| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>AMENDED 6/17/2025<br><br>The following reflects the findings of the California Department of Public Health during an annual recertification survey and during the investigation of a complaint on 5/27/2025 through 5/30/2025.<br><br>Complaint Numbers: CA00965415<br><br>One deficiency was issued for complaint number CA00965415 (see F880)<br><br>Facility Census: 49<br><br>Resident Sample Size: 13<br><br>Highest scope and severity: E | F 000 | Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law. | |
| F 552 SS=D | Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)<br><br>§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:<br><br>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.<br><br>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.<br><br>§483.10(c)(5) The right to be informed in | F 552 | F552 – Right to be informed/ Make Treatment Decisions<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 5/30/25, the Quality Assurance Nurse (QAN) offered and secured the consent from Resident 45 regarding the Celexa medication. (Exhibit #1) | 06/20/25 |

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

JC Frances C. Baloy, Administrator 06/20/2025

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.

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| F 552 | Continued From page 1<br>advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on the interview and record review, the facility did not obtain informed consent for one of the five residents (Resident 45) who was diagnosed with depression-a mood disorder characterized by persistent sadness and loss of interest that can affect daily life-and was being treated with the medication Celexa (a medication that treats depression) .<br><br>This deficient practice had the potential for Resident 45 to not be informed of the risks and benefits of Celexa.<br><br>Findings:<br><br>During a review of Resident 45's Admission Record (Face Sheet), the Admission Record indicated Resident 45 was admitted to the facility 1/28/2025 with diagnoses of paroxysmal atrial fibrillation (a rapid and irregular heartbeat), coronary artery disease (CAD, a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), and congestive heart failure (CHF, a serious condition in which the heart doesn't pump blood as efficiently as it should).<br><br>During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 45 was cognitively (mental action or process of acquiring | F 552 | • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/2/25, the Social Service Director (SSD) and QAN reviewed the list of residents with psychoactive medications orders to ensure that informed consents were signed and obtained. (Exhibit #2)<br><br>- No other resident was affected of the same deficient practice.<br><br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25 and 6/18/25, the Director of Nursing (DON) provided in services to the licensed nurses regarding the facility's policy and procedure (P&P) titled "Use of Psychotropic Medications" dated 3/17/2025. (Exhibit #3)<br><br>- Starting on 6/16/25, the SSD will conduct a weekly review for three months of the informed consents for those residents who will be receiving psychoactive medications orders. In addition, the SSD will review the informed consents of the newly admitted residents. (Exhibit #4)<br><br>- Starting on 6/16/25, the SSD will report to the administrator any non-compliance. | |

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| F 552 | Continued From page 2<br>knowledge and understanding through thought, experience, and the senses) intact and was taking antidepressant medication.<br><br>During a review of Resident 45's Order Summary Report, the Order Summary Report indicated a physician order was placed on 2/12/2025 for Celexa Oral tablet 20 milligrams (mg, a unit of measurement), give 1 tablet by mouth one time a day for depression manifested by low interest and motivation with activities of daily living (ADLs, self-care activities).<br><br>During an interview and record review on 5/30/2025 at 11:53 a.m., the Quality Assurance Nurse (QAN) stated that informed consent for Resident 45's Celexa medication was not obtained. The QAN stated that informed consent was required before starting the medication, but it was not obtained. Informed consents are important to ensure residents are aware of the medication's risks and benefits.<br><br>During a review of the facility's policy and procedure (P/P) titled "Use of Psychotropic Medications" dated 12/2022, the P/P indicated a psychotropic medication was any drug that affects brain activities associated with mental process or behavior and include antidepressants. The P/P indicated prior to initiating a psychotropic medication, the resident, family, and/or resident representative must be informed of the risk and benefits of the medication and it was to be documented in the resident chart. | F 552 | • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The SSD will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans | F 656 | | |

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| F 656 | Continued From page 3<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this | F 656 | F656 – Develop/Implement Comprehensive Care Plan<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 6/2/25, the Quality Assurance Nurse (QAN) added the monitoring of the side effect for Apixaban which included monitoring bleeding for Resident 45. (Exhibit #5)<br><br>- On 5/29/25, the Registered Nurse Supervisor 1 (RNS1) added the bowel incontinence and bowel and bladder retraining in the care plan for Resident 10 and Resident 44. (Exhibit #6)<br><br>- On 5/30/25, the Director of Nursing (DON) included the hypoglycemia monitoring in the care plan for Resident 23. (Exhibit #7)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/17/25, the Director of Staff Development (DSD) and QAN and reviewed the list of residents with anticoagulants, possible candidates for bowel and bladder retraining and residents at risk for hypoglycemia to ensure care plans were completed accurately. (Exhibit #8)<br><br>- No other resident affected of the same deficient practice. | 06/20/25 |

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| F 656 | Continued From page 4<br>section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for four out of seventeen sampled residents (Resident 10, Resident 23, Resident 44, and Resident 45) related to:<br><br>1. Resident 45's usage of Apixaban (a blood thinner medication).<br><br>2. develop and implement care plans of bowel and bladder retraining and bowel incontinent for Resident 10.<br><br>3. develop and implement care plans of bowel and bladder retraining and bowel incontinent for Resident 44.<br><br>4. develop and implement care plans of hypoglycemia [a condition in which a person's blood sugar (glucose) level is lower than normal] for Resident 23.<br><br>These deficient practices could result in the Resident's needs not being met, negatively impacting their well-being, and leading to suboptimal patient outcomes.<br><br>Findings:<br><br>1. During a review of Resident 45's Admission | F 656 | • What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25 and 6/18/25, the Director of Nursing (DON) provided in services to the active licensed nurses regarding the facility's policy and procedure (P&P) titled "Comprehensive Care Plans" dated 12/19/2022. (Exhibit #9)<br><br>- Starting on 6/17/25, the DON and QAN will conduct a weekly review for three months to ensure care plan was developed and implemented particularly to anticoagulant medications, hypoglycemia and bowel and bladder assessment and training program. (Exhibit #10)<br><br>- Starting on 6/17/25, the DON will report to the administrator any non-compliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The DON will discuss any trends or patterns during the monthly QA committee meeting for three months for | |

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| F 656 | Continued From page 5<br>Record (Face Sheet), the Admission Record indicated Resident 45 was admitted to the facility 1/28/2025 with diagnoses of paroxysmal atrial fibrillation (a rapid and irregular heartbeat), coronary artery disease (CAD, a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), and congestive heart failure (CHF, a serious condition in which the heart doesn't pump blood as efficiently as it should).<br><br>During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 45 was cognitively (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and was taking anticoagulant (blood thinning) medication.<br><br>During a review of Resident 45's Order Summary Report, the Order Summary Report indicated a physician order was placed on 2/14/2025 for Apixaban Oral Tablet 5 milligrams (mg, a unit of measurement), give one tablet by mouth twice a day for CAD.<br><br>During an interview and concurrent record review of Resident 45's care plans on 5/30/2025 at 11:53 a.m., the Quality Assurance Nurse (QAN) stated Resident 45 was receiving the anticoagulant medication Apixaban but Resident 45's care plan for Apixaban was not comprehensive and person-centered. The QAN stated Resident 45's care plan related to Apixaban was missing information on monitoring for side effects including bleeding. The QAN stated a comprehensive person-centered care plan for blood thinners was important because it | F 656 | review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 656 | Continued From page 6 | F 656 | | |

informed the nursing staff what to monitor for and to look for any side effects and the interventions needed.

2. During a review of Resident 10's Admission Record, the Admission Record indicated, Resident 10 was initially admitted to the facility on 3/31/2023 and last re-admission was on 5/27/2023 with diagnoses including urinary retention (a condition in which you are unable to empty all the urine from your bladder) and multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord).

During a review of Resident 10's History and Physical (H&P) , dated 5/28/2024, the H&P indicated, Resident 10 had the capacity (ability) to understand and make decisions.

During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 10 required dependent assistance (Helper does all of the effort) from two or more staff for hygiene, dressing, bed mobility, transfer, and setup or clen-up assistance (Helper sets up or cleans up) from one staff for eating. The MDS section H (Bladder and Bowel) indicated, had no trail of a toileting program (scheduled toileting, prompted voiding, or bladder training).

During a concurrent interview and record review on 5/29/2025, at 2:27 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 10's Bowel and Bladder Assessment , dated 10/20/2023 was reviewed. The Bowel and Bladder Assessment indicated, Resident 10 was frequently incontinent

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| F 656 | Continued From page 7 | F 656 | | |

for bladder and frequently incontinent for bowel (two or more episodes, but with one continent episode per week). The Bowel and Bladder Assessment indicated, Resident's assessment score was 10 and she was a candidate for prompted retraining. RNS 1 stated, Resident 10 should have been placed in bowel and bladder program as the assessment on 10/20/2023 and the care plan should be initiated for retraining.

During a concurrent interview and record review on 5/29/2025, at 3:05 p.m., with RNS 1, Resident 10's Care Plan (CP) , dated from 10/2024 to 5/29/2025, there was no care plan for bowel incontinence and bowel and bladder retraining. RNS 1 stated, Care plan is the residents' plan of care and if it is not initiated or updated, it might delay the treatment. stated, staff should have initiated or update Estrada's care plan for bowel incontinence and retraining.

3. During a review of Resident 44's Admission Record, the Admission Record indicated, Resident 44 was initially admitted to the facility on 1/9/2025 and last re-admission was on 3/31/2025 with diagnoses including Myasthenia Gravis (a rare long-term condition that causes muscle weakness) and urinary tract infection (UTI- an infection in the bladder/urinary tract).

During a review of Resident 44's H&P, dated 1/10/2025, the H&P indicated, Resident 44 had the capacity (ability) to understand and make decisions.
During a review of Resident 44's MDS dated 4/7/2025, the MDS indicated Resident 44 required dependent assistance (Helper does all of the effort) from two or more staff for toilet

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| F 656 | Continued From page 8<br>hygiene, dressing, bed mobility, transfer, and moderate assistance (Helper dose less than half the effort) from one staff for personal hygiene.<br><br>During a concurrent interview and record review on 5/29/2025, at 2:37 p.m., with RNS 1, Resident 44's MDS , dated 2/16/2025 and 4/7/2025 were reviewed. The MDS dated on 2/16/2025, indicated, Resident 44 had urine incontinence frequently and bowel incontinence frequently. The MDS dated 4/7/2025 indicated that Resident 44 had not undergone a toileting program trial and was always continent. RNS 1 noted a change in Resident 44's condition from frequent incontinence to constant incontinence. RNS 1 stated, Resident 44 should have received bowel and bladder training before she had further declined. RNS 1 stated, the staff should have initiated and implemented the care plan for bowel and bladder retraining.<br>During a concurrent interview and record review on 5/29/2025, at 3:05 p.m., with RNS 1, Resident 10's Care Plan (CP) , dated from 1/9/2025 to 5/29/2025, there was no care plan for bowel incontinence and bowel and bladder retraining. stated, staff should have initiated or updated Zazueta's care plan for bowel incontinence. RNS 1stated, there was no care plan for bowel incontinence and retraining. stated, any concern with the resident should be care planned. RNS 1 stated, care plan is the resident's care of plan. RNS 1 stated, all care plan interventions should be implemented, and all interventions practiced should be in care plan. RNS 1 stated, care planning was important because the care plan ensure that the resident received the most appropriate and effective care as it planned.<br>4. During a review of Resident 23's Admission | F 656 | | |

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| F 656 | Continued From page 9<br>Record, the Admission Record indicated, Resident 23 was initially admitted to the facility on 8/9/2024 and last re-admission was on 11/2/2024 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities).<br>During a review of Resident 23's History and Physical (H&P) , dated 11/2/2024, the H&P indicated, Resident 23 had the capacity (ability) to understand and make decisions.<br>During a review of Resident 23's Minimum Data Set ([MDS]-a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 23 required dependent assistance (Helper does all of the effort) from two or more staff for bed mobility, transfer, hygiene, dressing, and moderate assistance (Helper does less than half the effort.) from one staff for eating.<br>During a concurrent interview and record review on 5/29/2025, at 2:17 p.m., with RNS 1, Resident 23's Care Plan (CP) and Nurses Progress Notes (NPN) , dated from 10/2024 to 5/2025 (CP) and 10/31/2024 (NPN) were reviewed.<br>Nurses progress Notes, dated 10/31/2024, indicated, Resident 23's blood glucose was 40 milligram per deciliter (mg/dl) on 10/31/2024 at 9:10 p.m. The Nurses Progress Notes indicated, the staff noticed Resident 23 was unresponsive around 8:56 p.m. and checked vital signs for blood pressure, respiration rate, heart rate, oxygen level. The Nurses Progress Notes indicated, Paramedic arrived at 9:03 p.m. and Blood sugar level was 40 mg/dl. The Care Plan dated from 10/2024 to 5/2025, indicated, there was no care plan for hypoglycemia. RNS 1 stated, there was no care plan for hypoglycemia. | F 656 | | |

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| F 656 | Continued From page 10<br>RNS 1 stated, significant event should be care planned and intervention should be implemented for each specific care plan.<br>During an interview on May 30, 2025, at 4:08 p.m., the Director of Nursing (DON) explained that a resident's care plan is a specific plan of care that should be implemented as stated. The DON mentioned that care plan interventions need to be carried out and reevaluated. The interventions are discussed and decided upon during Interdisciplinary Team {(IDT) meetings, which involve team members from different disciplines collaborating with a common purpose to set goals, make decisions, and share resources and responsibilities}. These interventions aim to prevent recurrent events or issues.<br>During a review of the facility's policy and procedure (P/P) titled Comprehensive Care Plans dated 12/19/2022, the P/P indicated it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. | F 656 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record reviews, the | F 658 | F658 – Services Provided Meet Professional Standard<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- Resident 23 was transferred to acute and returned to the facility on 11/2/24. Resident 23 has no hypoglycemic | 06/20/25 |

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| | 055758 | A. BUILDING _____ B. WING _____ | 05/30/2025 |

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| F 658 | Continued From page 11<br>facility did not ensure that residents received appropriate treatment and care for hypoglycemic episodes in accordance with professional standards of practice. Specifically, for one of three sampled residents (Resident 23), the facility failed to ensure the resident consumed a meal after receiving insulin and did not monitor blood glucose levels or provide necessary treatment during the hypoglycemic episode.<br><br>This failure led to Resident 23's preventable hospitalization for further evaluation and treatment.<br><br>Findings:<br><br>During a review of Resident 23's Admission Record, the Admission Record indicated, Resident 23 was initially admitted to the facility on 8/9/2024 and last re-admission was on 11/2/2024 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 23's History and Physical (H&P), dated 11/2/2024, the H&P indicated, Resident 23 had the capacity (ability) to understand and make decisions.<br><br>During a review of Resident 23's Minimum Data Set ([MDS]-a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 23 required dependent assistance (Helper does all of the effort) from two or more staff for bed mobility, transfer, hygiene, dressing, and moderate assistance (Helper does less than half | F 658 | episode after returning from acute. The care plan was developed and implemented. (Exhibit #11)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/17/25, the Director of Staff Development (DSD) and Quality Assurance Nurse (QAN) reviewed the list of residents receiving insulin injection to ensure blood sugar monitoring was done and meal was offered after the insulin injection to prevent hypoglycemia episode. (Exhibit #12)<br><br>- No other resident affected of the same deficient practice.<br><br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25 and 6/18/25, the Director of Nursing (DON) provided in services to the active licensed nurses regarding the facility's policy and procedure (P&P) titled "Hypoglycemia Management," revised 12/19/2022. (Exhibit #13)<br><br>- Starting on 6/17/25, the QAN and DSD will conduct a weekly observation for three months to ensure licensed nurses are offering food and snacks after the insulin injection. (Exhibit #14) | |

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| F 658 | Continued From page 12<br>the effort.) from one staff for eating.<br><br>During a concurrent interview and record review on 5/29/2025, at 2:17 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 23's Transfer Form (TF) and Nurses Progress Notes (NPN) , both dated 10/31/2024 were reviewed. Transfer Form indicated, Resident 23's blood glucose was 40 milligram per deciliter (mg/dl) on 10/31/2024 at 9:10 p.m. The Nurses Progress Notes indicated, the staff noticed Resident 23 was unresponsive around 8:56 p.m. and checked vital signs for blood pressure, respiration rate, heart rate, oxygen level. The Nurses Progress Notes indicated, Paramedic arrived at 9:03 p.m. and Blood sugar level was 40 mg/dl. RNS 1 stated, the nursing staff should have checked blood glucose level as soon as they found the resident unresponsive to rule out hypoglycemic episode. RNS 1 indicated that the staff should have consulted the primary physician for Glucagon, a medication that increases blood sugar levels, to address hypoglycemic episodes promptly and prevent delays in treatment. RNS 1 stated, staff probably forgot to check the blood glucose level until paramedics arrived. RNS 1 stated, if Resident 23 was assessed and treated earlier, the resident might not need to be transferred to General Acute Care Hospital (GACH).<br><br>During a concurrent interview and record review on 5/30/2025, at 10:01 a.m., with Director of Staff Development (DSD), Resident 23's Medication Administration Record (MAR) and Documentation Survey Report (as known as Activities of Daily Living flowsheet) , both dated 10/31/2025 were reviewed. The Medication | F 658 | - Starting on 6/17/25, the DON will conduct weekly review for three months to ensure residents receiving insulin will not have any hypoglycemic episode. If identified with hypoglycemic episode, a change of condition will be created, care plan will be revised and responsible party and physician will be notified for possible adjustment of the insulin. (Exhibit #15)<br><br>- Starting on 6/17//25, the DON will report to the administrator for any non-compliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>-The DON will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 658 | Continued From page 13<br>Administration Record indicated, Resident 23 received eight units of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) because his blood glucose level was 302 mg/dl on 10/31/2024 at 4:30 p.m. The Documentation Survey Report (ADLs Flowsheet) indicated, Resident 23 ate zero percent of dinner on 10/31/2024 at 5 p.m. DSD stated, staff should have ensured that resident ate the meal after giving insulin to prevent hypoglycemic episode. stated, staff should have contacted doctor to use Glucagon from Emergency Medication Kit (E-kit- a portable kit containing a small quantity of medications that can be dispensed when pharmacy services are not available) from medication storage room.<br><br>During an interview on 5/30/2025, at 4:08 p.m., with Director of Nursing (DON), DON stated, staff should have got Glucagon prn order for emergency. DON stated, staff should have ensured the resident had eaten his meal after giving insulin to prevent hypoglycemia [a condition in which a person's blood sugar (glucose) level is lower than normal]. stated, staff should have checked blood glucose as soon as found him unresponsive, not after the paramedics arrived to treat immediately. DON stated, if the staff provided all the necessary care and treatment in timely manner, the resident might not need to be transferred to GACH.<br><br>During a review of Resident 23's Order Summary Report (OSR) dated 5/29/2025, it was noted that an order to monitor for signs and symptoms of hypoglycemia including confusion, sweating, shakiness, and unresponsiveness was placed on | F 658 | | |

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| F 658 | Continued From page 14 | F 658 | | |

5/3/2025. The Order Summary Report also indicated that there was no order for Glucagon or any medication to treat hypoglycemia.

During a review of Resident 23's Care Plan (CP) , dated from 10/1/2024 to 5/27/2025, the Care Plan indicated, there was no care plan for hypoglycemia.
During a review of the facility's Policy and Procedure (P&P) titled, Hypoglycemia Management , revised 12/19/2022, the P&P indicated, Policy: It is the policy of this facility to ensure effective management of a resident who experiences a hypoglycemic episode ...Effective management of hypoglycemia is important to ensure that the resident does not have further decline in their condition. Compliance Guidelines: 3. Residents that have a diagnosis of diabetes or on medications that could lower the blood sugar should have orders for glucose monitoring and treatment of hypoglycemia, unless otherwise ordered by the practitioner ... 5.If the blood glucose reading is 70 mg/dL or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's orders, with follow up blood glucoses as indicated, and notify the practitioner of the results as ordered.

During a review of the facility's Policy and Procedure (P&P) titled, Nursing Care of the Resident with Diabetes Mellitus , revised 12/19/2022, the P&P indicated, Conditions Associated with Diabetes: The following complications are associated with diabetes: 3. Hypoglycemia (blood sugar below reference ranges). Signs and symptoms of hypoglycemia usually have a sudden onset and may include the following: stupor, unconsciousness and/or

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| F 658 | Continued From page 15<br>convulsions; and coma... Glucose monitoring: 3. Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. | F 658 | | |
| F 690 SS=E | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must | F 690 | F690 – Bowel/Bladder Incontinence, Catheter, UTI<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 6/16/25, the Director of Nursing (DON) conducted a bowel and bladder assessment for Resident 3, 10, and 44. The respective residents were offered bowel and bladder training. (Exhibit #16)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/17/25, the Director of Staff Development (DSD) and Quality Assurance Nurse (QAN) reviewed the bowel and bladder assessments of the resident. The bowel and bladder training were offered to those residents that qualified for the bowel and bladder program. (Exhibit #17)<br><br>- No other resident affected of the same deficient practice. | 06/20/25 |

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| F 690 | Continued From page 16<br>ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure three of three sampled residents (Resident 10, Resident 44, and Resident 3) who were incontinent (unable to voluntarily control retention of urine or feces in the body) of bowel and bladder, were provided a retraining and/or toileting program to regain the resident's normal bowel and bladder function as much as possible by failing to:<br><br>A. ensure Resident 10's bowel and bladder assessment was done and follow through quarterly, and Resident 10 received bowel and bladder retraining as the assessment indicated.<br><br>B. Ensure Resident 44's bowel and bladder assessment was conducted upon admission, and that Resident 44 participated in the bowel and bladder retraining program.<br><br>C. Ensure Resident 3 was offered a bowel and bladder training to restore as much bladder function as possible.<br><br>This failure had a potential to result in Resident 10, Resident 44, and Resident 3's inability to regain control of bowel and bladder function and can lead to a loss of dignity.<br><br>Findings:<br><br>A. During a review of Resident 10's Admission | F 690 | • What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25 and 6/18/25, the Director of Nursing (DON) provided in services to the active licensed nurses regarding the facility's policy and procedure (P&P) titled "Bladder and Bowel Incontinence: A Care Solution," Copyright 2022. (Exhibit #18)<br><br>- Beginning on 6/17/25, the Minimum Data Set Director (MDSD) will review the bowel and bladder assessment of the residents weekly for three months to identify those residents who are good candidates for bowel and bladder training program. The MDSD will include those residents who are newly admitted in the facility. (Exhibit #19)<br><br>- Starting on 6/17/25, the MDSD will report to the administrator for any non-compliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The MDSD will discuss any trends or patterns during the monthly QA | |

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| F 690 | Continued From page 17<br>Record, the Admission Record indicated, Resident 10 was initially admitted to the facility on 3/31/2023 and last re-admission was on 5/27/2023 with diagnoses including urinary retention (a condition in which you are unable to empty all the urine from your bladder) and multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord).<br><br>During a review of Resident 10's History and Physical (H&P) , dated 5/28/2024, the H&P indicated, Resident 10 had the capacity (ability) to understand and make decisions.<br><br>During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 10 required dependent assistance (Helper does all of the effort) from two or more staff for hygiene, dressing, bed mobility, transfer, and setup or clen-up assistance (Helper sets up or cleans up) from one staff for eating. The MDS section H (Bladder and Bowel) indicated, had no trail of a toileting program (scheduled toileting, prompted voiding, or bladder training). The MDS section H indicated, Resident 10 had urinary incontinent frequently (seven or more episodes of incontinence, but at least one episode of continent voiding) and bowel incontinent always.<br><br>During an interview on 5/27/2025, at 11:10 a.m., with Resident 10, in Resident 10's room, Resident 10 stated, she did not want to talk about her incontinence issue because it made her feel embarrassed.<br><br>During a concurrent interview and record review | F 690 | committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 690 | Continued From page 18<br>on 5/29/2025, at 2:27 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 10's Bowel and Bladder Assessment , dated 10/20/2023 and 4/3/2024 were reviewed. The Bowel and Bladder Assessment on 10/20/2023 showed Resident 10 was frequently incontinent for both bladder and bowel, with two or more episodes but at least one continent episode per week. The Bowel and Bladder Assessment, dated 10/20/2023, indicated, Resident's assessment score was 10 and she was a candidate for prompted retraining. The Bowel and Bladder Assessment, dated 4/3/2024, indicated, there was no score or indication of the candidate for retaining or not. RNS 1 stated, the assessment on 4/3/2024 was not completed and there should be the follow up assessment at least yearly. RNS 1 stated, there were no residents in retraining program and did not know why.<br><br>During a review of Resident 10's Order Summary Report (OSR) , dated 5/29/2025, the Order Summary Report indicated, there was no order for bowel and bladder retraining.<br><br>During a review of Resident 10's Care Plan (CP) , dated from 10/2024 to 5/29/2025, there was no care plan for bowel and bladder retraining.<br><br>B. During a review of Resident 44's Admission Record, the Admission Record indicated, Resident 44 was initially admitted to the facility on 1/9/2025 and last re-admission was on 3/31/2025 with diagnoses including Myasthenia Gravis (a rare long-term condition that causes muscle weakness) and urinary tract infection (UTI- an infection in the bladder/urinary tract). | F 690 | | |

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| F 690 | Continued From page 19<br>During a review of Resident 44's H&P, dated 1/10/2025, the H&P indicated, Resident 44 had the capacity (ability) to understand and make decisions.<br><br>During a review of Resident 44's MDS), dated 4/7/2025, the MDS indicated Resident 44 required dependent assistance (Helper does all of the effort) from two or more staff for toilet hygiene, dressing, bed mobility, transfer, and moderate assistance (Helper dose less than half the effort) from one staff for personal hygiene.<br><br>During a concurrent interview and record review on 5/29/2025, at 2:37 p.m., with RNS 1, Resident 44's MDS section H , dated 2/16/2025 and 4/7/2025 were reviewed. The MDS section H, dated on 2/16/2025, indicated, Resident 44 had urine incontinence frequently and bowel incontinence frequently. The MDS section H, dated 4/7/2025, indicated, Resident 44 had no trial of a toileting program and Resident 44 had bowel and bladder continence always. RNS 1 stated, there was a change of Resident 44's from frequent incontinence to always incontinence. RNS 1 stated, Resident 44 should have received bowel and bladder training before she had further declined.<br><br>During a concurrent interview and record review on 5/29/2025, at 2:50 p.m., with RNS 1, Resident 44's Bowel and Bladder Assessment , dated 1/26/2025 was reviewed. The Bowel and Bladder Assessment indicated, there was no bowel and bladder score and no indication of a candidate for retraining or not. RNS 1 stated, there should be a new assessment done after change of condition noted on MDS, dated 4/7/2025. RNS 1 stated, it | F 690 | | |

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| F 690 | Continued From page 20 | F 690 | | |

was important to provide bowel and bladder retraining program to residents to promote resident's well-being and maintain their function to prevent further decline.

During an interview on 5/30/2025, at 4:08 p.m., with Director of Nursing (DON), DON stated, the staff should screen the resident for bowel and bladder function and placed the resident in retraining program if the resident screened as a possible candidate. DON stated, retraining program was important to preserve current level of function, to prevent further decline, and to promote achieving highest functional level. DON stated, the facility currently had no one in retraining program and did not have any policy and procedure. DON stated, the facility should have the system to recognize the candidate and provided standardized retraining program. DON stated the staff were following education material as a policy.

During a review of Resident 44's Order Summary Report (OSR) , dated 5/29/2025, the Order Summary Report indicated, there was no order for bowel and bladder retraining.

During a review of Resident 44's Care Plan (CP) , dated from 1/9/2025 to 5/29/2025, there was no care plan for bowel and bladder retraining.

c. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on 5/16/2018 with a diagnosis including chronic kidney disease stage 4 (severe kidney damage), type 2 diabetes mellitus with hyperglycemia (chronic condition where blood sugars are

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| F 690 | Continued From page 21 | F 690 | | |

consistently high), and hypertension (high blood pressure).

During a review of Resident 3's MDS, dated 5 /4 /2025, the MDS indicated Resident 3's cognition was moderately impaired. The MDS indicated Resident 3 was dependent (resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) with toilet hygiene, lower body dressing, putting on and taking off footwear and substantial / maximal assistance ( helper lifts or holds trunk or limbs and provides more than half the effort with upper body dressing).

During a record review of Resident 3's Care Plan Report (CPR), the CPR dated 6/20/2022 indicated a focus on bowel incontinence (inability to control bowel movements ) with a goal indicating the resident would be continent (ability to control your bowel and bladder) during daytime through the reviewing date. The intervention was to take resident to toilet at the same time each day the resident usually has a bowel movement.

During a record review of Resident 3's B&B assessment form dated 10/20/2023 Resident 3 had a score of 10 indicating she was a candidate for prompt toileting. The bowel and bladders assessments since the one dated 10/20/2023, were incomplete, one dated 9/17/2024 and 9/17/2024 were both incomplete.

During an interview and record review on 5/30/2025 at 10:44 a.m., with the Director of staff development (DSD), the DSD stated Resident

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3's Bowel and Bladder assessment form indicated the resident was a candidate for the bowel and bladder training program. The DSD stated when a resident is a candidate, they are placed on the DSD's task sheet, and the DSD would notify the Certified Nurse Assistant (CNA) and the Licensed Vocational Nurse (LVN) so there was a B&B program in place. The DSD stated she did not know why Resident 3 was not getting B&B training. The DSD stated because Resident 3 did not get B&B training, the resident could be at risk for skin breakdown which can also lead to a dignity issue.

During an interview on 5/30/2025 at 4:09 p.m., with the DON, the DON indicated if there has been an assessment and the resident is a candidate the facility should try B&B training for the resident. The DON stated it as important for facility staff to carry out assessments and implement.

During a review of the facility's Policy and Procedure (P&P) titled, Bladder and Bowel Incontinence: A Care Solution , dated 2022, the P&P indicated, Introduction: resident experiencing incontinence may have feelings of shame, embarrassment, a loss of independence and may isolate themselves due to fear of accidents. ... Restorative Toileting Program: These programs are individualized, resident-centered, and communicated to the staff and resident. They must be care planned and reevaluated at least quarterly and whenever there is a change in the resident's cognition, continence, or activity of daily living (ADL) status. The use of the bladder/bowel assessment,

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| F 690 | Continued From page 23<br>bladder and bowel diary and bladder/bowel tool can aid the restorative nurse in determining the best program for the resident and serve as part of the documentation of the program and its progress ...Care and Care Planning: Care planning for bladder and/or bowel incontinence must be resident centered and must incorporate their goals for care and updated accordingly. Care plans must take into account the results of the resident's assessment, interventions for any reversible causes and appropriate interventions for management of incontinence. | F 690 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. | F 755 | F755 – Pharmacy Services/Pharmacist/ Records<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 6/2/25, the Quality Assurance Nurse (QAN) included the monitoring for the anticoagulant medication for Resident 45. (Exhibit #20)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/17/25, the Director of Staff Development (DSD) and QAN reviewed the list of residents on anticoagulant medication to ensure monitoring for side effects, including bleeding, was included. (Exhibit #21) | 06/20/25 |

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| F 755 | Continued From page 24<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on the interview and record review, the facility did not monitor anticoagulant (blood thinning medication) usage for one out of six sampled residents (Resident 45).<br><br>This deficient practice had the potential for complications related to anticoagulant use including bleeding to go unnoticed for Resident 45.<br><br>Findings:<br><br>During a review of Resident 45's Admission Record (Face Sheet), the Admission Record indicated Resident 45 was admitted to the facility 1/28/2025 with diagnoses of paroxysmal atrial fibrillation (a rapid and irregular heartbeat), coronary artery disease (CAD, a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), and congestive heart failure (CHF, a serious condition in which the heart doesn't pump blood as efficiently as it should).<br><br>During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 45 was | F 755 | - No other resident affected of the same deficient practice.<br><br>• What measures put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25, the Director of Nursing (DON) provided in services to the active licensed nurses regarding the facility's policy and procedure (P&P) titled "Comprehensive Care Plans" dated 12/19/2022. (Exhibit #22)<br><br>- Beginning on 6/17/25, the QAN will review the care plan and electronic medication record (eMAR) weekly for three months of those residents who received anticoagulant medication to ensure monitoring for side effect including bleeding was indicated. (Exhibit #23)<br><br>- Starting on 6/17/25, the QAN will report to the administrator for any non-compliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The QAN will discuss any trends or | |

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| F 755 | Continued From page 25<br>cognitively (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and was taking anticoagulant (blood thinning) medication.<br><br>During a review of Resident 45's Order Summary Report, the Order Summary Report indicated a physician order was placed on 2/14/2025 for Apixaban Oral Tablet 5 milligrams (mg, a unit of measurement), give one tablet by mouth twice a day for CAD.<br><br>During an interview and concurrent record review of Resident 45's care plans, medication administration record (MAR), and Physician's Orders on 5/30/2025 at 11:53 a.m., the Quality Assurance Nurse (QAN) stated Resident 45 was receiving the anticoagulant medication Apixaban but Resident 45's care plan for Apixaban was not comprehensive and person-centered. The QAN stated Resident 45's care plan related to Apixaban was missing information on monitoring for side effects including bleeding. The QAN stated a comprehensive person-centered care plan for blood thinners was important because it informed the nursing staff what to monitor for and to look for any side effects and the interventions needed. The QAN stated it was important to monitor side effects of anticoagulants because the nursing staff needed to ensure there was no bleeding. The QAN stated after reviewing Resident 45's MAR and physician's orders, Resident 45 was not being monitored for anticoagulant side effects.<br><br>During an interview on 5/30/2025 at 4:09 p.m., the director of nursing (DON) stated it was important to monitor the side effects of | F 755 | patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 755 | Continued From page 26<br>anticoagulant usage because the resident needed to be monitored for any signs of bleeding or adverse reactions to the medication. The DON stated the potential outcome of not monitoring the resident for anticoagulant side effects was the resident could be bleeding, and the nursing staff would not know.<br><br>During a review of the facility's policy and procedure (P/P) titled "Comprehensive Care Plans" dated 12/19/2022, the P/P indicated it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. | F 755 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide | F 761 | F761 – Label/Store Drugs and Biologicals<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 5/29/25, the Licensed Vocational Nurse (LVN1) removed the Triamcinolone Acetonide External Cream 0.5% in the medication cart.<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/16/25 and 6/17/25, the Director of Staff Development (DSD) and Quality Assurance Nurse (QAN) conducted a | 06/20/25 |

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| F 761 | Continued From page 27<br>separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was noted that one tube of Triamcinolone Acetonide External Cream 0.5% (used to treat rashes) belonging to Resident 26 was not labeled or dated in medication cart 1.<br><br>This deficient practice had the potential for the medication to be used after it was expired.<br><br>Findings:<br><br>During a review of Resident 26's Admission record (face sheet), the Admission Record indicated Resident 26 was admitted to the facility 2/21/2025 with diagnoses of type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and history of falling.<br><br>During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 2/27/2025, the MDS indicated Resident 26 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions).<br><br>During a review of Resident 26's Physician's Orders, an order was placed 2/21/2025 for | F 761 | medication cart check to ensure medications stored were label accordingly and not expired. (Exhibit #24)<br><br>- No other resident affected of the same deficient practice.<br><br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/17/25 and 6/18/25, the Director of Nursing (DON) provided in services to the active licensed nurses regarding the facility's policy and procedure (P&P) titled "Labeling of Medications and Biologicals" dated 12/19/2022. (Exhibit #25)<br><br>- Beginning on 6/16/25, the QAN and DSD will conduct medication cart check weekly for three months to ensure medications stored were labeled accordingly and not expired. (Exhibit #26)<br><br>- Starting on 6/17/25, the QAN will report to the administrator for any noncompliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; | |

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| F 761 | Continued From page 28<br>Triamcinolone Acetonide External Cream 0.5 % (Triamcinolone Acetonide (Topical)) Apply to Rash topically (outside the body) every 12 hours as needed for Rash.<br><br>During an observation on 5/28/2025 at 2:19 p.m., a review of medication cart 1 with licensed vocational nurse (LVN) 1 was conducted. A tube of Triamcinolone Acetonide External Cream 0.5% was found in medication cart 1 without a label indicating Resident 26's name or the date the medication was opened.<br><br>During an interview on 5/30/2025 at 4:09 p.m., the director of nurses (DON) stated the Triamcinolone Acetonide External Cream 0.5 % that was found not to be labeled or dated on 5/28/2025 belonged to Resident 26. The DON stated that all medication carts needed labeled and dated medications. The pharmacy label should have included Resident 26's information on the medication tube.<br><br>During a review of the facility's policy and procedure (P/P) titled "Labeling of Medications and Biologicals" dated 12/19/2022, the P/P indicated all medications used in the facility were to be labeled and dated in accordance with state and federal regulations to facilitate consideration of precautions and safe administration of medications. The P/P indicated, labels for individual drug containers must include: The resident's name; The prescribing physician's name; The medication name (generic and/or brand name); The prescribed dose, strength, and quantity of the medication; The prescription number (if applicable); The date the drug was dispensed; appropriate instructions and | F 761 | - The QAN will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 761 | Continued From page 29<br>precautions (such as shake well, take with meals, do not crush, special storage instructions); the expiration date when applicable; and the route of administration . The P/P indicated, medications intended for external use must be clearly identified as such and be labeled FOR EXTERNAL USE ONLY. | F 761 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record reviews, it was determined that the facility did not store food in a sanitary manner, which is necessary to prevent the growth of microorganisms. These microorganisms can cause foodborne illnesses, such as those | F 812 | F812 – Food Procurement, Store/ Prepare/Serve- Sanitary<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 5/27/25, the Dietary Supervisor (DS) removed and discarded the food items identified without label and exceeded the used by dates.<br><br>- On 5/27/25, the DS called the attention of cook 2 (CK2) to perform hand hygiene and change gloves in between task.<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- Not applicable.<br><br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; | 06/20/25 |

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| F 812 | Continued From page 30<br>resulting from contaminated food with pathogenic bacteria, viruses, parasites, or toxins. This issue affected 47 out of the 50 residents at the facility due to the following deficiencies:<br>A. Ensuring food items were dated, labeled, and discarded properly.<br><br>B. Ensuring Cook (CK) 2 performed hand hygiene (washing Hands) and changed gloves between tasks during trayline (Resident's trays are assembled and check for accuracy before food is delivered to them).<br><br>This failure had the potential to impact residents, resulting in exposure to pathogens and placing them at risk for foodborne illnesses. Symptoms of such illnesses include upset stomach, cramps, nausea, vomiting, diarrhea, and fever, potentially leading to serious medical complications and hospitalization.<br><br>Findings:<br><br>A. During a concurrent observation and interview on 5/27/2025, at 8:22 a.m., with Dietary Supervisor (DS) in dry storage, some food items were not properly dated, labeled, sealed, or discarded for the following:<br><br>a. opened and used sundried tomatoes in a plastic bin with Receiving Date (RD) of 12/16/2024, no Open Date (OD), and Used By (UB) of 12/15/2025.<br><br>b. fresh vegetable (Yams/sweet potatoes) in a bin with RD of 5/13/2025 and UB 11/13/2025. one of the yams was damaged with cuts and inner part was exposed to air without sealing. | F 812 | - On 5/28/25, the Infection Prevention Nurse (IPN)/DS provided one on one in service to CK2 regarding the facility policy and procedure entitled, "Food Safety and Food Storage," revised 11/4/2024 and "Hand Hygiene," revised 12/19/2022. (Exhibit #35)<br><br>- On 5/28/25, the DS provided in-service to the active kitchen staff regarding the policy and procedure entitled, "Dry Storage Chart," dated 2023, "Refrigerated Storage Chart," dated 2020, "Date Marking for Food Safety," revised 12/19/2022, and "Food Storage", revised 8/29/2023. (Exhibit #36)<br><br>- Beginning on 6/17/25, the DS will conduct observations weekly for three months to ensure food items were stored and label accordingly. In addition, observation the kitchen staff perform hand hygiene and change gloves in between task. (Exhibit #37)<br><br>- Starting on 6/17/25, the DS will report to the administrator for any non-compliance.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; | |

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| F 812 | Continued From page 31<br><br>c. opened and used gold medal variety muffin mix in a box with RD 6/11/2024, no OD, and no UB. The manufacture recommended UB was 3/25/2025.<br><br>d. opened and used Alta Dena Low-fat Cultured Buttermilk in a pack with RD of 5/20/2025, OD of 5/22/2025, and UB of 6/4/2025.<br><br>DS stated, it was all dietary staff (including herself) responsibility to check all food items for labels, dates, properly stored and sealed. DS stated that these practices were necessary to ensure the food items remained in good condition, as they were consumed by the residents. DS stated, once the food items were opened, there should be different shelf life (a time limit on how long a product can be stored before it becomes unsuitable for consumption or use). DS stated, all staff should refer to "Dry Storage Chart" for shelf life after opening and labeled UB date on food items. DS stated that all food items should be labeled with the receiving date when delivered. Additionally, they must have an open date and a use-by (expiration) date.<br><br>During a concurrent observation and interview on 5/27/2025, at 8:39 a.m., with DS, in the refrigerator #1, there were food items that were not dated and discarded properly, as follows:<br>a. opened and used pasteurized (a process in which heat is applied to foods and drinks to kill pathogens) eggs in a box with RD of 4/29/2025 and no UB.<br><br>b. opened and used snap peas in a zip lock bag with RD 5/13/2025, OD 5/18/2025, and no UB | F 812 | - The DS will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 812 | Continued From page 32<br>DS stated, all food items should be dated, and dietary staff should follow "Refrigerated Storage Chart" to ensure safety of perishable items that required refrigeration.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Dry Storage Chart", dated 2023, the P&P indicated, opened dried vegetables' shelf life was one year and keep cool airtight container, if possible, refrigerate. The P&P indicated, fresh vegetables (sweet potatoes' shelf life was two to four weeks. The P&P stated, opened muffin mix's shelf life was nine month and store in airtight container. The P&P indicated, the buttermilk should be refrigerated.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Refrigerated Storage Chart", dated 2020, the P&P indicated, opened buttermilk's shelf life was three to five days. The P&P indicated fresh eggs' shelf life was two to three weeks and store in covered containers. The P&P indicated, peas' shelf life was three to five days.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Date Marking for Food Safety", revised 12/19/2022, the P&P indicated, "Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food ...Policy explanation and Compliance Guidelines for Staffing: 2. The food shall be clearly marked to indicate the date or day b which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall | F 812 | | |

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| F 812 | Continued From page 33 | F 812 | | |

include the date of opening, and the date the item must be consumed or discarded or may refer to the food storage charts posted as the use by dates if manufacturer expiration dates are not present, the food storage charts are the used by dates. 5. The discard date may not exceed the manufacturer's use by date, whichever is earliest. The date of opening counts as day 1."

During a review of the facility's policy and procedure (P&P) titled, "Food Storage", revised 8/29/2023, the P&P indicated, "Policy: Any expired or outdated food products should be discarded ...Procedure: All products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared. Use Use-By dates on all food stored in refrigerators and use dates according to the timetable in the dry, refrigerated, and freezer storage charts."

B. During a concurrent observation and interview on 5/27/2025, at 12:28 p.m., with Cook (CK) 2 in the kitchen, CK 2 was placing lunch plates in the lunch cart during trayline. When CK 2 completed with placing the lunch plates in the trays with station 1's lunch cart, she touched doorknob to open the door and pushed the cart to outside with gloves on. CK 2 grabbed the doorknob again to close the door. After closing the door, CK 2 did not wash her hands and did not change her gloves and touched the stations 2 resident's tray. CK 2 stated, she should have washed her hands between the tasks and touching different surfaces to prevent spreading infection and cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). CK 2 stated, she

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| F 812 | Continued From page 34<br>should have performed hand hygiene and changed her gloves between the tasks to prevent cross contamination.<br><br>During an interview on 5/30/2025, at 4:08 p.m., with Director of Nursing (DON), DON stated, all staff should perform hand hygiene between tasks to prevent cross contamination and protect vulnerable residents from infections.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, "Food Safety and Food Storage", revised 11/4/2024, the P&P indicated, "Policy Explanation and Compliance Guidelines:6. Staff should wash hands prior to handling clean dishes, and shall handle them by outside surfaces. 7. Staff shall adhere to safe hygienic practices to prevent contamination of food from hands of physical objects."<br><br>During a review of the facility's Policy and Procedure (P&P) titled, "Hand Hygiene", revised 12/19/2022, the P&P indicated, "Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors ... Policy Explanation and Compliance Guidelines: 6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. | F 812 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | F880 – Infection Control Program<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice; | 06/20/25 |

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| F 880 | Continued From page 35<br>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and | F 880 | - On 6/2/25, the Infection Prevention Nurse (IPN) initiated the reporting of COVID-19 outbreak to California Department of Public Health (CDPH). Exhibit #27)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- Not applicable<br><br>• What measures put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- On 6/2/25, the Director of Nursing (DON) provided one on one in service to the IPN regarding the facility policy and procedure entitled, "Infection Outbreak Response an Investigation," dated 12/19/2022. (Exhibit #28)<br><br>- Starting on 6/2/25, the IPN will review the number of cases daily until the outbreak is over and report to CDPH accordingly.<br><br>- Beginning on 6/2/25, the IPN will report to the CDPH the COVID-19 outbreak.<br><br>- On 6/13/25, the IPN received Respiratory Illness Outbreak clearance letter. (Exhibit #29) | |

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| F 880 | Continued From page 36<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to report the outbreak (urgent emergencies accompanied by rapid efforts to save lives and prevent further cases) of corona virus- 19 (COVID-19, a highly contagious infection, caused by a virus that can easily spread from person to person) to the State Agency (CDPH, California Department of Public Health) starting on 5/14/2025 for six out of six sampled Residents (Resident 12, Resident 30, Resident 37, Resident 40, Resident 44, and Resident 45). | F 880 | How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The IPN will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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| F 880 | Continued From page 37 | F 880 | | |

These deficient practices had the potential for continued spread of the COVID-19 infection to all the facility's residents and staff.

Findings:

1. During a review of Resident 12's Admission Record (Face Sheet), the Admission Record indicated Resident 12 was admitted to the facility 1/2/2025 with diagnoses of pneumonia (infection in the lungs), and neoplasm of the prostate (prostate cancer).

During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 12 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment.

During a review of Resident 12's Lab Results Report dated 5/14/2025, the report indicated Resident 12 tested positive for COVID-19 on 5/14/2025.

2. During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility 1/28/2025 with diagnoses of paroxysmal atrial fibrillation (a rapid and irregular heartbeat), coronary artery disease (CAD, a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), and congestive heart failure (CHF, a serious condition in which the heart doesn't pump blood as efficiently as it should).

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| F 880 | Continued From page 38<br>During a review of Resident 45's MDS dated 4/30/2025, the MDS indicated Resident 45 was cognitively intact.<br><br>During a review of Resident 45's Change of Condition (COC) assessment dated 5/23/2025, the COC indicated Resident 45 tested positive for COVID-19 on 5/23/2025.<br><br>3. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility 2/21/2025 with diagnoses of stage 4 kidney disease (severe loss of kidney function) and lupus (An illness that occurs when the immune system attacks healthy tissues and organs).<br><br>During a review of Resident 37's MDS dated 5/27/2025, the MDS indicated Resident 37 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment.<br><br>During a review of Resident 37's Lab Results Report dated 5/18/2025, the report indicated Resident 37 tested positive for COVID-19 on 5/18/2025.<br><br>4. During a review of Resident 30's Admission Record, the Admission record indicated Resident 30 was admitted to the facility 3/31/2025 with diagnoses of hypertension (high blood pressure) and neoplasm of the cecum (colon cancer).<br><br>During a review of Resident of Resident 30's MDS dated 4/7/2025, the MDS indicated Resident 30 was cognitively intact. | F 880 | | |

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| F 880 | Continued From page 39<br><br>During a review of Resident 30's Lab Results Report dated 5/14/2025, the report indicated Resident 30 tested positive for COVID-19 on 5/14/2025.<br><br>5. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on 3/31/2025 with diagnoses of bronchitis (Inflammation of the lining of bronchial tubes (carry air to and from the lungs)) and morbid obesity (overweight).<br><br>During a review of Resident 44's MDS dated 4/7/2025, the MDS indicated Resident 44 had moderate cognitive impairment.<br><br>During a review of Resident 44's Lab Results Report dated 5/14/2025, the report indicated Resident 44 tested positive for COVID-19 on 5/14/2025.<br>6. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility 4/23/2025 with diagnoses of hyponatremia (low salt).<br><br>During a review of Resident 40's MDS dated 4/28/2025, the MDS indicated Resident 40 had moderate cognitive impairment.<br><br>During a review of Resident 40's Lab Results Report dated 5/20/2025, the report indicated Resident 40 tested positive for COVID-19 on 5/20/2025.<br><br>During an interview on 5/29/2025 at 1:52 p.m., | F 880 | | |

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| F 880 | Continued From page 40<br>the infection prevention nurse (IPN) stated the outbreak for COVID-19 began 5/14/2025 with 3 Residents testing positive. The IPN stated she reported to the Los Angeles County Department of Public Health (Local Agency) and the Centers of Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN, federal system) but not to the State Agency. The IPN stated she thought when she reported the outbreak to the Local Agency it reported it to the State Agency as well.<br><br>During an interview on 5/30/2025 at 4:09 p.m., the Director of Nursing (DON) stated COVID-19 was a reportable disease. The DON stated she was not aware the State Agency was not informed of an outbreak if the outbreak is only reported to the Local Agency. The DON reviewed the All Facilities Letter (AFL, a letter from the State Agency's Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C. The information contained in the AFL may include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) 23-08 and now understood outbreaks had to be reported to the Local Agency as well as the State Agency.<br><br>During a review of AFL 23-08 dated 1/18/2023, the AFL indicated COVID-19 outbreaks were considered an unusual infection occurrence facilities needed to report outbreaks and unusual infectious disease occurrences to the local public health officer and their respective District Office (DO, State Agency).<br><br>A review of the facility's policy and procedure | F 880 | | |

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| F 880 | Continued From page 41<br>(P/P) titled "Infection Outbreak Response and Investigation" dated 12/19/2022, the P/P indicated an outbreak was to be reported to the local and/ or state health departments in accordance with the state's reportable diseases website. | F 880 | | |
| F 881 SS=E | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to implement their policy and procedure (P/P) for Antibiotic Stewardship (the effort to measure and improve how antibiotics (a medication used to kill bacteria and to treat infections) are prescribed by clinicians and used by patients) for two of five sampled residents (Resident 43 and Resident 154) who were prescribed antibiotics without meeting criteria.<br><br>This deficient practice had the potential for Resident 43 and Resident 154 to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use.<br><br>Findings: | F 881 | F881 – Antibiotic Stewardship Program<br><br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>- On 5/2925, the Infection Prevention Nurse (IPN) reviewed the antibiotic stewardship for Resident 43 and 154 and notified the MD. (Exhibit #30)<br><br>• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- On 6/2/25, the IPN reviewed the list of residents on antibiotics, checked if the residents met McGeer's criteria and if the physician were notified for the antibiotic time out. (Exhibit #31)<br><br>- No other resident was affected of the same deficient practice.<br><br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; | 06/20/25 |

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| F 881 | Continued From page 42<br>During a review of Resident 43's Admission Record (Face Sheet), the Admission Record indicated Resident 43 was admitted to the facility on 12/9/2024 with diagnoses of type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with a foot ulcer (wound), osteomyelitis (bone infection), and complete amputation (removal) of the right foot at the ankle level.<br><br>During a review of Resident 43's minimum data set (MDS, a resident assessment tool) dated 2/15/2025, the MDS indicated Resident 43 was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact.<br><br>During a review of Resident 43's Order Summary Report, the Order Summary Report indicated an order was placed 5/3/2025 for Piperacillin Sod-Tazobactam (a medication used to treat infections) Solution Reconstituted 3-0.375 grams (gm, a unit of measurement) intravenously (administered in the vein) three times a day.<br><br>During a review Resident 43's Infection Screening Evaluation dated 5/3/2025, the Infection Screening indicated Resident 43's symptoms did not meet McGeer's (is for defining true infection) criteria.<br>During a review of Resident 43's Antibiotic Time Out dated 5/5/2025, the Antibiotic Time Out form done for the use od Piperacillin did not indicate Resident 43's physician was notified that McGeer's criteria was not met for Resident 43.<br><br>During a review of Resident 154's Admission Record, the Admission Record indicated | F 881 | - On 6/2/25, the Director of Nursing (DON) provided one on one in service to the IPN regarding the facility policy and procedure entitled, "Antibiotic Stewardship Program" dated 12/2022. (Exhibit #32)<br><br>- Starting on 6/1725, the IPN provided in-service to the active licensed nurses regarding the policy and procedure entitled, "Antibiotic Stewardship Program" dated 12/2022. (Exhibit #33)<br><br>- Beginning on 6/17/25, the DON will review the Antibiotic Stewardship Program weekly for three months to ensure the physicians were notified if there is an antibiotic time out. (Exhibit #34)<br><br>- Starting on 6/17/25, the IPN will report to the administrator for any non-compliance<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- The IPN will discuss any trends or patterns during the monthly QA committee meeting for three months for review and recommendation and will re-evaluate if any further concerns identified after.<br><br>• Date of completion: June 20, 2025 | |

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|---|---|---|---|
| | 055758 | A. BUILDING _____ B. WING _____ | 05/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 881 | Continued From page 43<br>Resident 154 was admitted to the facility 5/24/2025 with diagnoses of acute kidney failure (AKF) and urinary tract infection (UTI, infection of the system of organs that make urine).<br><br>During a review of Resident 154's medical record, the history and physical and MDS had yet to be completed.<br><br>During a review of Resident 154's Physician's Orders, an order was placed 5/24/2025 for Ciprofloxacin HCL (medication used to treat infection) Oral tablet 500 milligrams (mg, a unit of measurement), give by mouth once daily for UTI until 5/29/2025.<br><br>During a review of Resident 154's Infection Screening Evaluation dated 5/24/2025, the Infection Screening indicated Resident 154 did not meet McGeer's criteria.<br><br>During an interview on 5/29/2025 at 1:52 p.m., the infection preventionist nurse (IPN) stated she Reviewed Resident 43's Infection Screening Evaluation dated 5/3/2205 and Resident 154's Infection Screening Evaluation dated 5/24/2025, the IPN stated neither Resident 43 nor Resident 154 met McGreer's criteria. The IPN stated Resident 43's Antibiotic Time out dated 5/5/2025 did not indicate the physician was notified Resident 43 did not meet McGreer's criteria. The IPN stated she was not aware Resident 154 had been taking antibiotics and the Antibiotic Time Out had not been done for the usage of Ciprofloxacin. The IPN stated the Antibiotic Time Out should be completed within 48 hours of the start of an antibiotic. The IPN stated it was important to review antibiotics as soon as | F 881 | | |

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| F 881 | Continued From page 44<br>possible and while the antibiotic was still active to ensure the resident needed the antibiotic and they were receiving the correct antibiotic. The IPN stated the physician needed to be informed that a resident did not meet criteria for antibiotic usage and if the physician still chose to continue the antibiotics, the conversation needed to be documented in the resident's chart.<br><br>During an interview on 5/29/2025 at 4:09 p.m., the director of nursing (DON) stated the potential outcome of antibiotic stewardship not being done correctly or in a timely manner was the resident could become resistant to the antibiotic if the antibiotic was not necessary.<br><br>During a review of the facility's policy and procedure (P/P) titled "Antibiotic Stewardship Program" dated 12/2022, the P/P indicated the purpose of the antibiotic stewardship program was to optimize the treatment of infections while reducing adverse events associated with antibiotic use. The P/P indicated the facility used McGeer criteria to define infections. The P/P indicated education regarding antibiotic stewardship program shall be provided to facility staff, prescribing practitioners, residents, and families. | F 881 | | |
| F 912 SS=B | Bedrooms Measure at Least 80 Sq Ft/Resident<br>CFR(s): 483.90(e)(1)(ii)<br><br>§483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by:<br>Based on observation , interview and record review the facility failed to ensure 33of 33 | F 912 | F912 Bedrooms Measure at Least 80 Sq Ft/Resident<br>• How Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>- On 6/19/25, the facility submitted a formal request for recognition of variation of room space for recertification. (Exhibit #38) | 06/20/25 |

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| F 912 | Continued From page 45<br>Residents room requirements of 80 square feet (sq.ft - a unit of area measurement ) per residents in multi-bed resident rooms were implemented.<br><br>This deficient practice had the potential to result in inadequate provision of safe nursing care, and privacy for the residents.<br><br>Findings :<br><br>During a review the facility's Client Accommodation Analysis form provided by the facility on 5/27/2025 the facility had 33 rooms that measured less than 80 sq.ft per resident in multi-resident bedrooms and two rooms that measured less than 100 sq.ft for a single bedroom. The resident rooms were as follows:<br><br>Room 1 (2) beds 143.75 sq.ft.<br>Room 2 (2) beds 143.75 sq.ft.<br>Room 3 (2) beds 143.74 sq.ft<br>Room 4 (2) beds 143.75 sq.ft.<br>Room 5 (2) beds 143.75 sq.ft.<br>Room 6 (2) beds 143.75 sq.ft.<br>Room 7 (2) 143.75 sq.ft.<br>Room 8 (2) 143,75 sq.ft<br>Room 9 (2) 143.75 sq.ft.<br>Room 10 (2) 143.75 sq.ft.<br>Room 11 (2) 143.75 sq.ft.<br>Room 12 (2) 143.75 sq.ft.<br>Room 13 (2) 143.75 sq.ft.<br>Room 14 (2) 143.75.sq.ft<br>Room 15 (2) 143.75 sq.ft<br>Room 16 (2) 143.75 sq.ft.<br>Room 17 (2) 143.75.sq.ft.<br>Room 18 (2) 143.75 sq.ft. | F 912 | • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;<br><br>- All residents has the potential to be affected by the deficient practice.<br>• What measures were put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;<br><br>- Social Services Director will monitor residents for comfort and offer recommendations or alternatives if needed, upon admission, room change, quarterly after admission and annually after admission and as needed.<br><br>• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;<br><br>- Administrator will report findings and trends to QA committee meeting on a monthly basis for 3 months then quarterly thereafter.<br><br>• Date of completion: June 20, 2025 | |

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| F 912 | Continued From page 46<br>Room 19 (2) 143.75.sq.ft.<br>Room 20 (2) 143.75 sq.ft.<br>Room 21 (2) 143.75 sq.ft.<br>Room 22 (2) 143.75 sq.ft.<br>Room 23 (2) 143.75.sq.ft.<br>Room 24 (2) 143.75.sq.ft.<br>Room 25 (2) 143.75 sq.ft<br>Room 26 (2) 143.75 sq,Ft.<br>Room 27 (2) 143.75 sq.ft.<br>Room 28 (2) 143.75 sq.ft.<br>Room 29 (2) 143.75 sq.ft.<br>Room 30 (2) 143.75 sq.ft<br>Room 31 (2) 143.75 sq.ft<br>Room 32 (2) 143.75.sq.ft<br>Room 33 (2) 143.75 sq.ft.<br>Room 34 ( 3) 220 sq.ft.<br><br>During an interview on 5/30/2025 with the Maintenance Director (MS), the MS stated he was aware the room sizes were smalerl than required. The MS stated he has had no residents complaining they do not have enough room or that the rooms were too small. The MS stated the nurses do not complain the rooms are too small.<br><br>During an interview on 5/2025 with the Administrator (ADM), the ADM stated she was aware the room sizes needed to be at least 160 square feet per resident in multiple resident's rooms . The ADM stated she had no complaints from residents or staff indicating the rooms were too small. The ADM stated she has an approved room waiver dated 2025.<br><br>During a review of the facility's room waiver letter dated 2025, the room waiver letter indicated, it was approved on 2025. | F 912 | | |

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| F 912 | Continued From page 47<br>During an observation and interview on 5/27/2025 through 5/30/2025 , the residents residing in their rooms had enough space to move freely inside the rooms . Each resident in the above rooms had beds and side tables with drawer. There was adequate room for the operation and use of walkers canes, wheelchairs and shower chairs. Residents room size did not affect the nursing care or privacy provided to the residents.<br><br>During a review of the facility's policy and procedures(P&P) titled , "Residents Rooms" revised 12/2/2024 the P&P indicated residents bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in single resident bedrooms. | F 912 | | |