue, and the dial to set the amount of oxygen administration was not working. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1010 hours, an interview was conducted with LVN 1. LVN 1 was informed of the above findings and stated the physician's order for the oxygen administration for Resident 2 should have been followed. On 4/17/25 at 1251 hours, an interview was conducted with the DON. The DON was informed and acknowledged all of the above findings. The DON stated the physician's order for the oxygen administration for Resident 2 should have been followed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45064 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the licensed nurses followed their P&P for medication administration for three of 14 final sampled residents (Residents 9, 10, and 36). * The facility failed to ensure the physician was notified when the medication, Biotene (medication spray to relieve dry mouth, tongue, and throat) was not available for Resident 9 and missed three doses on 4/5/25, and two doses on 4/6/25. The facility failed to ensure Resident 36's IV medication Ertapenem (antibiotic administered intravenously to treat serious infections) was administered on 3/12, 3/18, 3/19, and 4/16/25. * The facility failed to ensure the physician's orders for the route of medication administration for Resident 10 were accurate. The medication route was ordered to be oral instead of via the GT. These failures had the potential to negatively affect the residents' health. Findings: 1. Review of the facility's P&P Manual for Long Term Care: Medications revised 10/2018 under Ordering and Receiving Medications from Pharmacy - Promptness of Availability of New Orders, page 14, showed all new drug orders other than those specified here- in, should be available the day ordered by the physician unless the drug would not normally be started until the next day. Review of the facility's P&P Manual for Long Term Care: Medications revised 10/2018 under Charting Doses Administered - General Principles, page 33, showed medications charted as unavailable should notify pharmacy, central supply as soon as possible, and/or get orders from MD to hold medication, or start when available. On 4/14/25 at 0845 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 9. Resident 9 stated she had chemotherapy for cancer and was stopped when she fell twice at home. Medical record review for Resident 9 was initiated on 4/16/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's MOS dated 3/30/25, showed a BIMS score of 15, which meant Resident 9 was cognitively intact. Review of Resident 9's Order Summary Report dated 4/15/25, showed a physician's order dated 4/5/25, for Biotene dry mouth moisturizing mouth/throat solution one spray by mouth three times a day for dry mouth. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's April 2025 MAR showed documentation of code 9 (chart code meaning: other/ see progress notes) on the following: - dated 4/5/25 at 0900, 1300, and 1700 hours; and - dated 4/6/25 at 0900 and 1300 hours. Review of Resident 9's progress note dated 4/5/25, showed Resident 9 complained of dry mouth, physician was made aware and ordered Biotene medication three times a day for dry mouth. The progress notes on 4/5/25 at 1214 hours and 4/6/25 at 0918 hours, showed waiting on the order and pending delivery, respectively. There were progress notes documented for the entries on 4/5/25 at 1300 hours and 1700 hours. In addition, there was no progress note documented for 4/6/25 at 1300 hours to explain the MAR documentation coded as 9. On 4/16/25 at 0920 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 9 verbalized that she was uncomfortable of her dry mouth and requested to have the Biotene medication. LVN 1 stated if the medication was not available, she will notify the physician. On 4/16/25 at 0928 hours, an interview and concurrent medical record and facility record review for Resident 9 was conducted with LVN 2. LVN 2 stated, usually if a medication was not delivered at night, she will call the pharmacy and ask when the medication will be delivered and will call the physician if the medication will not be available indefinitely. Reviewed with LVN 2 the facility's P&P on Charting Doses Administered on medications charted as unavailable showed, should notify the pharmacy or central supply ASAP, and/or get orders from the MD to hold the medications, or start when available. LVN 2 stated, But like this order of Biotene, it would not be necessary, to notify the resident's physician. On 4/16/25 at 1200 hours, an interview and concurrent medical record and facility document review for Resident 9 was conducted with the DON. The DON verified the documented entries in MAR for the Biotene medication dated 4/5 and 4/6/ 25, as not administered pending delivery and should have informed the physician as outlined in the facility's Medication P&P. 2. Review of the facility's P&P Manual for Long Term Care: Medications revised 10/2018 under Charting Doses Administered- General Principles page 33 and Charting Routine Medication Administration page 34, showed: - each dose administered to a Resident 5hall be properly recorded in the resident's medical record; - the initials of the nurse must be recorded on the front of the MAR in the proper column for the correct date and time of administration for each routine medication given. Review of Resident 36's medical record was initiated on 4/14/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's diagnoses showed Resident 36 had UTI as the admitting diagnosis and ESBL Resistance. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 36's Order Summary Report dated 4/15/25, showed a physician's order dated 4/13/25, for Ertapenem (an antibiotic medication to treat infections) Sodium Solution reconstituted 1 gram intravenously every 24 hours for UTI, ESBL for 24 days. Review of Resident 36's MAR for March and April 2025 showed undocumented Ertapenem IV administration as follows: - dated 3/12, 3/18, 3/19, and 4/16/25. On 4/17/25 at 0906 hours, an interview and concurrent medical record review for Resident 36 was conducted with RN 1. RN 1 verified there was no documentation to show Resident 36 received the Ertapenem medication as ordered by the physician for 3/12, 3/18. 3/19, and 4/16/25, a total of four doses. RN 1 further stated, Let me check it out. On 4/17/25 at 0919 hours, an interview and concurrent medical record review for Resident 36 was conducted with the DON. The DON verified the missing MAR documentations for the Ertapenem medication on 3/12, 3/18, 3/19, and 4/16/25. The DON stated, It is not signed. The DON further stated what was not documented was not done or not administered and will speak to the licensed nurses. The DON also stated the licensed nurses had to document right after administering the medications. 3. Review of the facility's P&P titled Medication Administration dated 10/2018 showed the complete act of medication administration included the licensed nurse to verify the medication to the prescriber's orders. Prior to the medication administration, the licensed nurse must compare the resident's MAR to the medication label. On 4/17/25 at 0808 hours, a medication administration observation for Resident 10 was conducted with LVN 2. LVN 2 was observed administering all the medications ordered by the physician for 0900 hours via the GT to Resident 10. Medical record review for Resident 10 was initiated on 4/15/25. Resident 10 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 4/4/25, showed Resident 10 had an enteral feeding tube and had a medical diagnosis of dysphagia. Review of Resident 10's Nutritional Evaluation V6 dated 4/4/25, showed Resident 10 should have the NPO diet due to the resident's swallowing problems. Review of Resident 1 O's Order Summary Report, showed the following physician's orders: - dated 4/2/25, to administer 650 mg of Tylenol (pain medication) by mouth every four hours as needed for general pain. - dated 4/2/25, to administer 30 ml of milk of magnesia (laxative medication) by mouth as needed for bowel management daily if no bowel movement in three days. - dated 4/5/25, to administer 30 ml of pro-stat (supplement) oral liquid by mouth one time a day for skin healing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's MAR for April 2025 showed Resident 10 was administered the Pro-Stat protein supplement from 4/6 to 4/17/25 at 0900 hours, and signed for by the licensed nurses as administered via the oral route. On 4/17/25 at 0829 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 2. LVN 2 reviewed Resident 10's medical record and verified the above findings. LVN 2 stated Resident 10 had a GT, and all of Resident 1 O's medications should be administered via GT. LVN 2 further stated the ordered route for the above medications should be changed to accurately reflect the care the resident was receiving, which was to receive the medications via GT. On 4/17/25 at 0832 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 1. RN 1 reviewed Resident 10's medical record and verified the above findings. On 4/17/25 at 1145 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings for Resident 10.

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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. 45064 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils had smooth cleanable surface and in good condition. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Resident Diet Information dated 4/14/25, showed 38 of 40 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed the dishes, trays and utensils shall be routinely checked for stains or spots. Chipped or cracked dishes, trays shall be discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/14/25 at 0804 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the RD and Chef de Cuisine. The following was observed and verified by the RD and Chef de Cuisine: - Three white basting brush used for butter spread were discolored, had frayed bristles and worn out. - Four rubber spatulas with red handles used for mixing food were stained, discolored, and worn out. - One white plastic spatula was chipped, cracked at the edges, old and worn out. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One stainless steel spatula with black handle was peeling and partially melted. - One clear plastic spatula was old and worn out. - Two stainless steel ice cream scoop was discolored, old and worn out. - One stainless steel spatula with white handle was deformed at the edges and handle was discolored and worn out. - Two slotted stainless steel serving spoon with black handle was peeling, discolored, and partially melted. - Two scoops with black handle used for food portioning was peeling, old and worn out. - One scoop with cream handle used for food portioning was discolored, peeling, old and worn out. The RD and Chef de Cuisine acknowledged the above findings and stated the worn out and old utensils should have been replaced and discarded for infection control purposes. 2. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed the cutting boards need to be washed and sanitized between each use. Replace cutting boards once lined with knife marks and they are un-sanitizable. Color-coded cutting boards are desirable designating boards for raw products versus cooked products. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 4/14/25 at 0804 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the RD and Chef de Cuisine. The white and yellow cutting boards were observed fuzzy, heavily marred and had deep groves. The RD and Chef de Cuisine verified the findings and stated the cutting boards should have been replaced for infection control purposes.

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	555922	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards Skilled Nursing	1 Amistad Drive Ladera Ranch, CA 92694

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. A plan to maximize recruitment and retention of direct care staff; and 3. A contingency plan for staffing needs. These failures had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, showed CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included a plan to maximize the recruitment and retention of the direct care staff member, and a contingency plan for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited, to the availability of direct care nurse staffing or other resources needed for resident care. Review of the Facility's assessment dated [DATE], failed to show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 4/16/25 at 1454 hours, an interview and concurrent review of the Facility Assessment was conducted with Administrator. The Administrator verified there were no direct care staff, direct care representatives, residents, residents' representatives, and residents' family members actively involved in developing the Facility Assessment. The Administrator further verified there were no plan to maximize the recruitment and retention of the direct care staff or include a contingency plan for the staffing needs. The Administrator verified the Facility assessment dated [DATE], and acknowledged the Facility Assessment was not updated based on the latest update from CMS

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 45064 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 14 final sampled residents (Resident 7) was accurate. * The facility failed to ensure Resident 7's information on the POLST form related to the Advanced Directive was accurate. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate. Findings: Review of facility's P&P titled Record Content dated 11/2017, showed the complete entries must be accurate. Medical record review for Resident 7 was initiated on 4/15/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's POLST dated 9/12/24, showed under Section D -Information and Signatures, the box for the Advance Directive not available was checked. On 4/15/25 at 1001 hours, an interview and concurrent medical record review for Resident 7 was conducted with the SSD. The SSD stated Resident 7 had an Advance Directive which was uploaded in the resident's EMR on 9/17/24. The SSD stated Resident 7's POLST Section D was inaccurate, and the box for Advance Directive was available and reviewed should have been checked and dated to reflect the accuracy of Resident 7's current medical record. The SSD verified the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of 14 final sampled resident (Resident 2) attained and maintained their highest practicable well-being. * The facility failed to coordinate the care of Resident 2 with the contracted hospice. The hospice calendar did not show complete SN and HA visits were provided as per the physician's orders. Furthermore, the facility failed to ensure staff awareness of the facility's hospice designee/coordinator. These failures posed the risk of Resident 2 not receiving the necessary hospice care and services. Findings: Review of the facility's P&P titled Palliative/End of Life Care Protocol revised 3/24/21, showed the community and hospice will identify the specific services that will be provided by each entity and this information will be communicated with the resident and family, and in the plan of care. Review of the Nursing Facility Services Agreement between the facility and Hospice Provider A with the effective date of 4/21/23, showed the following: - Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Inpatient Services furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge. Review of the facility's documents showed the hospice coordinator/designee was the SSD. Medical record review for Resident 2 was initiated on 4/14/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 2/8/25, showed Resident 2 had no capacity to make health care/medical decisions; however, the resident could make simple needs known. Review of Resident 2's Order Summary Report dated 4/14/25, showed a physician's order dated 3/19/25, to admit to Hospice Provider A on routine level of care for primary hospice diagnosis of Alzheimer's disease. Review of Resident 2's care plan report dated 4/1/25, showed the interventions included Hospice Provider A staff discipline visit frequencies as follows: SN visits one time a week and three times a week as needed for symptom management and HA visits two times a week for personal care/AOL care support. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1010 hours, an interview was conducted with LVN 1. LVN 1 was asked regarding the SN and HA visit frequency. LVN 1 stated the SN came once a week and as needed but unsure how often the HA came to the facility and visited Resident 2. LVN 1 verified the hospice calendars for March and April 2025 were not completely marked and did not show the days of SN and HA visits. LVN 1 stated the hospice calendar should have been marked accurately to know when the hospice team would see Resident 2. Furthermore, LVN 1 was asked who the facility's hospice designee/coordinator was, and responded that it was the DON. On 4/17/25 at 1251 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the facility's hospice designee/coordinator was the SSD.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45064 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the facility's monthly Infection Prevention and Control Surveillance Log was accurate. In addition, the facility failed to ensure the Surveillance Data Collection Form was complete and accurate to determine whether the resident's infection meet the McGeer's criteria for true infection. These failures posed the risk for not identifying resident infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other resident in the facility. Findings: Review of the facility's P&P titled Surveillance of Infections Protocol revised 9/24/24, showed the facility will track and trend for potential/actual infections and will monitor and take measures to prevent or minimize a potential outbreak. The Infection Control Surveillance Log is maintained by IP. The IP/DON/Designee will review the log and will trend all validated infections using the McGeer's criteria monthly. The Infection Control Committee will monitor and report to the QAPI Committee at least quarterly. 1. Review of the facility's monthly Infection Prevention and Control Surveillance Log showed inaccurate documentation for January and February 2025: For January 2025, the total number of residents who were screened as HAI were 13 and CAIs were 13. In addition, the total number of the residents who did not met the criteria for true infection were 10. However, the Infection Control Monthly Summary for January 2025 showed the total number of the residents who were assessed as HAis were nine and GAis were six. The total number of the resident who did not met the criteria for true infection was five. The data from the surveillance log did not match to the monthly reported data of infections of the facility. The reported percentage rate of infection of the facility was inaccurate for January 2025. For February 2025, the total number of the residents on the surveillance log who were screened as HAi's were nine and GAis were 15. In addition, the total number of the residents who did not met the criteria for true infection were 14. However, the Infection Control Monthly Summary for February 2025 showed the total number of the residents who were assessed as HAis and GAis had no data reported. The total number of the residents who did not met the criteria for true infection was five. The data from the surveillance log did not match with the monthly reported data of infections of the facility. The reported percentage rate of infection of the facility was inaccurate for February 2025. 2. Review of the facility document titled Surveillance Data Collection Form for Residents 47, 98,445, and 447 showed the following information: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For Resident 47, the Surveillance Data Collection Form dated 1/15/25, showed Resident 47 was administered with Flagyl (antibiotic) 500 mg every 12 hours for three days and cefuroxime (antibiotic) 250 mg by mouth every 12 hours for three days for pneumonia. The McGeer's criteria were met; however, the Surveillance Data Collection Form failed to show if Resident 47 had HAI or CAI. For Resident 98, the Surveillance Data Collection Form dated 2/3/25, showed Resident 98 was administered with cefuroxime (antibiotic) 500 mg by mouth every 12 hours for two days for UTI. The McGeer's criteria were not met; however, the Surveillance Data Collection Form failed to show if Resident 98 had HAI or CAI. For Resident 445, the Surveillance Data Collection Form dated 2/6/25, showed Resident 445 was administered with Flagyl (antibiotic) 500 mg every 12 hours for three days and Macrobid (antibiotic) 100 mg by mouth twice a day for seven days for UTI. The McGeer's criteria were met; however, the Surveillance Data Collection Form failed to show if Resident 445 had HAI or CAI. For Resident 447, the Surveillance Data Collection Form dated 1/29/25, showed Resident 447 was administered with Fluconazole (antibiotic) 100 mg tablet once a day for five days for UTI. The McGeer's criteria were met however, the Surveillance Data Collection Form failed to show if Resident 447 had HAI or CAI. On 4/17/25 at 0841 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated she used the McGeer's criteria to determine for a true infection for the residents. The IP stated the infection control summary was reported to the QAPI and used to determine the trend of the infection rate in the facility. The IP was informed of the reported numbers for the HAI and CAI on each month from the surveillance log not matching with the total numbers on the infection control monthly summary report for January and February 2025. The IP verified the numbers were inaccurate. The IP stated the numbers of the infection should have matched to the monthly summary report to ensure an accurate information about the infection control of the facility. The IP was asked to review the Surveillance Data Collection Form for Residents 47, 98, 445, and 447. The IP verified and acknowledged the forms were incomplete. On 4/17 /25 at 1253 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified and acknowledged the above findings.